TRANSCRIPT OF PROCEEDINGS

INQUIRY INTO THE COVID-19 HOTEL QUARANTINE PROGRAM

BOARD: THE HONOURABLE JENNIFER COATE AO

DAY 18

10.00 AM, WEDNESDAY, 16 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

MR D. STAR QC appears with MS J. DAVIDSON, MR T. GOODWIN and MR J. HARTLEY for the Chief Commissioner of Victoria Police

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

MS S. McNICOL QC appears with MR E. NEKVAPIL and MR D. PORTEOUS for the Minister for Police and Emergency Services

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

MR A. WOODS appears for Rydges Hotels Ltd

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

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

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

CHAIR: Good morning, Mr Ihle.

MR IHLE: Good morning, Madam Chair.

CHAIR: Ready to proceed?

MR IHLE: We are. The first witness this morning will be Professor Sutton. But prior to having him be sworn in or take the affirmation, I'll tender a statement of a witness who won't be called. That's the statement of Jacinda de Witts, a Deputy Secretary of the Department of Health and Human Services, formerly the Deputy Secretary of the COVID-19 Response. Her statement is DHS.9999.0016.001_R, so I tender that document.

CHAIR: Exhibit 151.

EXHIBIT #151 - STATEMENT OF JACINDA DE WITTS

MR IHLE: And, Madam Chair, as with the other statements, there's a number of documents referred to in that statement, and I tender them as a bundle.

CHAIR: That bundle will be marked Exhibit 152.

EXHIBIT #152 - ANNEXURES TO STATEMENT OF JACINDA DE WITTS

MR IHLE: If the Board pleases.

There are no other matters prior to commencing with the witness, so I call Professor Brett Sutton.

CHAIR: Good morning, Professor Sutton.

PROF SUTTON: Good morning, Madam Chair.

CHAIR: I'm sure you've had explained to you that for the purposes of giving your evidence you need to take a solemn promise and I understand you wish to take the affirmation.

PROF SUTTON: That's correct.

CHAIR: So I'll ask my Associate to take you through that. Thanks, Madam Associate.

PROFESSOR BRETT ANDREW SUTTON, AFFIRMED

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

MR IHLE: Thanks, Madam Chair.

EXAMINATION BY MR IHLE

MR IHLE: Good morning, Professor.

A. Good morning, Mr Ihle.

Q. Can we start with your full name, please.

A. Brett Andrew Sutton.

Q. And you are a Professor of Medicine?

A. I'm a professor at Monash University in the Department of Public Health, and, yes, I'm a public health physician.

Q. Thank you. You're also Victoria's Chief Health Officer?

A. That's correct.

Q. And that's a position you have held since March of last year?

A. Yes, substantively.

Q. And you also hold the position of Victoria's Chief Human Biosecurity Officer?

A. That's right.

Q. Thank you. You've provided a statement to this Inquiry in response to a number of questions that were posed to you?

A. Correct.

Q. That's a statement dated 13 August of this year?

A. I believe so.

Q. It comprises some 48 pages and then there's an attachment as well, but the

substantive content of the statement is 48 pages long?

A. That's correct.

Q. Are the contents of the statement truthful and accurate?

A. Yes.

Q. I tender the statement of Professor Sutton dated 13 August, Madam Chair.

CHAIR: Exhibit 153.

MR IHLE: If the Board pleases.

EXHIBIT #153 - STATEMENT OF PROFESSOR BRETT ANDREW SUTTON

MR IHLE: I referred just a moment ago to an attachment to that statement, Professor. That's a list of directions made from 16 March through till 3 August.

A. Correct.

Q. Are the contents of that list both truthful and accurate?

A. To the best of my knowledge, yes.

Q. Thank you. I tender the attachment to the statement of Professor Sutton, being the list of directions from 16 March to 3 August inclusive, Madam Chair.

CHAIR: Exhibit 154.

EXHIBIT #154 - ATTACHMENT TO STATEMENT OF PROFESSOR BRETT ANDREW SUTTON – LIST OF DIRECTIONS TO 3 AUGUST 2020

MR IHLE: As the Board pleases.

Professor, finally in relation to the documents you tender, there are a number of other documents referred to in the body of your statement; is that right?

A. That's correct.

Q. And they're documents that you've had reference to in the preparation of your statement and documents that you seek the Board have before it, to read the answers

you have provided in full context?

A. That's correct.

Q. I tender as a bundle, Madam Chair, those documents referred to in the statement of Professor Sutton.

CHAIR: Exhibit 155.

EXHIBIT #155 - ANNEXURES TO STATEMENT OF PROFESSOR BRETT ANDREW SUTTON

MR IHLE: As the Board pleases.

Professor, can I just ask you to briefly outline your role as Chief Health Officer of Victoria? What does it involve?

A. Essentially it's an expert advisory position to Government on matters of health protection or public health, classically issues of food safety, environmental health and safety and communicable disease control and prevention. It's also a statutory position that holds powers delegated to me by the Secretary of the Department of Health and Human Services under the *Public Health and Wellbeing Act* that are broadly for the protection of the health and wellbeing of the Victorian population. And I'm also represented nationally in the Australian Health Protection Principal Committee with all other Chief Health Officers, Chief Preventative Health Officers or Directors of Public Health in that committee chaired by the Chief Medical Officer and I'm represented in other national bodies, such as the NHMRC Council, and I provide policy and strategic advice on matters of public health more generally, and I am a spokesperson on matters of public health when appropriate for the Department.

Q. Thank you. Can I just ask you, then, in a business-as-usual model --- if there's such a thing for a Chief Health Officer, let's say when we're not in a pandemic or State of Disaster or emergency --- can you explain your reporting lines? Who reports to you and who do you report to?

A. Certainly prior to the COVID-19 pandemic, I was reported to by two Deputy Chief Health Officers, Deputy Chief Health Officer for communicable diseases with a portfolio across a number of areas relevant to communicable disease, including the immunisation team, communicable disease prevention and control, communicable disease epidemiology and surveillance, the Department's notification and support unit with regard to sexually transmitted infections and a Public Health Medical Unit consisting of senior medical advisers, often public health physicians, also a Deputy Chief Health Officer - Environment who covered a portfolio of broad environmental health risks and regulation and compliance matters, but was as diverse as

legionnaire's disease in cooling towers, radiation management, pest control, environmental health risk management and food safety, in the broader sense of managing the risk of food-borne outbreaks in particular but also support to Local Government in their enforcement of matters related to food safety.

There was also a position of business support unit that gave broad support to the branch in support of all my functions.

Q. In that business-as-usual model, if we can call it that, to whom do you report?

A. To the Deputy Secretary of Regulation, Health Protection and Emergency Management.

Q. And that position is currently held by Ms Skilbeck; is that right?

A. That's correct.

Q. And then when we move into the COVID-19-specific era, did your line of report --- that is, who you report to --- change at some time?

A. It did. We stood up a command and control structure, an Incident Management Team, and so my direct reports changed in the sense that I was supervisor for the Public Health Commander and whomever was in that role through that period. I remained reporting to Melissa Skilbeck, but at some point Jacinda de Witts provided support to that response, and then I formally reported to her as a Deputy Secretary role across COVID division.

Q. During that period, did you have two lines of report, one to Ms Skilbeck, one to Ms de Witts, or did it all consolidate into Ms de Witts?

A. No, it remained a dual reporting line.

Q. And why was that?

A. Essentially because the business-as-usual functions continued and my statutory obligations to protect the health and wellbeing of Victorians across that broader portfolio continued. And even though there was a pretty substantial delegation to the Deputy Chief Health Officer - Environment and an Acting Deputy Chief Health Officer for communicable disease, so that I didn't have to spend enormous amounts of my day on the details of all of those other business-as-usual incidents and activities, I was still accountable in that sense and I did need to maintain that line of accountability to the Deputy Secretary of that division.

Q. Yes. So if we look at the structure of the portfolio of health, if we can call it that, we have the Minister of Health?

A. Correct.

Q. We have the Secretary of the Department of Health and Human Services?

A. Yes.

Q. Below the Secretary, we have a number of Deputy Secretaries, and you've identified two of those positions that you report to through the COVID-19 response.

A. That's correct.

Q. Are you aware of the structure in other states of other relevant Chief Health Officers and who they directly report to?

A. Not in full. But I understand that Queensland and New South Wales have Chief Health Officers who are more akin to a Deputy Secretary level and report to a Secretary, I believe.

Q. Yes. In Ms de Witts' statement, a document which has just been tendered as an exhibit in this proceeding, Ms de Witts describes her role as the Deputy Secretary of COVID-19 Public Health Division as providing yourself and the Public Health Command operationally with executive functions. That's at paragraph 9. Can you describe, at least from your perspective, what that means?

A. Effectively it was representing work and ensuring that the issues that arose that required executive awareness and action at the executive board level of DHHS or reporting through to the Secretary were facilitated by Ms de Witts and, you know, providing the overarching coordination of the activities of a very large workforce that had been in a command and control structure, but that was growing, that was complex and that was likely to require a sustained response over several months and potentially, you know, well into 2021. And so it was to try and bring a more sustained, almost bureaucratic structure to that command and control structure that had brought in people from various other divisions of the Department, but also staff from Safer Care Victoria, a number of seconded individuals from other academic institutions and other agencies. And so it was to really give the oversight to come of the bureaucratic requirements administratively and organisationally to that rather large beast.

Q. Yes. Ms de Witts also identifies in her statement that you and your team --- first of all, is it correct to call the Public Health Command part of your team?

A. Public Health Incident Management Team or Public Health Command, yes, that's fair.

Q. One of the functions of your team, indeed the primary function of your team, is to provide advice to the Government. Is that fair?

A. Yes, it is.

Q. And Ms de Witts says that, notwithstanding your reporting to her in respect of that advice, specifically on COVID-19, that she didn't really have a role in approving that advice?

A. That's a fair statement.

Q. Yes. So is she merely a conduit through whom that advice travels up to the particular level?

A. Not merely a conduit, but yes, she was a point of liaison for that advice into the Department, although there were other direct mechanisms for that advice to occur, for me to raise issues with the Minister directly. We had a number of other meetings where Ms de Witts was not present and not required to be present for that policy or strategic advice to be provided to the Secretary or to the Minister's office.

Q. Now, the types of advice we're discussing covered a range of topics, did it not?

A. It did.

Q. It included infection prevention and control advice?

A. Not so much to the Minister or advice to the Secretary on those matters. They were operationally managed within the Public Health Incident Management Team. But they were broad areas of responsibility.

Q. Did the advice that came out of the Public Health Command or the Public Health Incident Management Team include from time to time advice on the use of personal protective equipment?

A. Again, yes, they were matters that the Public Health Incident Management Team landed and developed policy guidance on for various purposes in non-healthcare settings and healthcare settings.

Q. And cleaning in both of those settings as well?

A. Yes, they would have.

Q. And you say, Professor, at paragraph 143, first of all, that notwithstanding you've provided this advice, that --- and this is the quote from 143:

> *My team and I did not have oversight in relation to [IPC] personnel and processes in place at each hotel.*

I just want to unpack that for a moment in the context of the advice and policies we've just been talking about. Are you saying there that although the Public Health Command prepares these advices and policies, they're then deployed into the system

at large --- and we're going to come specifically to the system specifically in respect of hotel quarantine --- but your team doesn't have oversight into how those policies are being proliferated and whether and how they're being complied with?

A. Yes, I think that's a fair statement. We were providing advice through the infection prevention and control cell within the Public Health Incident Management Team to innumerable settings across the state, from public transport settings to residential settings to various other settings, and so oversighting how that guidance or policy direction was implemented across the State in all of those settings was not part of our purview.

Q. Coming specifically now to hotel quarantine. We know and have been taken to a number of policies that came out of your team about the use of PPE. I think you referred to the use of PPE in non-healthcare settings, cleaning, those types of matters. And acknowledging that your team didn't have oversight in it, it's the case, isn't it, as you've stated at paragraph 144, that until the outbreak, and specifically Rydges and Stamford, you were "not aware of the sufficiency of the infection control processes in place"?

A. That's correct.

Q. So these policies are drafted by your team. They're then sent to whoever needs to proliferate them down to the people on the ground and your team's not aware, at least until the outbreak, as to the level of compliance or otherwise?

A. That's correct.

Q. I want to turn briefly, if I may, Professor, to your role as the Human Biosecurity Officer of Victoria. That's a role that you hold in addition to your role as the Chief Health Officer?

A. That's correct.

Q. That's a role, Human Biosecurity Officer, which exists not under Victorian legislation but under Commonwealth legislation?

A. That's correct.

Q. In your experience, is it usual that the Chief Health Officer or Chief Medical Officer of a State or Territory holds that dual commission, one as Chief Health Officer and also as the Human Biosecurity Officer?

A. It's neither uncommon nor common. About half of the Chief Health Officers, I think, across Australia might hold that role as well. But it's often held by the lead for communicable disease within those jurisdictions, so a level down, if you like. So the Director of Communicable Disease Control within a jurisdiction or a Deputy Chief Health Officer position for communicable diseases would not infrequently

hold that position instead of the Chief Health Officer.

Q. And the legislation which governs the function and power of the Human Biosecurity Officer of a particular State is the Commonwealth *Biosecurity Act 2015*?

A. That's correct.

Q. And, broadly speaking --- this is not a law exam, but broadly speaking --- you're familiar with the powers that exist under that Act?

A. I am.

Q. You would agree then, wouldn't you, Professor, that under section 60 of that Act officials can make a number of orders pursuant to the powers vested by that Act?

A. Yes.

Q. And they are orders or powers that can be exercised in respect of individuals who are suspected of having the symptoms of a listed human disease?

A. Yes.

Q. Or in relation to individuals who are suspected of being exposed to persons who have those symptoms?

A. Correct.

Q. "Listed human disease" is a term of art under that Act. Are you able to assist us as to whether COVID-19 is a listed human disease?

A. It is a listed human disease. There's a listed human disease designation of coronavirus with human pandemic potential and so it would fall under that specific designation if it's not otherwise specifically listed.

Q. And that general designation of human coronavirus with pandemic potential was a listed human disease long before we actually saw this virus, wasn't it?

A. It was, on the basis of the experience of SARS, even the experience of MERS, that human-to-human transmission with these coronaviruses occurs, the disease is very severe, and that therefore, even if a pandemic hasn't occurred, the potential is there.

Q. And the powers that vest firstly within you as the Human Biosecurity Officer, but indeed others --- we have Chief Human Biosecurity Officers, Human Biosecurity Officers and Biosecurity Officers, a cascading sort of sequence of positions?

A. Yes, although it's fair to say that the Chief Human Biosecurity Officer in any

jurisdiction doesn't have different powers to Human Biosecurity Officers in general. There's a title that is held, so that there's a go-to person, if you like, as the Chief Human Biosecurity Officer, and therefore coming together with other CHBOs in national fora to discuss human biosecurity matters. But in terms of the exercise of those powers under the *Biosecurity Act*, it's the same for all biosecurity officers.

Q. Yes, thank you. And those powers include --- well, first of all, those powers exist irrespective of whether a State of Emergency or State of Disaster has been declared, don't they?

A. They do.

Q. And those powers include requiring an individual to provide contact information?

A. Yes.

Q. Requiring an individual to provide health details?

A. Correct.

Q. Restricting the behaviour of an individual?

A. Potentially, yes.

Q. Requiring individuals to undergo risk minimisation intervention, including decontamination and/or medical treatment?

A. Yes.

Q. Or requiring individuals to accept isolation from the community for a specified period?

A. Correct.

Q. In your role as Human Biosecurity Officer for the State of Victoria, did you ever consider utilising any of these powers --- that is, under the Commonwealth legislation --- in respect of the COVID-19 response?

A. Certainly I had consideration of what role the *Biosecurity Act* might play with respect to individuals travelling internationally and arriving in Victoria. I think one of the issues with the *Biosecurity Act* is that it has always been applied with respect to individuals arriving and with regard to the assessment of those individuals and their risk to the community. And the orders and the powers that apply in those orders, that you've elucidated, are really for the purpose of managing that individual who might be a risk by virtue of having a listed human disease or being suspected of having that listed human disease and is not historically, and as far as I know in any other jurisdiction in Australia, applied to a class of persons more broadly for the

purpose of the *Biosecurity Act*.

Q. If I can understand that answer, and excuse me if I'm oversimplifying it, but is that a way of saying that the *Biosecurity Act* or the powers under the *Biosecurity Act* are not particularly well tailored for a situation where you're dealing with a lot of people and need to make orders in respect of a lot of people?

A. I think that's fair to say. And certainly my understanding, the intention of the *Biosecurity Act* is to manage the risk of importation of serious diseases, listed human diseases, at ports of entry in Australia, with the Human Biosecurity Officers having a role on behalf of the Commonwealth to manage them at that point of entry, and that the exercise of those powers would effectively be meeting them at that point of entry and then managing that risk there, including referral to hospital or referral to an isolation ward until such risk has passed, and not the management of those individuals when they have already entered a jurisdiction and are within a community more broadly.

It's not out of the question, as far as I understand it, but it's never been spoken of as a routine application of those powers amongst Chief Human Biosecurity Officers.

Q. I asked you the question first of all in the general sense, whether you considered using those powers during the COVID-19 response. Specifically when the issue of the Hotel Quarantine Program arose and that was directed to people that were entering the country from overseas, did that enliven some consideration of the *Biosecurity Act* powers?

A. It did. But again, to the extent that the more usual application of powers would be under Victoria's own public health and wellbeing powers which had been drafted with consideration of managing pandemics and, you know, this particular risk, I think the legal view presented to me was that it was the application of the *Public Health and Wellbeing Act* powers that were more appropriate in this setting.

Q. Just so that I can understand that, we have two suites of powers, both that vest largely in you: one as the Human Biosecurity Officer under the Commonwealth legislation, those powers include the ability to direct people into isolation for specified periods; on the other hand, powers that vest in you as the Chief Health Officer --- and we'll come to those specifically in a moment --- but in the context of a State of Emergency being declared, that includes authorising authorised officers to exercise those public health risk powers in section 200.

A. That's correct.

Q. And is your evidence to the Board that that latter category --- that is, the powers under the *Public Health and Wellbeing Act* --- are better suited to the situation that was faced in respect of COVID-19 and specifically the Hotel Quarantine Program?

A. Again, not being a lawyer, it's my view that the *Public Health and Wellbeing Act*

specifically had in mind the scenarios of pandemics. It was drafted with knowledge that Australia had gone through pandemics in the last century where such powers might need to be utilised and had had a design that enabled the exercise of some of those necessary or potentially necessary powers to manage pandemic risk.

Q. Thank you. Let's move to those powers in more specific detail. Under the *Public Health and Wellbeing Act*, there is a range of powers. First of all, there's those ones we've touched on. They're the section 200 powers that vest in the authorised officers pursuant to an authorisation conferred by yourself as Chief Health Officer.

A. Yes.

Q. You describe those powers in paragraph 12(d) of your statement as "coercive emergency powers".

A. Correct.

Q. Can you explain --- perhaps it's self-evident, but can you explain --- what you mean by "coercive" in that context?

A. In the sense that those powers enable an authorised officer, orally or in writing, to exercise the powers under the State of Emergency that can include detaining persons for a reasonable period of time in order to manage the risk specifically of transmission of coronavirus in this pandemic or restricting the movement of people within an area. That's less relevant in this setting, but it does refer to circumstances where you might have what's called a cordon sanitaire that applies to a well-defined geographical area where you don't want the movement of people in or out because the transmission of illness is thought to be entirely within that area. But the detaining of people are essentially the reference to those coercive powers.

Q. I just want to seize upon the adjective "coercive" in that context. "Coercive" means, and you intend it to mean, "the ability to do something in respect of a person irrespective of or even against their will".

A. That's correct.

Q. You can force someone to do something even if they don't want to do it?

A. That's correct.

Q. You also identify in paragraph 12(b) a number of coercive powers --- again, you've used the adjective "coercive" --- that vest in your office as Chief Health Officer under the *Public Health and Wellbeing Act*?

A. That's right.

Q. The powers you referred to at 12(b), as opposed to 12(d), they are powers that

subsist in your office, irrespective of a State of Emergency having been declared, aren't they?

A. That's right.

Q. So they're powers that you as the Chief Health Officer hold as long as you hold the office of Chief Health Officer?

A. That's right.

Q. And that includes the power at section 113 of the *Public Health and Wellbeing Act* to order coercive examination or testing of a person?

A. That's right.

Q. And in section 117, we see powers that are broadly reflective of those under the *Biosecurity Act*. That includes, for example, refraining people from certain behaviours?

A. Yes.

Q. Orders that restrict or prohibit people from engaging in particular activities?

A. Correct.

Q. Powers requiring people to reside at a particular premises?

A. Correct.

Q. To submit to supervision?

A. Yes.

Q. And to submit to isolation from the community or even detention?

A. Correct.

Q. It also includes a power --- that is, these coercive powers that exist notwithstanding there being no State of Emergency --- the power to direct a person to provide truthful information?

A. Correct.

Q. Now, those powers that we've just gone through --- 113, 117, 188 --- did you consider using any of those powers in respect of the COVID-19 response?

A. I didn't. They have, again routinely --- not routinely, but they have historically ---

been used from time to time for individual persons for those issues. They relate to infectious diseases and some other settings such as with respect to food safety, where directing individuals or directing premises is warranted on an individual basis. Testing orders, for example, might be applied if a healthcare worker has been exposed to a needlestick injury and you want to know the status with respect to infectious diseases, hepatitis B or C or HIV, of the person whose blood was in the syringe who was involved in that needlestick injury. And if that information is not forthcoming and if you think it's appropriate and proportionate to make sure that person is tested to find out, then those orders can be applied in that instance. So that's an example.

There are some examples, again, where someone with an infectious disease is putting others at risk by virtue of their behaviour, sexual behaviours or other behaviours, where the risk to other people is so grave that you either provide a letter of warning or that you give direction to constrain their activities; and, again, those have been applied infrequently but historically for individual persons.

Q. You say that those powers have routinely or historically been used in those types of cases. Are you aware of any reason as to why they could not have been used in response to, say, for example, contact tracing efforts?

A. Again, not being a lawyer, I don't know exactly why those powers, which are clearly the powers that are being used with respect to contact tracing --- well, they're not enforced in contact tracing, contact tracing is overwhelmingly done through a voluntary and cooperative engagement with cases in close contact, but they are available and if they were felt to be required, I wouldn't discount them from being used, including for ensuring the provision of appropriate information or to direct people to behave appropriately. But for a class of persons across an entire State, the use of those individual public health orders is impractical.

Q. So you say that they are available, but is it the case that you haven't considered using them?

A. The issues where they might be required haven't been raised with me, so I take that to mean that there haven't been circumstances where a recommendation from the Case, Contact and Outbreak Management Team haven't seen circumstances where they feel that such coercive powers would be beneficial to the work that they're doing. I think there is always a consideration about how the exercise of such powers might affect ongoing engagement with the critical function of case and contact management.

The trust and rapport that is fundamental to being able to engage with people and have the honest provision of information and also the willingness of people to come forward for testing, with an understanding that if they test positive they will need to go through a process of defining their close contacts, constraining where they move to and constraining their behaviours. So there is always a trade-off, if there is an individual who might not be providing that information or who might not be

compliant with advice, what the consequences might be for the broader community going forward.

Q. What about those powers in respect of testing? We heard that in the Hotel Quarantine Program testing was entirely voluntary for those that were in the system. First of all, the evidence reflects that testing was only available for those that were showing symptoms, but then later became more available. Firstly, is that your understanding of the evolution of testing in the Hotel Quarantine Program: it was only available for those with symptoms, but then later became much more readily available for everyone?

A. Yes, essentially that's the case. In the beginning of the Hotel Quarantine Program across Australia, there was certainly a view that anyone who became symptomatic needed to be tested because they were developing the signs and symptoms of the coronavirus and they needed to be either excluded from having that illness or to be confirmed as positive and therefore managed in isolation. And later --- and you have to bear in mind that the purpose of quarantine is to have someone isolated for a 14-day period, because the 14-day period is the maximum incubation period for coronavirus. So that from the time of being exposed to the time of developing illness, it's 14 days. And if you haven't developed illness in that 14-day period, then you haven't become infected, and therefore you don't need to remain in isolation beyond that period.

What became known over time is that some people can have extremely mild symptoms, some people might develop asymptomatic illness, so with no symptoms whatsoever but potentially be infectious. And we were reflecting on the fact that some people might want to minimise their symptoms whilst in quarantine in order to not be detained for longer than that 14-day period. Because if they developed symptoms on day 11, 12, 13 and they wanted to get out of quarantine, they might not declare it and it might not be easy to identify those individuals as unwell, especially if they had very mild asymptomatic illness.

So the testing at day 3 and day 11 was something that Victoria instituted --- I think we were the first to do it routinely in Australia --- in part to pick up those with very mild illness who may not even be aware that they were becoming unwell, but also as an additional stopgap measure to identify illness in people who might be minimising their own symptoms.

Q. Professor, I just want to take up something that you just said in answer to that question. As I understand it, you said that there may be people who downplay their symptoms because they fear that they will remain in quarantine for a longer than otherwise period. It was never the case, was it, that people who were symptomatic were held beyond the 14 days?

A. Not in hotel quarantine, but they would have had a requirement for isolation for the entire duration of their illness.

Q. At home?

A. At home. Or, indeed, if they felt that they couldn't isolate at home, then we would support them with alternative accommodation arrangements.

Q. Just coming back to where I started, was there ever any thought about using the powers that vested in you, either under the *Biosecurity Act* Commonwealth or the *Public Health and Wellbeing Act*, to enforce testing?

A. No, there wasn't. Again, it was a stopgap measure for those in quarantine, essentially. It became increasingly apparent that if you want to make hotel quarantine as robust as possible and have not one in 100 or even one in 1,000 leave quarantine potentially infectious and not being aware of it, that making more stringent requirements for testing is a reasonable consideration. It didn't come to mandatory testing, but there was a change in the directions, in the public health directions which specified that those who were refusing testing at the day 11 or thereabouts mark would be held for an additional 10 days if they didn't get tested. And those additional 10 days are really a conservative measure of the infectious period if someone were to become unwell on the very last day of quarantine. Most people who develop illness have recovered and are no longer infectious before seven days are up, and certainly the great majority will be not infectious at the 10-day mark. So that mechanism was used instead.

Q. That mechanism, though --- and you talked about the majority and vast majority --- always recognised the possibility, did it not, that people would be released from quarantine carrying the virus and still infectious?

A. That's right. As for --

Q. And those --

A. Sorry.

Q. Sorry. No, no, please go on.

A. As for others in the community who are identified as cases who were also isolating at home.

Q. Were you --- were the substance of the outbreak management reports brought to your attention?

A. I was in copy on a group email with the summary of the outbreaks that were added every day and those that were still active. They numbered dozens at different points in time.

Q. It came to your attention, didn't it, that there was a person at the Stamford Hotel who completed their hotel quarantine and then subsequently tested positive for

COVID?

A. That's correct.

Q. And that subsequent test revealed on a genomic tracing basis a connection between the virus that that person had and the source of the virus at the Stamford Hotel?

A. That's correct.

Q. You're also aware that that person who left hotel quarantine unaware that they were COVID-positive actually transmitted COVID to the person who drove them away from hotel quarantine?

A. That's correct.

Q. That perhaps demonstrates, does it not, Professor, the risk of a 14-day period where people will be released from quarantine without knowing definitively whether they're COVID-positive or not?

A. Yes, I think that has become part of the reflections on strengthening the testing regimen within hotel quarantine, for that very purpose.

Q. And it's the case, isn't it, that there were others who would have been released from hotel quarantine where their status as to whether they were COVID-positive or not was not known?

A. Yes, that is potentially the case. Again, they would have been questioned as to whether they had any symptoms and would have been released on the basis that they were declaring that they were symptom-free.

Q. And even those that were declaring that they did have symptoms, they were then falling to be treated just like every other member of the community?

A. Who had coronavirus, correct.

Q. Well, first of all, if they only had symptoms but no confirmed test, they were not falling subject to isolation at home, were they?

A. No, but people who had symptoms were being tested. There were individuals who were symptom-free who were not being tested, who were finishing their quarantine period, again, symptom-free, who were being released.

Q. Sorry, I just want to understand that a bit better. Are you saying that everyone who had symptoms was tested?

A. That was my understanding. It wasn't --- it wasn't brought to my attention that

there were individuals who were symptomatic leaving hotel quarantine without a test.

Q. There was no power though, was there, to keep them in hotel quarantine if they were merely demonstrating some symptoms but refusing a test?

A. No, other than the issue being escalated to me and for consideration of an individual public health order for the purpose of testing or the purpose of isolation, for example.

Q. But that didn't happen?

A. That did not happen.

Q. I want to ask you a couple of questions about what you've addressed in your statement at paragraphs 58 and following about pandemic planning. And as I understand your evidence today, you say that the *Public Health and Wellbeing Act* has been drafted, at least in part, to deal with the situations that might arise from time to time when we have pandemics.

A. That's correct.

Q. You talked about, in paragraph 58, of being aware of an exercise in August of 2018 called the Alchemy Exercise. First of all, I understand that you weren't involved in that exercise?

A. That's correct. I was invited to be involved as Deputy Chief Health Officer for Communicable Diseases at that time, but I wasn't able to make it.

Q. What do you know about that exercise and what does it involve?

A. Again, not having been directly involved, my understanding was that it was a biosecurity issue in animals. I think it was an avian influenza scenario with transmission to humans and then with concerns about disease transmission with pandemic potential.

Q. The next exercise I want to ask you about is something called Exercise Teapot, which was undertaken on 10 September last year. First of all, was that an exercise that you were involved in?

A. I was.

Q. Can you explain what that exercise was about and what came out of it?

A. It was an exercise that had a scenario of essentially a mass water contamination and mass presentation of illness at a gathering, and it was essentially akin to the outbreak of E.coli that occurred across Europe that you might be aware of, where

fenugreek seeds were implicated and there were many, many deaths across Europe and thousands of people who became unwell, so a similar E.coli contamination event, where the issue was the coordination of Local Government water authorities, the Water Unit within the Health Protection Branch that have carriage of, oversight of water safety with respect to drinking water under the *Water Act*, *Clean Water Act*, and the coordination of Emergency Management and public health responses to that mass event.

Q. You say in your statement --- and perhaps I'm misreading it, Professor, and tell me if I am --- that Exercise Teapot "was a discussion exercise attended by representatives of the Department and multiple agencies, which explored a complex multiagency emergency involving widespread outbreaks including of [MERS]". Can you talk us through how MERS came in to what might have been a discussion about E.coli and fenugreek?

A. I might be overstating the role that MERS played in that scenario. It was an add-on at the end. So it was primarily a water-borne disease outbreak scenario but then there were some individuals at that mass gathering who presented with respiratory illness who were confirmed as having MERS coronavirus, and so it was "How do we manage these parallel contemporary challenges across agencies?" But it wasn't looked at in-depth. It was very much a, "And here's the additional challenge for all of us."

Q. Professor, have you had an opportunity or did you watch the evidence of Professor Grayson on the first day of evidence in these hearings?

A. I'm afraid I haven't.

Q. Professor Grayson touched upon, in answer to some questions from Senior Counsel Assisting, the lessons that could be learned or have been learned in relation to previous pandemics, and he cited SARS, he cited swine flu, and he cited MERS as three relatively recent and prominent examples of pandemic situations.

A. Or potential pandemic situations.

Q. Yes. Well, first of all, the virus that's known as H1N1, tell us a little bit about that. When did that become a problem globally and how was it managed?

A. So with respect to swine flu, H1N1 was the new virus that emerged with swine flu. There are other H1N1s that have been circulating over time, but I'm sure your reference is to the pandemic H1N1. And so it emerged and had pandemic potential and swept around the world in 2009. It was, as pandemics go, relatively mild compared to --- certainly compared to 1918-19, 1967-1968. It was probably the mildest of all of those four pandemics.

That said, pandemics affect a significant proportion of the world's population. They go to every country in the world almost. Certainly influenza pandemics are known to

travel to almost every corner of the world. And even mild, as a pandemic, is usually on the very severe end of what a seasonal flu season looks like. And so it was challenging regardless. As a mild pandemic, it didn't stretch health services in the way that previous pandemics might have, but it was certainly a significant challenge with respect to trying to minimise the illness and deaths that occurred from that.

The other features of influenza pandemics is that they don't affect the vulnerable cohorts classically identified in seasonal flu. Those are individuals who are very elderly, those with significant pre-existing chronic illness. Even though they are also vulnerable to pandemic flu, pandemic flu can often affect other younger and fitter cohorts of the population. So pregnant women, for example, were at much more significant risk of illness and death from H1N1 and there were other younger cohorts of individuals who were also challenged with that flu.

Q. You're aware, aren't you --- well, first of all, in your role as Chief Health Officer, part of your responsibility is to be forward-thinking about how we deal with pandemics that might be coming down the line, new infection stages, things like that?

A. That's correct.

Q. And your engagement on national committees is at least in part directed to those types of issues as well?

A. Yes. We certainly --- well, it was more as Deputy Chief Health Officer - Communicable Disease, and CDNA, the Communicable Disease Network Australia, which I was the Victorian representative on, in that role, that talked through the Australian Health Management Plan for Pandemic Influenza, its revisions, and the Victorian Health Management Plan for Pandemic Influenza as a reflected piece with a Victorian focus.

Q. Professor, are you aware, given those significant roles you've previously had and of course the significant roles that you currently hold, of an Australian Government Department of Health and Ageing review of the Australian health sector's response into the H1N1 pandemic?

A. Yes.

Q. Yes. I might ask that that document be brought up, Madam Chair. It's HQI.0001.0003.0001.

Now, Professor, you understand this document to be the result of a review that was done by the Department of Health --- that is, the Commonwealth Department of Health --- but with input from State agencies about how Australia handled H1N1 and the lessons that might be learned from it going forward?

A. Yes.

Q. Is that right? Yes. Can we go to page v, please, the page headed "Executive Summary". And if we can highlight the first text box in the top left column, please. This is a document with which you're generally familiar, Professor?

A. Yes. It's been some years since I've looked at it, but I would have seen this.

Q. Yes. You will see that it starts clearly:

> *There are many lessons for health officials and governments to learn from the experience of the 2009 pandemic.*

Then you will see it goes on to say:

> *.... key elements being effective communications, robust science-based decision making and a flexible public health response system able to respond rapidly to a crisis.*

With the familiarity you have, notwithstanding it might be a few years old, you recall those things to be the real key take-home messages from this review, don't you?

A. Yes.

Q. And if we can just zoom out from there, please, and if we go to the right-hand column about two-thirds of the way down, see the paragraph starting "Multi-stakeholder advisory mechanisms", if we could highlight that and expand it. See the second sentence:

> *For the future, well-structured expert advice should be developed from well-functioning advisory committees in preference to establishing new or separate pandemic advisory structures.*

I just want to ask you about that statement and perhaps in the context of the committees that exist at a national level that you are part of. Do you understand that the AHPPC, for example, was in existence prior to 2009?

A. Yes.

Q. And the other committee with which you've just spoken when you were the Deputy Chief Health Officer of Communicable Diseases that you had a role on, was that something that was in existence prior to 2009?

A. Yes, it was.

Q. Can you just describe to us briefly what the AHPPC is? First of all, what does it stand for? Because I'll try but I'll no doubt stumble over it incorrectly, so I'll leave it to the experts.

A. The Australian Health Protection Principal Committee. So it's a committee comprising jurisdictional representatives as Chief Health Officers or with their equivalent title, Directors of Public Health or Chief Preventative Health Officer, chaired by the Chief Medical Officer of the Commonwealth Government and with expert representation across various other relevant skills and competencies with respect to public health.

Q. And what's its purpose?

A. Its purpose is really to consider issues of public health of national significance and of importance for coordinated and evidence-based response. So it will --- a little bit like the Health Protection Branch representing broad health protection issues at a Victorian level, it considers similar issues at a national level. So they will be around issues of food-borne outbreaks, issues of communicable disease transmission and outbreaks, but also issues of environmental health significance.

Q. Can I ask that that document go to the page marked 38. I say "marked" because we have Roman numerals and then ordinary numerals. And if we can just zoom in at least on the left-hand column, you see, Professor, there --- I don't know if you can see it on your screen, it looks like you're looking across a room --- but at least under 5.2.4 it speaks of "Isolation and quarantine".

A. I can see the title.

Q. Let me take you more specifically to a portion of it. We see about three-fifths of the way down that left-hand column a paragraph that begins "A separate system", if that could be highlighted and brought up, just the first five or six lines of that:

> *A separate system of support was provided for contacts identified at the border, as planning had identified that there may have been a requirement for contact tracing ....*

And this is the part I'm most interested in, Professor:

> *.... and quarantining of large numbers of people after arrival in Australia.*

Now, first of all, quarantining of large numbers of people after arrival in Australia did not arise in the context of the H1N1 pandemic, did it?

A. Not in a formal sense, in the sense that some individuals who were identified as close contacts of known cases would have been told to quarantine for a time. But I wasn't part of the pandemic response in 2009. I was working in East Timor during that time.

Q. If we can just now move to page 40 of this same document. As that's happening, Professor, you would agree that this was a significant review in respect of looking at

Australia's health sector response to pandemics, both not only what we did in relation to H1N1 but perhaps what we ought to be looking at doing in the future should we face a similar scenario?

A. Yes, I think so.

Q. We see here --- perhaps it's a bit small on your page, as it is on mine --- at 5.3.4, quarantine is discussed more specifically. And at about point 4 of the page, just under halfway, there's a paragraph that begins "Policy and operational plans", and I'll ask that that be brought up. As at the time of H1N1, this review found:

> *Policy and operational plans for managing people in quarantine had not been finalised, both at state .... and national level, when the pandemic emerged.*

Do you see that there?

A. Yes.

Q. Then:

> *Accommodation for non-residents identified at the border and requested to quarantine themselves was an issue, as many hotels refused to provide accommodation to individuals ....*

A. Yes.

Q. Then it goes on:

> *The roles and responsibilities of all governments for the management of people in quarantine, both at home and in other accommodation, during a pandemic should be clarified.*

Now, this was identifying, was it not, that there were issues insofar as quarantine was implemented in respect of H1N1?

A. Yes.

Q. And specifically the need for the clarification of roles in --

A. Yes.

Q. --- any future quarantine situation?

A. Correct.

Q. It goes on:

A set of nationally consistent principles could form the basis for jurisdictions to develop operating guidelines, including plans for accommodating potentially infected people in future pandemics and better systems to support people in quarantine. It is the view of some stakeholders that quarantine of contacts should only be undertaken for severe pandemics.

First of all, are you aware of any further work that was undertaken, either at national or state level, to implement what this report is identifying by way of the need for clarification and/or the development of a set of nationally consistent principles?

A. No, I'm not aware of any work that occurred nationally or in any jurisdiction of Australia with respect to that.

Q. Yes. And if we can just go finally to the next page of the document, you see at the top of the page on the left-hand side the discussion around quarantine actually distils specifically into a specific recommendation. If we can highlight "Recommendation 13" which appears at the top left-hand part of the page:

Review the policy on quarantine and isolation, including management, support systems and communication.

That's plainly a recommendation that fell out of this report and is it your evidence that you're not aware of any work that was done to implement that recommendation?

A. That's correct.

Q. You would agree --- well, first of all, the Board has heard --- thank you, that document can come down and I tender the document, Madam Chair.

CHAIR: Exhibit 156.

EXHIBIT #156 - AUSTRALIAN GOVERNMENT DEPARTMENT OF HEALTH AND AGEING REVIEW OF THE AUSTRALIAN HEALTH SECTOR'S RESPONSE TO THE H1N1 PANDEMIC DOCUMENT ID HQI.0001.0003.0001

MR IHLE: If the Board pleases.

The Board has heard, Professor, a number of people give evidence about the difficulty in standing up this Hotel Quarantine Program in a very abbreviated period of time and it's been described as effectively setting it up from scratch. Do you understand that evidence has been given?

A. I do.

Q. W

here in 2011 the recommendation had been made to review the policy on quarantine and isolation, including management, support systems and communication, you would agree that that would have been very useful in the circumstances where hotel quarantine needed to be stood up in such a short period of time, had that work been undertaken in the nine years between that report and hotel quarantine becoming an issue?

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

For pandemic influenza, I think there has always been an assumption that it reaches every country, every corner of the world and that quarantine serves the purpose of minimising the peak of that pandemic and the pressures on the health system by reducing the total number of people who are infected and the waves of transmission.

I think the issue with coronavirus is that after the experience of Wuhan and with a reflection that the pandemic is of the greatest severity we've seen for 100 years, probably since Spanish Flu, that the impetus for a quarantine program that effectively kept it entirely out of the community, to the fullest extent possible, was a genuine objective. So I think in the planning and recommendations around quarantine in this document, and in the AHMPPI and the VHMPPI, there was much more consideration about trying to minimise transmission of influenza and not so much a consideration of an almost watertight, if you like, system of quarantine set up previously.

But I absolutely take your point that consideration of this recommendation and a pre-existing, ready-to-stand-up program would have been of great assistance compared to setting up a program de novo.

Q. Certainly avoids the need to set it up from scratch, as some have described it?

A. Correct.

Q. And some of the problems that sit around who is in control of setting it up?

A. Yes.

Q. And indeed how it would be set up?

A. Yes.

Q. And how it might be resourced to operate?

A. I think all of those issues that would go to planning and preparation and

pre-agreed governance, organisational structure, are things that could be laid out.

Q. Because these things --- that is, emergencies --- by definition happen very quickly, don't they?

A. Yes, they do. I think we were given some notice with COVID-19 because we saw it unfold over a period of time in China before it became an issue in Australia. But, nonetheless, things change extremely rapidly once there's importation into a country.

Q. On the question of notice, I just want to come to the question of notice about a hotel quarantine program or quarantine in a designated facility. Perhaps we can bring in Professor Sutton's statement at DHS.9999.002.0001. And if we can move to page 31 of that statement, please, Mr Operator, and if we can highlight paragraph 176. Professor, I just want to ask you about this part of your evidence. You say here:

> *.... prior to National Cabinet's announcement on 26 March 2020, the AHPPC did not endorse the idea of quarantining travellers at hotels (or other designated facilities).*

Now, this answer is given specifically to the question:

> *During March or April 2020 did the Committee agree or resolve that it was advisable to require all travellers arriving in Australia to undertake 14 days isolation at designated facilities?*

Do we read this paragraph, Professor, to mean that the AHPPC was not in agreement of the idea of a hotel quarantine program?

A. No. I think it's fair to say that the specific question in terms of a recommendation to National Cabinet didn't come up.

Q. So you say that the reading of paragraph 176 that we should take from that is that it wasn't even being discussed, the idea of quarantining returned travellers in a designated facility prior to 26 March?

A. No, that there wasn't a formal piece of work as a recommendation to National Cabinet that came before AHPPC.

Q. Okay. So is that --- we see there the word "endorse" there. Did the AHPPC, as far as you're aware, have a view about the desirability of quarantining people in hotels prior to the announcement of National Cabinet?

A. These are matters of Cabinet-in-Confidence for National Cabinet as a body reporting into National Cabinet, so I'm not sure I can speak further on the specific deliberations.

Q. Okay. But suffice to say you say that prior to 26 March, there was no formal endorsement of that as an idea?

A. Correct.

Q. Can I perhaps take you to a different document, Professor, and it's a document that you yourself have referred to in your statement. It's document HQI.0001.0002.0001. Now, this is a transcript of a press conference given by the Prime Minister on 27 March, along with the Commonwealth Chief Medical Officer, Dr Brendan Murphy. As I said, this is a document that you have referred to or at least the press conference is an event that you've referred to in your statement. I want to take you to some certain aspects of it, if I may. Perhaps if we go to the second page and the bottom paragraph. Now, Professor, you appreciate that this is the press conference that the Prime Minister gave whereby he announced what's now colloquially being referred to as the Hotel Quarantine Program?

A. Yes.

Q. You will see that the Prime Minister says there:

> *Today, we have decided to take further actions targeting what is our greatest area of concern and Dr Murphy will speak more to that. What we're announcing today enables us to deal with the increasing pressure we have from Australians coming home.*

You see later on in that paragraph:

> *Two-thirds of the cases that we currently have are from an Australian who has come home: two-thirds. That is very different to what we're seeing in other parts of the world. Our biggest issue, the biggest number of cases, relate to this.*

First of all, were you aware that the Prime Minister was going to announce the Hotel Quarantine Program prior to him actually making the announcement?

A. No, I wasn't.

Q. Perhaps if we move to page 3 --

A. I think it --

CHAIR: Sorry, did you --

A. It's fair to say, until National Cabinet has decided an issue, it's not fait accompli. So I guess no one should expect in advance of National Cabinet deliberations what an outcome might be.

MR IHLE: If we can move to page 3, the second paragraph there --- sorry, the third paragraph, my apologies. This is the part of the press conference where the Prime Minister announces the Hotel Quarantine Program, isn't it:

> *.... by no later than midnight tomorrow, that is 11:59pm Saturday states and territories will be quarantining all arrivals through our airports, in hotels and other accommodation facilities for the two weeks....*

That's the effect of that paragraph, isn't it ---

A. Correct.

Q. --- that the Prime Minister was there announcing the Hotel Quarantine Program?

A. Correct.

Q. And then finally if we might move to page 12, please, Mr Operator. The part that begins "Prime Minister", if we can highlight that. The Prime Minister told the people of Australia:

> *The decisions that I communicate from this podium....*

I'll just pause there. That includes the decision to have the Hotel Quarantine Program. Do you agree with that?

A. Yes.

Q. It says those decisions:

> *.... are the decisions of all Premiers, Chief Ministers, and myself. This is not some personal view of mine, these are the decisions of the National Cabinet based on the medical .... advice that we receive in terms of the restrictions that are necessary to deal with the management of the outbreak of the virus in Australia.*

Q. Just going back to that paragraph in your statement, paragraph 176, as at that time, at least as far as you're concerned, the AHPPC had not formally endorsed the idea of quarantining travellers at hotels or other designated facilities, had they?

A. Not with respect to a formal recommendation to National Cabinet, no. There were discussions about quarantine.

Q. Did that cause you some concern when you became aware that the Prime Minister said that the decisions of the National Cabinet were "based on the medical advice that we receive"?

A. No, I take it on face value that that's true.

Q. It's not --- I'll withdraw that. Let's move back to your statement, if we may, Professor.

First of all, I tender that document, Madam Chair.

CHAIR: This is the transcript of the media conference?

MR IHLE: It is, dated 27 March.

CHAIR: Exhibit 157.

MR IHLE: As the Board pleases.

EXHIBIT #157 - TRANSCRIPT OF PRIME MINISTER'S PRESS CONFERENCE DATED 27 MARCH 2020

MR IHLE: Now, we've already gone to paragraph 176, Professor. Perhaps if we go to paragraph 177. Now, you've clarified for us that prior to that announcement, there was no formal endorsement or recommendation by the AHPPC in support of a Hotel Quarantine Program. If we can go to paragraph 177, you say the following:

> *Following the National Cabinet's announcement of these requirements, the Committee met to consider a national response to COVID-19, but did not agree or resolve to advise returned travellers to undertake a 14-day quarantine at a designated [facility].*

It says "faculty". I assume that's meant to read "facility"?

A. "Facility".

Q. Yes. So not only was there no recommendation or advice given by the AHPPC prior to the announcement, here you say you've met following the announcement and there's still no agreement or resolution to advise to that effect. Do you agree with that?

A. Yes.

Q. Yes. That document can come down, thank you.

Professor, we've talked about the AHPPC. I want to talk about your view. You're the Chief Health Officer of Victoria. Do I understand that your view as at 27 March was that only high-risk cases were to be quarantined in a facility?

A. No. That's not accurate.

Q. What was your view?

A. Well, I supported the idea that all returned travellers should be quarantined in a hotel quarantine facility.

Q. That was your personal view, was it?

A. Yes.

Q. Okay. And did you advise the Deputy Chief Health Officer of that view?

A. We discussed it. We were in agreement that, although it was a significant constraint on individual liberties and individual rights, that it was both necessary and proportionate to do so. But we recognised that many of the Victorian Charter of Human Rights and Responsibilities issues were engaged in coming to that decision. It wasn't taken lightly by any means. But it was balanced against a recognition that already countries like Italy were going through thousands of cases and were facing a catastrophic epidemic that ultimately killed tens of thousands of people in that country, and, you know, is approaching a million deaths globally.

So I think we considered all of those issues at play in coming to a determination that that should be written into a Public Health Direction. The Deputy Chief Health Officer had to be satisfied in signing that, but I was absolutely in support of it.

Q. Professor, do you recall sending two emails to the Secretary of the Department of Health and Human Services, the first at about quarter to 11 on the evening of 26 March and the second the following morning at 7.30 in the morning, that is, 27 March?

A. If you could refer me to the documents, I might be reminded.

Q. I will refer you to the documents. But given your answer to a previous question, there might be some sensitivity around it. So perhaps, and noting the time --- I can see you've got a folder there, and I hope that you have these documents with you, but there's DHS.0001.0040.0001, an email from yourself to Ms Peake on 26 March at 10.47 pm. The next document is the same document number, except it ends in 0004. And the document that I specifically want you to have a look at is a document that ends in 0005. And it's a Word document that has a number of edits to it. That might refresh your memory.

A. Yes. I recall that.

Q. Yes. And that's a document the substance of which dealt with the idea of enforced quarantine of returned travellers, wasn't it?

A. Yes.

Q. And the edits that you had made to that document were to the effect that:

For international travellers arriving in Australia, only high-risk....

MS HARRIS QC: Madam Chair, could I just ask that the question recognise that there's nothing in the document that establishes the identity of the person making edits.

MR IHLE: Did you make the edits, Professor?

A. I don't recall. I don't know.

Q. Well, let me go back to the first document. The first email says:

Hi Kym,
Not sure if Brendan will accept this, but have agreed to edit his version and see where we land --- are you OK with this?

A. Yes, that's correct.

Q. So you're foreshadowing that you're going to make some edits?

A. Yes.

Q. And then we have a document that appears to have been edited at about 11.20 pm on the night of the 26th and it has edits. Am I correct in assuming that those edits are edits that you have made?

CHAIR: Ms Harris has an objection, Mr Ihle.

MS HARRIS QC: It is being suggested that the document makes apparent on the face of it both the identity of persons making edits and the timing of them. That's not the case, Madam Chair, from the document that I have. It is the case that there is a cover email, but it's far from clear, and we haven't been provided with a history that would suggest whether there are any pre-existing edits or anything of that nature. If it can just be made clear on the face of the question, given the difficulty with looking at the document itself.

MR IHLE: Very easy to do.

Professor, did you make the edits?

A. I don't recall making the edits, no.

Q. Okay. So what we have is an email at 22.47 hours on 26 March that says, "I have agreed to edit the version and see where we land." Then we have an email dated

27 March 2020 which has an attachment which is saved, by reference to time, 11.20 pm and that document has edits within it. Are you saying that you can't recall whether you edited that document, as you said to Ms Peake that you would?

A. That's correct. There were multiple individuals editing a document, including Professor Murphy, Ms Peake and myself.

Q. Yes, okay. Well, in any event, the outcome of the document that's attached to the latest of those emails provides that:

> *In addition to the existing enforced quarantine arrangements....*

Now, first of all, as at the evening of 26 March and the morning of the 27th, enforced quarantine arrangements were enforced quarantine in the home for returned travellers, was it not?

A. Correct.

Q. It goes on:

> *.... for international travellers arriving in Australia, it is recommended that in high-risk cases, monitored placement in a facility such as a hotel is enforced for those who would normally reside with others at home.*

Now, what I want to ask you is, as of the morning of 27 March, was that reflective of your preferred position in respect of quarantining of passengers?

A. No, it wasn't.

Q. Okay. Yes, thank you. As of the morning of 27 March, what was your preferred position in respect of the quarantining of returned passengers?

A. I was supportive of the National Cabinet's determination that all returned travellers should be in hotel quarantine.

Q. Yes. Thank you, Professor. I want to go on to once that decision was made, and perhaps now is a convenient time for a mid-morning break?

CHAIR: Yes, we will take a 15-minute break, Professor Sutton. It's right on 11.30. So if you could be ready to return at 11.45. Thank you.

A. Sure. Thank you.

ADJOURNED **[11.32 AM]**

RESUMED **[11.45 AM]**

CHAIR: Yes, Mr Ihle.

MR IHLE: Thank you, Madam Chair. I foreshadowed going on to a different topic, but I just wanted to pick up two final questions on the last topic with Professor Sutton.

Professor, just before the break, in answer to the question I asked you about your state of mind on 27 March and your preferred position, you said that you were supportive of National Cabinet's determination that all returned travellers should be in hotel quarantine. I just want to unpack that for a moment. Was it your preferred position that all returned travellers be in hotel quarantine for 14 days?

A. Yes.

Q. Was there any consideration given, as far as you're aware, to a more tailored and individual-specific approach?

A. Through National Cabinet, do you mean, or in discussions with AHPPC?

Q. Well, first of all, let me ask you about your preferred view. Did you have a preferred view that individuals should be treated as individuals, or if you just enter this country, it's 14 days?

A. I think, given where we were at with the pandemic in Australia, the rapidly rising numbers of cases and the likelihood that control of numbers would get beyond us in a relatively short period of time, it was my view that the initial implementation of hotel quarantine should be for all travellers, especially given the emergent risk in countries where we didn't necessarily see that risk until it arrived on our shores.

You'd be aware that after restrictive travel from mainland China into Australia or a recommendation that all of those from mainland China quarantine at home, countries such as Italy, Iran and South Korea were added to that list, but it took some time for consideration of United Kingdom and the United States. But we did see a number of travellers arriving who were clearly infected in those countries.

So one of the considerations about not discriminating with a kind of risk-stratified approach is that it's very difficult to know what's been identified within a country. Are they testing enough? Had they identified whether there is significant transmission? What we know one week doesn't look the same the following week. So I think, yes, initially, that broad approach to quarantining everyone was certainly one that I supported.

Q. And, first of all, was that quarantining for 14 days?

A. Yes, it was.

Q. So not a situation where you would consider receiving a person into quarantine and then making an evidence-based risk assessment of that person?

A. No.

Q. And you've said now a couple of times initially that was your view. Did your view change over time?

A. Certainly we've had continuing discussions nationally about other potential approaches to mandatory quarantine, that attempts to risk-stratify and to do so on the basis, for example, of country of origin, how much testing is being done there and what the prevalence might be in those countries. Obviously there have been discussions with New Zealand about a travel bubble and an exemption to that quarantine process, and I'm aware of other Western Pacific nations like the Solomon Islands, like Vanuatu, that appear to be free of COVID-19. So I think going forward, it's not unreasonable to look at a risk-stratified approach.

But it really does depend on where a jurisdiction is at with respect to transmission in that jurisdiction, and each and every one of our jurisdictions, you know, States' and Territories' risk tolerance for having even a single case emerge from hotel quarantine and potentially bring virus to the community.

If we are in a situation like Europe, home quarantine is a very reasonable approach to take because there is no way that they're going to get to zero community transmission. But with much of Australia already at that level and with the potential prospect of the whole of Australia getting to that point, the tolerance for having one in 1,000 or even one in 10,000 travellers, knowing how many come through each week, bringing coronavirus to the community is probably extremely quite low. And they wouldn't like it in another jurisdiction, with the prospect of them not being able to ensure open borders or free travel across the country.

So I think it's not out of the question and there are probably ways to mitigate the risk very substantially with testing, with other mechanisms of ensuring compliance with home quarantine, but it hasn't been explored in full or agreed nationally, which is really a key consideration for me.

Q. Which is the key consideration, that it hasn't been explored in full or that it hasn't been agreed nationally?

A. Both, really. I think we need to understand the emerging epidemiology within Australia, but also globally and how that intersects with whatever future quarantine program might be modelled, but also that national agreement is an important approach to this as much as anything.

Q. When you were talking about risk stratifying, you were talking about where

people were travelling from. Was there any consideration given to individualised approaches based on clinical information such as symptomology, such as positive or negative tests being returned and therefore potentially allowing people to come out of quarantine earlier, not only just based on where they were from but based on whether they had tested positive or not or in fact returned a negative test and/or were not showing symptoms? Was there any kind of consideration for that or was it just a blanket 14 days from the start?

A. Initially it was a blanket 14 days. It obviously remained a blanket 14 days for the duration of hotel quarantine in Victoria, until the program was essentially put on hold. And in large part it's because testing cannot tell you that you won't develop symptoms in that 14-day period. If you're tested on day 3 or day 5 or day 7, it can tell you that you haven't developed illness in that seven-day period, which is when the majority of people develop illness, but it won't tell you about the remaining seven days and the 10 or 20 or 25 per cent of people who might still become unwell in that subsequent week.

So going the entire 14 days is the only absolute assurance or relatively strong assurance you can have that someone isn't infectious.

You can, of course, do a symptom check on a daily basis but, as I said, there are some individuals who will have very mild symptoms, others who will develop it right on the 13th or 14th day, others who might minimise their symptoms, and a small percentage who will become infected and remain completely free of symptoms. They are probably not much of a risk of transmission to others, but there is known to be transmission from asymptomatic individuals. So no guarantees, essentially, and a blanket approach is the only one that gives that high-level assurance.

Q. I understand that's the reasoning behind it. But coming back to my question, was there any consideration given to that type of nuanced or tailored approach that looked at the individual?

A. There was, but it was not --- it was not an approach that was agreed or preferred.

Q. Now, you've told us your views as of 27 March, that you were in support of the National Cabinet decision. Are you aware that there was not a consensus view held amongst the other respective Chief Health Officers in that respect?

A. Yes, I was.

Q. And what did you understand to be the basis of the contrary views?

A. Again, I suspect that's Cabinet-in-Confidence. But I really can't speak for other Chief Health Officers with respect to their views.

Q. So, just trying to understand, is that an objection to answering the question or is it

"I don't know the answer to the question"?

A. I think it's fair to say I don't know the answer to that question.

Q. All right. Then we can move on.

Once the decision as to hotel quarantine had been made, we've heard evidence that there was already installed in Victoria, under the State Health Emergency Response Plan, a State Controller.

A. Sorry, could you repeat that question?

Q. There was a State Controller already installed in Victoria prior to the decision in respect of hotel quarantine being made.

A. That's correct.

Q. And that's a State Controller who had been appointed initially in November of 2019. Do you understand that to be the case?

A. Not for this pandemic. Not for this pandemic.

Q. But generally the State Controller was appointed in --- November 2019 was Ms Spiteri?

A. Yes, for different purposes.

Q. Yes. And there was a document that at least Ms Skilbeck took us to which was called a Concept of Operations document, which is a document that sits alongside the SHERP.

A. That's correct.

Q. Now, that Concept of Operations document is a document that you had some involvement in drafting, did you not?

A. I certainly reviewed several versions and provided my edits and inputs and ideas.

Q. We understand that, at least relying on the terms of that document --- that is, the Concept of Operations document --- Ms Skilbeck appointed Ms Spiteri a State Controller on 1 February of this year in relation to the pandemic response.

A. That's right.

Q. When I say that Ms Skilbeck made the appointment, it was the Secretary that made the appointment, albeit on Ms Skilbeck's recommendation?

A. That's right.

Q. Now, at the time that you were involved in drafting this Concept of Operations document, which I think was in late 2019, or reviewing parts of it, did you think that, should a pandemic occur, it would be likely that you would not be appointed the State Controller, notwithstanding the presumption in the SHERP that that be the case?

A. I don't know that I had a pre-existing view of the probability. I think I imagined the possibility that I might not be appointed, but I wouldn't have said that I expected it to be more likely than not.

Q. Ms Skilbeck gave evidence to the Inquiry last Thursday. Did you follow her evidence at all?

A. No, not in full.

Q. Okay. At page 1219 of the transcript, Madam Chair, she was asked about her decision to recommend Ms Spiteri against the presumptive position in the SHERP that you be the State Controller, and she told this Inquiry that you were not in agreement with that decision.

A. That's correct.

Q. Are you aware that she's given that evidence?

A. Yes, I am.

Q. And is it correct that you were not in agreement with that decision?

A. That's right.

Q. Why?

A. I had a view that the position of State Controller is a not insignificant one with respect to the application of controls for the management of an emergency or incident, including a pandemic, and that the position has line of sight of operational elements that I, as Chief Health Officer and accountable with all of the powers that I'm exercising under the *Public Health and Wellbeing Act*, that it's important for me to have line of sight of the application of those controls and to be appropriately aware, you know, to have situational awareness of those operational activities.

Q. The emergency that required the appointment of a State Controller was a health emergency.

A. That's right.

Q. Is it your view, or was it your view then, that it's preferable then to have a State Controller, a person with operational line of sight, to have some health expertise?

A. Andrea Spiteri has some health expertise. She's an excellent leader in the emergency management space within DHHS. So I wouldn't say that she doesn't have health expertise. With respect to a pandemic specifically, I do have a view that a public health physician with communicable disease experience and tropical medicine experience and the specific qualifications and experience that I have is a not inappropriate appointment to the State Controller position, for sure.

Q. That's a very cautious way in which to say it, "not inappropriate". It's preferable, isn't it?

A. It is to me.

Q. Yes. And they were the views that you held in February?

A. Yes.

Q. And they're the views that you still hold today?

A. No. You'd be aware that the Secretary of the Department of Health and Human Services is the State Controller as of now and has been for some weeks. I think at the juncture that we're in, where there's a whole-of-Victorian-Government response of a really extraordinarily complex and large operational response, that as the head of this Department and with a deep understanding, oversight and direct reporting of all of the divisions within Health and Human Services, and they are all engaged in this response very deeply, that Ms Peake is an appropriate State Controller at this juncture. In February, my view was different.

Q. In February --- I'll ask you a slightly more specific question, then. Your view in February was, as this health emergency was then unfolding, it was preferable that someone with your type of experience and your type of training be the State Controller?

A. Yes. And it's not just about my training and experience; it's about the position that the State Controller sits in within the emergency management arrangements and the oversight of certain operational activities that I think it's important as Chief Health Officer to be across.

Q. And you've said that, as I understand it, you consider Ms Peake as an appropriate person, given where we're at in the pandemic now, but your view now is that in the initial phases, someone such as you was preferable?

A. That's right.

Q. And when those decisions were being made by Ms Skilbeck --- that is, to make

the recommendation to the Secretary --- did you express those views and the reasons for it to Ms Skilbeck?

A. I did. I don't know the extent to which I went into my personal reasoning. I expressed my preference. I certainly spoke to my accountabilities and my sense of accountability with respect to pandemic control, and I think delineated the role that a State Controller is defined as, as the individual who applies the controls in an incident or emergency and is a decision-maker in that regard.

Q. Did you express those views directly to the Secretary?

A. Not directly to the Secretary, no.

Q. Do you know if your views were brought to her attention?

A. I don't know absolutely, no.

Q. Did you express those views to the Minister?

A. No.

Q. Do you know whether your views were conveyed to the Minister?

A. I do not know. I don't think so.

Q. In respect of this operational line of sight of which you've spoken and the need to embed someone with public health experience in the command of the Hotel Quarantine Program, Dr Romanes has made some observations in a statement that's been tendered before this Board. Firstly, have you read Dr Romanes' statement?

A. I have.

Q. So you'd be familiar with the part at paragraph 84 where he says:

> *From what I could see, the program was characterised ....*

And first of all, the program he's talking about there is the Hotel Quarantine Program:

> *.... the program was characterised and managed predominantly as an accommodation or logistics program.*

Do you recall reading that in Dr Romanes' statement?

A. I do.

Q. And is that consistent with your observation of the Hotel Quarantine Program,

that it was managed predominantly as an accommodation or logistics program?

A. I really didn't have sufficient insights into the management of the quarantine program to form a view.

Q. Do you have a view now?

A. No. I still haven't seen the historical operational decision-making, planning, preparation, administration, logistics to form a view.

Q. Dr Romanes goes on:

> *I drew this view from observations of the appointment of senior leadership figures that did not have significant public health experience ....*

Pausing there for a moment, you're aware that senior leadership figures within the Operation Soteria structure were people that did not have significant public health experience?

A. Yes.

Q. Dr Romanes, who was present at some of the Operation Soteria governance meetings --- first of all, I understand you were not --- but he says:

> *.... the Operation Soteria meetings I attended did not involve the [Public Health Command] initially, and did seem to me to focus heavily on logistics considerations.*

Are you able to comment on that observation he makes at all?

A. Only that we discussed it and I took his view as his honest, albeit subjective, appraisal of that focus.

Q. And he expressed to you, didn't he, at the time that this was occurring, that which he then reflects upon in his statement at paragraph 84:

> *While the program had significant logistical .... implementation at that time, these were part of the challenge only and I felt that public health considerations needed to be concurrently addressed.*

Now, first of all, that's a sentiment that he expressed to you at the time?

A. Yes, it was.

Q. That's a matter that you and he discussed together?

A. Yes.

Q. And including discussions that were had with the Deputy Chief Health Officer as well?

A. Correct.

Q. And, indeed, you've identified yourself at paragraph 159 of your statement that you held reservations about the lack of involvement of Public Health Command in Operation Soteria?

A. That's right.

Q. You go on to explain those reservations or contextualise them by saying that you felt an ethical responsibility for the welfare of those that were detained in quarantine. That's at paragraph 159, Madam Chair.

A. That's correct.

Q. Now, this was an issue that the Public Health Command raised specifically with Operation Soteria, did they not?

A. I believe so.

Q. You were copied into an email dated 9 April, sent by Dr Romanes to a number of the senior officials within Operation Soteria?

A. Yes, I was.

Q. I'll ask that the document be brought up, Madam Chair. It's document ID DELW.0001.0011.2116_R.

First of all, if we can just zoom in on the top part of that page, which shows who the email is from and who it was addressed to, you see there, Professor, that this was an email sent by Dr Romanes on 9 April, addressed directly to Ms Spiteri, who was the State Controller.

A. Yes.

Q. And to Mr Eagle, from whom the Inquiry heard yesterday, but also CC'd into this email are Pamela Williams, who the Inquiry has heard from was Operation Soteria Commander or Accommodation Commander; Braedan Hogan and Meena Naidu; Merrin Bamert; Annaliese van Diemen, the Deputy Chief Health Officer; and yourself.

A. Yes.

Q. Firstly, do you recall receiving this email?

A. I do.

Q. And does this email reflect the substance of the conversation that you were having with Dr Romanes around that time about concerns to do with the governance of Operation Soteria?

A. I think it's generally reflective and consistent with those conversations. It goes into significantly more granular detail.

Q. If we can highlight the bottom paragraph we see there, the one that starts "There appears" --- it's actually the second substantive paragraph. This is an email, before we go to this, that you would say Dr Romanes was really sending on behalf of yourself, Dr van Diemen, and himself. Do you agree with that?

A. Yes, I think so.

Q. You see here he says:

> *There appears to be a lack of a unified plan for this program, and there is considerable concern that the lead roles have not had an opportunity to be satisfied there is a policy and set of processes to manage the healthcare and welfare of detainees, for whom this program is accountable.*

First of all, that's something you recall reading in the email?

A. It is.

Q. And, secondly, that accurately reflected the way you were feeling at the time about the program?

A. Well, as I say, I didn't have direct experience of the program, so my concerns were in a sense arising out of my conversations with Dr Romanes and his direct view, or as a point of liaison or as a member of the group that met to consider the accommodation concerns.

Q. So based on those things you'd been told by Dr Romanes, assuming them to be true, that was a view that you held?

A. Yes.

Q. We can take that highlight down. And if we can go to the next paragraph and highlight that, please:

> *There are now a considerable complexity and considerable risk that unless governance and plans issues are addressed there will be a risk to the health and safety of detainees.*

Again, is that something, whether it be based on your own observations or what's being reported to you by Dr Romanes, is an accurate reflection of your state of mind at the time?

A. Again, just taking Dr Romanes' reflections and insights on face value, I understood that to be his view.

Q. If we can highlight the next paragraph, please. You see here, Professor, that it says:

> *The Chief Health Officer and Deputy Chief Health Officer are formally requesting an urgent review governance of the mandatory quarantine (detention) program, also known as Operation Soteria ....*

Were you, at that time, formally requesting an urgent review?

A. In discussion with Dr Romanes prior to that email being sent, I did support this being called out as something that required urgent review. So absolutely, Dr Romanes was acting on behalf of me in highlighting concerns that he held.

Q. And we've got provided there, with those five dot points, what the arrangements needed to include, effectively as a minimum.

A. That's right.

Q. Do you agree with that?

A. Yes.

Q. And just finally, if we can highlight the section that appears under "Plan for the mandatory quarantine (aka Operation Soteria)", towards the bottom of the page:

> *The Chief Health Officer and Deputy Chief Health Officer require a single plan to be produced for review by 10am tomorrow morning Friday 10 April. This plan must include ....*

And again we have some dot points. The final paragraph there:

> *The plan will need to show all processes and policy decisions, and manage health and safety of detainees.*

Again, based on the discussions you had, that was an accurate reflection of what you thought was required but at that point missing?

A. Yes. Again, on the basis of the insights that Dr Romanes had into some of the challenges within hotel quarantine, primarily related to health and welfare issues,

these were things that he felt required an urgent review and consolidation.

Q. You say he felt, and you endorsed his position on those?

A. I did. I did, I did.

Q. I tender the document, Madam Chair. That can come off the screen.

CHAIR: Exhibit 158.

EXHIBIT #158 - EMAIL CHAIN FROM DR FINN ROMANES DOCUMENT ID DELW.0001.0011.2116_R

MR IHLE: That email was an email sent by Dr Romanes but drawing on the full force of your office as Chief Health Officer, wasn't it?

A. It was.

Q. It highlighted the urgency of the situation?

A. Yes.

Q. And effectively required immediate remedial action?

A. Yes.

Q. And you identify, Professor, in your statement, that sometime during the process of the Operation Soteria operation that a Public Health Command liaison position was created.

A. That's right.

Q. When did that come to fruition?

A. I think it was in the development of this plan. It wasn't landed by 10 am the following day. And I think that was a pretty high expectation. There is a lot of complexity in that program, as I understand it, and there was a lot to work through. But my understanding is that Dr van Diemen, in discussions with the State Controller, came to the conclusion that a division of responsibilities, with the Emergency Operations Centre having primary focus on the logistic and operational aspects of the Hotel Quarantine Program, and Public Health having carriage of the policies and guidance with respect to health and welfare, infection control and the like.

Q. I'll come back to the question. Do you know when that position was created?

A. I don't know specifically. I believe it did come out of an agreement between Dr van Diemen and the State Controller shortly after that.

Q. But notwithstanding --- I mean, that email was effectively demanding, was it not, that Public Health have a seat at the Operation Soteria table.

A. Yes.

Q. And have some operational line of sight as to what was actually happening from a health perspective?

A. That's correct.

Q. And the result of those demands was the creation of the Public Health Command liaison role?

A. That's correct.

Q. And even that, you say in your statement, was not an optimal way of getting line of sight into the operation of the program with respect to health and welfare?

A. That's right. I think clearly the liaison role was able to sit in on meetings where a number of issues and concerns about --- arising from the program were raised. But it is not the same as having direct oversight and direct view of the daily challenges and operational complexities of that program, which I understood to be substantial, and I think in many ways the public health view and the public health expertise with respect to that would have been beneficial to be more directly engaged.

Q. Because, for example, if we take your position, Professor Sutton, you weren't aware that there were difficulties or problems with the infection prevention and control measures until after the outbreak?

A. That's correct.

Q. That's a fair summation, isn't it?

A. It is.

Q. And indeed, you weren't even aware that private security were being used in the Hotel Quarantine Program until after the outbreak?

A. That's correct.

Q. In that vein, you, in your capacity as Chief Health Officer, made two formal requests of the Chief Commissioner of Police for assistance, did you not?

A. I did.

Q. Now, the first of those was on 16 March. That was before there was any conceived Hotel Quarantine Program. The second of those requests was made on 29 March, the day after hotel quarantine had become operational. What did that request entail?

A. It was essentially formalising my desire to mobilise police to support authorised officers in the exercise of their functions to the extent that was feasible.

Q. What type of support were you envisaging there?

A. I was envisaging --- I mean, it was for those who were engaged in the operations to really determine at the coalface what those specific elements of assistance might be. But the follow-up of those individuals in isolation at home and/or in quarantine at home was a specific concern of mine because I wanted to really see that there would be some opportunity for checking in and/or compliance and enforcement measures as appropriate.

Q. Yes. Just one moment.

So did you have any preconceived idea when you sent that request about whether police would be involved actually at the hotels?

A. No, not a preconceived idea. It was very much in flux.

Q. That was something you left to those that were effectively running the operation?

A. Yes.

Q. We touched upon before, the fact that you weren't aware of the engagement of private security until after the outbreak. You were able, were you not, to see the risks created by the use of that workforce; that is, private security?

A. Yes, absolutely. In retrospect, there are a number of vulnerabilities with respect to transmission risk because of that workforce, and that's not to impugn or vilify any individual involved in that. But the demographics of that workforce cohort provide for significant risks of transmission within the community. The casualised labour that was involved meant that a number of them had other work that they needed to do, which brought the risk of transmission to other workplaces and other individuals. The casualised nature of their work and the dependency they had on that work led to an incentive to stay at work, both in hotel quarantine work but in their other work, I would imagine, while potentially symptomatic, even potentially while diagnosed and aware of that diagnosis.

I'm aware that there were potential cultural and language issues with respect to understanding the policies and procedures of physical distancing and the broader

infection prevention and control measures that were in place, and I think there may well have been issues about the identification of their close contacts, because it effectively takes them out of the workforce for a 14-day period if they're identified. I can't speak to whether that was actually at play for a number of these staff but, in retrospect, it's clear that there must have been close contacts who were not identified because we're aware that this virus extended to the broad community without a clear epidemiological link back to the staff at hotel quarantine, which means that there are unidentified close contacts in that chain who were never raised as close contacts with the Outbreak Management Team.

Q. Professor, you're an expert in public health.

A. I hope so.

Q. We all do.

A. Good!

Q. You're an expert in communicable diseases?

A. Yes.

Q. You can readily see some of the difficulties or risks created by the use of that workforce in this setting?

A. Yes.

Q. And no one asked you your opinion before private security were brought in to be the first line in hotel quarantine, were you?

A. No. Recognising that it was a decision made within hours of that announcement out of National Cabinet, and presumably without a recognition of some of these public health issues that we're all acutely aware of after the facts.

Q. And presumably also then, Professor, without the input of any public health experts or communicable diseases experts?

A. As far as I'm aware, not.

Q. You recall when these issues were first brought to your attention, you expressed a view that this was really the wrong cohort of workers to be engaged in this type of work? Do you recall that?

A. I don't know if I used those words, but I think I certainly highlighted some of the challenges that I've just mentioned with respect to the risk of transmission to the broader community and indeed amongst the workforce itself.

Q. Can we bring up document DHS.5000.0034.6968_R. Now, Professor, this is a chain of emails which includes emails passing between yourself and Professor Brendan Murphy on 20 June. If we can go to the third page, please. Just to put this in context, highlight that top paragraph. We'll see when we scroll back, Professor, that this is an email sent by Brendan Murphy to yourself on 19 June at 8.26 pm, where he says:

> *Been reflecting on the quarantine breaches we have had and the issue raised by Annaliese [that's a reference to Dr van Diemen] today, where a hotel working continued to work while symptomatic and didn't identify ....*

And Professor Murphy asked the question about whether it's possible to pay these workers their normal weekly hours for the two-week period that they're required to quarantine. Do you recall receiving this email?

A. I do, vaguely, yes.

Q. If we can go back to page 2, the bottom email there, the substance of that email. Now, that's a follow-on email that Professor Murphy has again sent to yourself and to Dr van Diemen, saying to you:

> *The other thing I was wondering is whether there is anything we can do to help in your enhancement of infection control ....*

He goes on to say:

> *.... do we need to do more .... up the training and supervision, etc. etc.*

Do you recall receiving that email?

A. I do.

Q. If we can just scroll up then, in response to that email, about 20 minutes later --- sorry, that's Murphy again. You see before Murphy responds to you:

> *Thanks Brendan. We've got good training and IPC supervision but the workforce is the wrong cohort.*

That's you expressing to Professor Murphy precisely what I just took you to, isn't it, your recognition that this private security workforce was simply the wrong cohort?

A. Yes.

Q. And in response, what Professor Murphy sends back to you is:

> *If you needed a short-term surge workforce in the meantime, Aspen ....*

First of all, who are Aspen?

A. Aspen are a private medical organisation that provide medical human resources as required.

Q.

.... or even ADF ....

Did you take that to mean the Australian Defence Force?

A. I did.

Q.

.... could help at very short notice.

Did you understand really that what Professor Murphy was offering there was to give you at least a short-term surge workforce to assist with that wrong cohort that you had identified?

A. Yes.

Q. And specifically focusing in on that, the very short notice that would be required to be able to deploy Australian Defence Force personnel?

A. Yes.

Q. Did you convey that offer made by Professor Murphy to you to anyone else?

A. I don't recall doing so. I knew that Dr van Diemen, as Public Health Commander, was in copy and that she was aware of this offer and this issue, and she was the individual in a position in Public Health Command to liaise, as we've raised earlier, with the Operation Soteria program.

Q. Can you just scroll over to the bottom of the next page, please. Your response on 21 June is:

> *Thanks Brendan. Merrin [which is a reference to Ms Bamert] --- in copy --- is overseeing this operation and I'm sure will touch base as required. I think Aspen, in particular, could strengthen the program but its security staffing that is our main risk at the moment.*

Do you know what, if anything, was done around that late period of June in respect of private security in the Hotel Quarantine Program to address those problems that you were talking of?

A. I'm aware in general terms that the outbreak squads, the Outbreak Management Team, the Infection Prevention and Control Cell within our Public Health Incident

Management Team were looking at all the elements that might be required to respond to the risks that they identified in responding to the breaks.

MR IHLE: I tender the document, Madam Chair.

CHAIR: The series of emails, Mr Ihle?

MR IHLE: The series of emails. The last two I haven't gone to, but in the series, there's probably no reason why they ought not also be tendered. It's DHS.5000.0034.6968, the series of emails between 19 June and 21 June, including those to which we've just referred.

CHAIR: Thank you. Exhibit 159.

EXHIBIT #159 - SERIES OF EMAILS FROM 19 – 21 JUNE 2020 DOCUMENT ID DHS.5000.0034.6968

MR IHLE: As the Board pleases.

Professor, I just want to ask you about the concept of a COVID-positive or so-called hot hotel. Do I understand correctly from your statement that the idea of designating a particular hotel within the program as a COVID-positive hotel was not a matter discussed with you prior to that decision being made?

A. No, it wasn't directly discussed with me.

Q. Do you know whether it was discussed --- sorry, I'll withdraw that.

Going back to the question of oversight, the Public Health Command, of which we've discussed, that's not --- they're not a team that had oversight in relation to the operational aspects of Operation Soteria. Do you agree with that?

A. I do.

Q. That they wrote the policies and then others went and implemented them?

A. Correct.

Q. You say in your statement at paragraph 152 that the idea of a COVID-positive or hot hotel "clearly represented a risk of transmission from quarantined individuals to contracted staff".

A. Yes.

Q. And that's something, as a public health expert and a communicable diseases

expert, would have been readily apparent at the time that decision was made, to you?

A. A hot hotel being a greater risk than --

Q. Yes.

A. --- a pure quarantine hotel? Yes.

Q. Yes. You go on to say that, had you been consulted, you would allow specific infection prevention and control measures to be adopted to take into account that increased risk?

A. Yes.

Q. What types of things would you have recommended, had you been asked?

A. I'm not an infection prevention and control expert. I would have absolutely gotten the input of the IPC team and the broader groups that they engage with around what step-up level of infection prevention and control might be required. But in general terms, the requirements for PPE would be higher because you're dealing with known positive cases or suspected cases. And that you would try and make infrastructural and structural elements to minimise the risk of transmission. So structural elements that create a greater distance between those staff supporting the program and anyone who is a client of the program, that you would stratify the zones where those positive individuals are, separately to staff; that ventilation and flow would all be addressed; and that you would have stringent measures with respect to cleaning and disinfection; and the oversight of all of those elements in terms of training and auditing and review and revision.

Q. Yes. Just one moment. Thank you, Professor.

Just one final topic that I want to take you to, and I just want to get this sequence right. In your statement, you say that the AHPPC did not endorse Hotel Quarantine Program prior to the announcement of National Cabinet.

A. Correct.

Q. A decision was made by National Cabinet and the AHPPC still did not endorse or make that recommendation?

A. They didn't come to an agreement on it, no.

Q. Yes. You would agree that the detention orders that were made in respect of those returned travellers were a necessary element of giving effect to the National Cabinet's decision?

A. Correct.

Q. And the powers to order detention and isolation are powers that vest in you personally under the *Public Health and Wellbeing Act*, irrespective of whether there's a State of Emergency?

A. For individuals, yes.

Q. And they vest within you under the *Biosecurity Act* as well?

A. Correct.

Q. In your role, one of your functions is to authorise authorised officers under section 199?

A. Correct.

Q. Does that mean that you yourself are not an authorised officer?

A. My belief is that I am also an authorised officer.

Q. Okay. Well, why was it the case then, Professor, that you didn't issue the Detention Notices and that you left that instead to the Deputy Chief Health Officer, Dr van Diemen?

A. My understanding was that legal opinion was that there was some potential ambiguity in the *Public Health and Wellbeing Act* at that time that made it not entirely clear whether I had the power to issue those directions as an authorised officer.

Q. Well, they're the directions under section 200, but you had the power to make directions under other provisions, as the Chief Health Officer, didn't you?

A. Yes.

Q. But you chose not to use those ones?

A. I didn't choose anything. The advice of our senior legal representatives in the Department was that I should have an authorised officer sign those directions for the avoidance of any doubt with respect to the Act.

Q. Okay. And that's just based on legal advice?

A. Correct.

MR IHLE: Thank you. Professor, that concludes the questions that I have for you.

May I say --- and I see that we already have Mr Moses on screen --- I have had

notice of an application by Unified Security, but I've also had notice of an application by the Department of Justice and Community Safety. But perhaps, given Mr Moses has joined us, I'll call on him in the first instance.

MS HARRIS QC: Madam Chair, can I just raise one matter? In the course of Professor Sutton giving evidence, I think Mr Moses' instructors have notified us of a further document they wish to take him to. Obviously that's not been possible, as is the anticipation in the Practice Directions, to raise this with him in advance.

It may be that it would be appropriate for us to have some time to actually see what they wish to tender or to deal with with Professor Sutton first. There might be some overlap with other documents previously notified, but on my quick assessment of that email from Mr Moses' instructors, it does just look like they've notified something new.

MR MOSES SC: Yes, Madam Chair. The document is DHS.0001.0012.1504. The Professor gave evidence about this document, which is the *Public Health and Wellbeing Act 2008* request for assistance from the Chief Health Officer to the Chief Commissioner of Police. This is the document that he referred to in his evidence.

CHAIR: Mr Moses, do you mean the document that's now become Exhibit 159?

MR MOSES SC: No, Madam Chair, that's the email chain.

CHAIR: Yes.

MR MOSES SC: So this is a different document. Counsel Assisting asked some questions of the witness in respect of the request for assistance to the Chief Commissioner of Police.

CHAIR: I see.

MR MOSES SC: If I can just take the witness to the document, which is part of the exhibits that are relevant to the Professor, it's DHS.0001.0012.1504.

And my learned friend Ms Harris is correct, it was sent whilst he was giving his evidence because it was something that arose during the course of his evidence. That's why, as my learned friend would know as counsel and as an advocate, sometimes these issues arise as the witness is giving his evidence and it can't be done in a way that is dealt with before somebody gives their evidence. I think she would appreciate that.

CHAIR: Do you want to say anything about that, Ms Harris? Have you got access to that document now?

MS HARRIS QC: I'm trying, Madam Chair. Unfortunately I'm having problems with the online hearing book at present.

MR MOSES SC: I will be coming to that, Madam Chair. If I can assist my friend right now anyway, there is just a short question I need to ask the witness and I can assure my friend that if by the time I get to that issue --- I won't be very long with my questions with the Professor --- then I will stop and ensure my friend has it if she hasn't got it and I won't ask the question.

MR IHLE: Madam, perhaps I can assist in this regard. That was a document, as I understand it, which was annexed to Professor Sutton's statement in any event and a document which had been identified as one that Professor Sutton may have been taken to today. So whilst I understand Ms Harris' concerns, no doubt she has seen that document because it was foreshadowed as a document that I was intending to take the Professor to, but that wasn't required in the instance.

MS HARRIS QC: Madam Chair, if that's the case, I don't know the document numbers off by heart so I wasn't sure that that was going to be something I had seen before, but I will be able to see that from Professor Sutton's exhibits. Thank you.

MR MOSES SC: I think Ms Harris is rightly suspicious of me! Thank you.

CHAIR: So you're making --- you have an application for leave to cross-examine, Mr Moses?

MR MOSES SC: I do, and I've notified our learned friend Counsel Assisting in respect of those topics that we wish to put to Professor Sutton in relation to his evidence. There are aspects of it that have fallen away as a result of the examination by Counsel Assisting. So the first one related to the decision-making process concerning the appointment of authorised officers to deal with the detention of people in the Hotel Quarantine Program. That issue has fallen away.

But for this issue, and that is, what, if any, assessment was undertaken by the Professor in relation to what he understood was going to be the capability of the authorised officers to exercise powers to detain people under the statutory framework --- I think I know the answer to that question, but I will put the question formally to him.

The other questions that we had highlighted related to Exhibit 159, and that is: when did Professor Sutton begin to have concerns about whether the model adopted in respect of Hotel Quarantine Program was appropriate with respect to the use of security in hotels. And the other issue related to the use of hotels so-called as red hotels in respect of putting COVID-19 patients in them, or people with that infection in there, and whether any consideration was given to the welfare of the workers, as well as those under detention.

So those were the range of areas. I should be quite brief, because Counsel Assisting has covered most of the issues that we wanted to cover.

CHAIR: All right. I'll grant you that leave, Mr Moses. Thank you.

MR MOSES SC: Thank you, Madam Chair.

CROSS-EXAMINATION BY MR MOSES

MR MOSES SC: Professor Sutton, you've taken us to your key roles and responsibilities at paragraph 11 of your statement. But, in short, would you agree that your first and highest obligation is the health and safety of the public, in accordance with the powers that you have?

A. Absolutely.

Q. Thank you. And Counsel Assisting has already taken you to paragraph 159 of your statement, but the question that I wanted to ask you was this: in relation to the appointment of authorised officers to exercise powers which would include the detention of citizens, did you undertake any review yourself as to how they would go about detaining individuals; that is, what capability did they have?

A. In the course of authorising all authorised officers --- and I think they probably number in their hundreds at this point in time --- I always receive a memo detailing the process of selection and the credentials or competencies as assessed by the program area. And so it's in reading that memo and having that assurance from the program area that they believe that the skills and competencies --- and they're delineated in specific terms --- are appropriate for the exercise of those specific powers for which they're authorised.

Q. Thank you. And in paragraph 61 of your statement, you say that you struggled to find the number of appropriately qualified authorised officers required for the roles; correct?

A. That's correct.

Q. And in respect of that struggle, did you consider that if there weren't appropriately qualified authorised officers, that perhaps the Hotel Quarantine Program should have been delayed in order that you be able to have appropriately qualified authorised officers to execute the very important role which was involved in being responsible for detaining persons against their will?

A. I certainly understood those pressures to come to bear on the operation of the program. But, again, as someone who wasn't a decision-maker or oversighting that program, I think they were matters for the program area, to determine how they might need to scale back, either in terms of the numbers of international arrivals or the allocation of arrivals across various Australian jurisdictions.

Q. To be fair to you though, that was not something that you were directly involved in, as you state at paragraph 119 of your statement, that you were not directly involved in the operational planning, approving or running of the Hotel Quarantine Program?

A. That's correct.

Q. Can I ask you --- and I'm not being critical at all, because there's been some confusion in the Inquiry as to who was responsible for what --- who did you understand was responsible for running the Hotel Quarantine Program, as the Chief Health Officer?

A. I understood it to be Operation Soteria Commander.

Q. Thank you. Now, Professor, can I just go to your evidence concerning security guards. You say that the first time you became aware that security guards were being used was after the outbreaks and from media reports. This is in paragraph 156 of your statement.

A. Yes.

Q. And can we assume then from that evidence that you were not informed by authorised officers or anybody else that, prior to the media reports about the outbreaks, that security guards were being used by authorised officers in order to assist in their detention of individuals? Is that a safe assumption to make?

A. It's some of the allegations about the security guards made in the media that was the first time that that came to my attention. But the use of security guards obviously came to my attention as soon as the outbreaks occurred, and they were reported through the Outbreak Management Team.

Q. But that was at that point that you became aware for the first time that private security firms were being used; correct?

A. That's correct.

Q. And had you been aware that they were being used at the commencement of the Hotel Quarantine Program, would you have raised the same concerns about security guards being used that you raised in Exhibit 159 that Counsel Assisting took you to, which is an email between yourself and Professor Murphy on or about 21 June?

A. I don't think so. I think the wisdom we have in hindsight is a key element here. I'm not sure anyone at the point in time of decision-making around hotel quarantine commencement might have been able to foreshadow some of the complexities of that workforce. I certainly wouldn't have had sufficient familiarity with it to have made some of the conclusions that I can make now by virtue of having seen some of those complexities play out. I would have obviously brought a public health view, but

I certainly couldn't say that I would have had the same level of concerns or understood what those concerns to be back at that point in time, in late March.

Q. Thank you. And can we assume that by 21 June 2020, the position as it involved the Hotel Quarantine Program was, as you've set out in your affidavit --- your statement, I apologise --- in paragraph 119, that you continued not to be involved in the operational planning, approval or running of the Hotel Quarantine Program or had that changed after the outbreak?

A. No, I wasn't personally involved. But I was aware that there was even stronger engagement with the Public Health Incident Management Team, the Infection Prevention and Control Cell, Public Health Commander, and others of relevance.

Q. Thank you, Professor. Madam Chair, could the witness have --- and could this be placed on the screen --- Exhibit 159, which is the email chain that Counsel Assisting tendered, the one of 21 June. There's just two questions that I want to raise with the witness arising out of something of his email of 21 June sent at 10:06:12 am on the Sunday.

CHAIR: Yes.

MR MOSES SC: Thank you, Madam Chair.

CHAIR: It might be helpful, Mr Moses, to the operator, to give a document identification number rather than the exhibit number.

MR MOSES SC: I apologise, Madam Chair. It's DHS.5000.0034.6968.

Professor, just at the bottom of that email chain, you will see that in response to an email sent by Professor Murphy --- and by all means if you want to refresh your memory, you can go to what you're responding to --- what you said in the email of 21 June was this, I just want to highlight the second sentence:

> *I think Aspen, in particular, could strengthen the program but its security staffing that is our main risk at the moment.*

Do you see that?

A. I do.

Q. If you were not involved in relation to --- if I can refer to it as the operational planning, approving or running of the Hotel Quarantine Program by June, at what point did you form the view that security staffing was the "main risk at the moment"? That is, what did you form --- what was the basis of that statement? Are you able to help us?

A. It was really out of the observations of the outbreak squads and the report of the

Outbreak Management Team that identified a number of issues with respect to awareness and practice of infection prevention and control elements within those hotels. Some of that related to physical distancing, some of that seemed to relate to the inappropriate use of PPE or the lack of PPE being worn when it should have been. So it was largely around the outbreak management reports that I formed that view.

Q. Again, not being critical of you, but in respect of those reports that were coming to you, is that because those reports were coming because of what had happened --- if I can refer to it as the outbreak at the Rydges and the Stamford --- that had caused there to be a spike in those who had contracted COVID-19? That is why those were being sent to you?

A. I received outbreak management reports on a routine basis. So any setting that develops an outbreak would be routinely circulated to a number of people, including myself.

Q. Thank you. What I want to suggest to you, Professor, is that, quite apart from what you have noted as security staffing being [indistinct] at the moment, I want to put to you directly that what in fact was the main risk in relation to what was occurring in respect of the outbreaks at the Rydges and the Stamford was there not being sufficient infection control measures in place. Do you accept that?

A. Yes.

Q. And do you accept, based on what you now know, that there were problems with respect of the --- of cleaners not being properly trained in cleaning hotels that had COVID-19-positive individuals in there? Do you accept that?

A. Based on what --

MS CONDON QC: Madam Chair, before Professor Sutton answers that question, I object to that question on the basis that the Professor has given quite clear evidence that he had no involvement in the operational details of the program.

MR MOSES SC: I think that's a fair objection, Madam Chair. But the point that we're trying to make is that the Professor has made a statement in the email of 21 June about security staffing, and what we're trying to elicit is whether he knew about the issue concerning the cleaners. If his evidence is he wasn't aware of that, then that's fine, but if he turned his mind to it at the time he sent the email and still proceeded to make the statement that he did, then that's a different proposition.

CHAIR: I think the objection then, Mr Moses, is well put. It's the question before it that you need to ask.

MR MOSES SC: Yes, thank you, Madam Chair.

Professor, in respect of your knowledge of what cleaning was being used at hotels --- and in particular I want to focus on Rydges, who had the COVID-19-positive individuals there --- were you aware prior to 21 June 2020 what cleaning was being undertaken at the Rydges Hotel?

A. No.

Q. And were you aware prior to 21 June 2020 which worker was the first worker to contract COVID-19 at the Rydges?

A. I don't think any of us can determine which worker was the first worker to contract the illness. We have notified cases on a particular day, but we can't speak definitively to which worker might have been the first to contract the illness.

Q. Are you aware of a document in evidence in this case that suggests that it was a hotel employee?

A. I am aware of the document.

MR IHLE: Just hang on, Professor. I object to the question. What the document tends to show, Madam Chair, is something quite different to who was the first to contract it, and I think the Professor has answered that question in the previous --- in answer to the previous question.

CHAIR: Yes.

MR MOSES SC: I think that, again, is an objection well taken.

Can I put it this way, in light of what Counsel Assisting has just said, and put it this way in reference to the document. I'm happy to identify the document if need be. But are you aware that the presumptive first case --- there's a document suggesting that a [redacted] was the presumptive first case?

A. I am aware of that.

Q. Thank you.

MR IHLE: Can I just interject. I'm sorry, Mr Moses. But, Madam Chair, for the purpose of the public transmission, information subject to a non-publication order has been identified in that question, and I'd ask that those managing the public broadcast be sensitive to that.

CHAIR: Yes, and I'll give that direction, Mr Ihle.

MR MOSES SC: Thank you, Madam Chair. Just for the record, it's DHS.0001.0036.0147.

The point that I wanted to make in respect of this, Professor, whether you agree with this, is that what Professor Brendan Murphy was raising in the email, which was the last page in the email chain, was a concern in relation to a hotel worker who continued to work while symptomatic and didn't identify because of fear of income loss. The concern really being raised by Professor Brendan Murphy wasn't just limited to security workers but also hotel workers. You understood that to be the case; correct?

A. I don't think I considered the specifics of whom it might apply to.

Q. Because if you go to the last page of the email chain, Exhibit 159, you will see that what the Professor was raising was being reflected in the quarantine breaches, where we've had an issue raised by Annaliese, "where a hotel worker continued to work while symptomatic and didn't identify because of fear of income loss. Is it possible to write into the hotel quarantine contracts a provision that any hotel or security worker", and then it continues.

So at the time you read this email, is it fair to say that what you focused on was the issue of security workers rather than what Professor Murphy was raising, which was also hotel workers?

MR WOODS: Commissioner, I raise an objection to the questions that are being asked. It's Mr Woods here on behalf of Rydges Hotels.

My learned friend Mr Moses I would assume knows well that, whatever is said in the email, the true state of affairs, as is known to the Commission, is that a hotel employee, once symptomatic and not at work, could not return to work. And that's at odds with the evidence that's before the Commission with the behaviour of security guards. And I'd ask that that be confirmed, because the way that this is being put at this stage is that this is reflective of the true state of affairs, and it's known to the Commission and to Mr Moses that that's simply not the case.

MR MOSES SC: Your Honour, I'm not sure what that objection is. That issue is a matter dealt with in submissions. My learned friend is no doubt open to advance submissions or put questions, but raising an objection --

CHAIR: I think the objection is that there's an incorrect factual basis for the way in which the question is put. Is that right, Mr Woods?

MR WOODS: That's correct, Commissioner. What's being --- what the question implies is that this is reflective of the true state of affairs, and it's well known that this is not the true state of affairs. The evidence that's before the Commission is clear that a hotel employee, while not working, was symptomatic and did not return to work.

Now, I don't want it to be put or it to be implied in the question, as I submit it was, that this is reflective of the true state of affairs, because it's not.

MR MOSES SC: Madam Chair, it's a bit of an unusual objection. All I've asked is asked the witness when he read the email, it's about that point in time, did he confine his understanding to the security workers --- because I think my learned friend for Rydges well knows what I am putting, and I think the objection that's being taken, with all due respect to him, is misconceived. He can put submissions at the end of the case, but this is not about putting anything positive to the witness about what's in the email and his state of mind at the time of responding that the main risk was security staffing. That's the point. And I think my friend would well know that, if one takes a step back and looks objectively at what I was putting.

So I press the question, Madam Chair, which was, at the time he read the email, did he focus on the issue of security workers because he overlooked the reference to hotel workers, or was there a reason why he was referring to security staffing as the main risk? That was the proposition.

CHAIR: All right. I'll allow that question, Mr Moses.

MR MOSES SC: Thank you, Madam Chair.

Professor, just in respect of that last email, Exhibit 159, when you've read that and then you responded as you did in the email chain, you will see on 21 June ultimately, by saying, "it's security staffing that is our main risk at the moment", when you responded, was that deliberate or was it because you had not turned your mind to also what Professor Brendan Murphy was raising about hotel workers also being a concern?

A. I'm afraid I can't recall what might have been in my mind in responding at that time.

Q. That's fine, Professor. I'm not being critical, I just wanted to understand where that came from, lest that come to have some significance at the end of the Inquiry.

The one final issue I wanted to raise with you was something concerning the Rydges Hotel where COVID-19 guests were. The case is at the moment --- and if you don't know, please say so --- the Brady Hotel is being used for COVID-19 cases, and that has, in effect, assistance being given there by Alfred Health in respect of a comprehensive clinical approach there. Do you understand that to be the case?

A. I do.

Q. Did you have any role at all, as the Chief Health Officer, in the establishment of what is currently going on at the Brady Hotel with the Alfred Health?

A. No.

Q. Again, then can we also assume that in respect of the Rydges venue as the hotel

for COVID-positive cases, that that was not something that you were involved in making that decision; correct?

A. That's correct.

Q. The final question that I want to ask you is this: do you think, sitting here today, that in respect of COVID-19-positive cases that, rather than quarantining them in a hotel, if the health system could accommodate it, would it be best that they be quarantined in an infectious diseases ward? Would that be the best practice, sitting here today?

A. I think --- yes, I think if the capacity is there in terms of the space and the human resources required, that it's clear that a clinical setting provides a higher level of clinical care and infection and prevention control than might occur outside of that setting. That's uncontroversial.

MR MOSES SC: Thank you, Professor. Madam Chair and Professor, thank you for your patience. I have no further questions.

CHAIR: Thanks, Mr Moses.

MR IHLE: Thanks, Madam Chair. The foreshadowed application by the Department of Justice and Community Safety has been withdrawn but there is a new application by the Chief Commissioner of Police, so I call on Ms Davidson.

CHAIR: Just let me check with Professor Sutton. Professor Sutton, we'd normally be taking the lunch break now. I'm not quite sure how much is left. But are you okay to continue at the moment?

A. If I collapse, you will see.

CHAIR: All right. Hopefully --

A. I'm fine.

CHAIR: Hopefully we're only talking about another 10 minutes or so.

A. Absolutely fine.

CHAIR: All right.

MS DAVIDSON: Thank you, Madam Chair. The issue I'd seek leave to ask Professor Sutton about relates to the --- it was referred to as a request on 29 March, the formal request for assistance from Victoria Police, and I'd seek to ask some clarifying questions in relation to that.

CHAIR: Yes, I'll grant you that leave, Ms Davidson.

MS DAVIDSON: Thank you.

CROSS-EXAMINATION BY MS DAVIDSON

MS DAVIDSON: Professor Sutton, there was, as I understand it, an initial request to Victoria Police on 16 March?

A. Correct.

Q. I wonder if you can be shown that request. It is DHS.5000.0055.3884. Professor Sutton, do you sort of recall the issues around the request for assistance and what needed to be done from a legal perspective in order for police to be able to provide assistance to enforce directions that you had made?

A. I don't recall the exact legal nuance involved. My understanding at the time of the *Public Health and Wellbeing Act* is that authorised officers can make a verbal request of Victoria Police to assist in the application of powers that they hold as authorised officers. I think there was --- I recall that there was some concern as to that not being sufficiently clear as a power of authorised officers, and that it would be of assistance to clarify the request formally with respect to police assisting AOs.

Q. Certainly. So, for example, in this case, the request here is in relation to directions that had been made dated 16 March 2020.

A. Yes.

Q. And presumably those directions were --- had the potential to expire, is that right, they were about to expire, for anyone, say, that had been quarantining for 14 days?

A. I don't --

CHAIR: What date are you referring to, Ms Davidson? Because the quarantine program didn't start --- obviously hadn't started as at 16 March.

MS DAVIDSON: Certainly. Maybe I could clarify with Professor Sutton. There had been directions for people to quarantine at home; is that correct?

A. Yes, that's correct.

Q. And police were involved in assisting and checking on those people and making sure that they were home. There were other sort of powers in relation to other directions that had been made, that police needed a specific power to enforce under the *Public Health and Wellbeing Act*. Would that be correct?

A. Yes.

Q. And so at this time on 16 March, you've got a number of people who are quarantining at home, and there were reports in the media, obviously, about people not complying with those directions; is that correct?

A. That's right.

Q. And police were involved in assisting you in terms of enforcing those directions?

A. I believe so.

Q. And so this direction, if someone --- this was concerned with directions that had been made on 16 March, this particular request for assistance?

A. Yes.

Q. And, of course, you subsequently made a number of other --

A. Directions?

Q. --- a number of other directions that needed some sort of power for police; would that be correct?

A. Yes, that's right.

Q. And then if I can ask --- and I'll ask that you be --- if you can just take a note that your request there is really limited to a sentence, and it relates to directions made under section 200 of the Act. But if I can ask that you then be shown the request that was made on 29 March, which is DHS.0001.0012.1504. And this was a request dated 29 March. And I think in answer to the question that you were asked about this, you said that you were envisaging that police would follow up individuals at home, and you gave an answer in relation to that. I'm sorry, I don't think I can access the online transcript at the moment. But is your expectation that this new direction was to replace the old one on 16 March? Is that your understanding?

A. I honestly can't read it from the screen, and my recollection is unclear. It might have been to replace. It might have been to provide additional clarity and detail around the exact request.

Q. So there is some additional clarity in relation to this request. So it says:

> *This request includes, but is not limited to, any actions that police officers need to take to monitor compliance with the directions, investigate and respond to alleged breaches of the directions and, where it is determined that persons have failed to comply with the directions without lawful excuse, take any necessary enforcement action, by taking steps to compel compliance and/or by*

issuing of fines or charging people for breaching section 203 of the Act or any other steps lawfully available to them.

Do you recall that there was this further direction that provided much greater clarity --

A. Yes.

Q. --- and assurance to Victoria Police in relation to their powers?

A. Yes, I do.

Q. And I know it's dated 29 March, but would you agree that that date is really in some respects coincidental? It wasn't a request that police assist specifically with the Hotel Quarantine Program, was it?

A. No, not at all.

Q. No, it was a direction to --- it was a request to ensure that police had sufficient powers to enforce compliance of all of the directions that were being given in relation to this public health emergency?

A. Yes, and I think it's fair to say that in writing this, I'm not providing police any powers that they didn't previously have, but it is a request that provides clarity around the powers of authorised officers to request the assistance of police in the execution of those powers as AOs.

MS DAVIDSON: Thank you, Professor Sutton. I've got no further questions, Madam Chair.

CHAIR: And, Professor Sutton, did you get a response to those requests?

A. I can't recall. I presume I did. I'm happy to search for that.

CHAIR: I'll ask you to do that, if you wouldn't mind, and get in touch with Mr Ihle after you've done those searches.

A. I shall do so.

CHAIR: You may be able to assist, Ms Davidson, with respect to the responses to those requests. I'll ask you to do that too, please.

MS DAVIDSON: I can, Madam Chair. My understanding is this is a formality that needs to happen in order for police to be able to, on an individual basis, on a day-to-day basis, enforce directions. So it may not be something that there is a general response to, but rather something that police just respond to by responding to the request for assistance on a day-to-day basis when authorised officers ask for it.

CHAIR: All right. But you will check that, please.

MS DAVIDSON: I'll follow that up.

CHAIR: Thank you. Mr Ihle?

MR IHLE: Just to clarify that last issue, if I may, Madam Chair.

RE-EXAMINATION BY MR IHLE

MR IHLE: Professor, in respect of that request you were taken to, that is the request of 29 March --- now, I appreciate around 29 March, you probably had a fair bit on your plate and executing documents that are, as Ms Davidson described it, just a formal process are probably not ones that occupy a great deal of your time and attention. But to come back to it, that was a formal request for assistance by Victoria Police for the enforcement in respect of all directions that were then in place. Is that so?

A. Well, it would have been to assist authorised officers, and those authorised officers would have had specific powers depending on the authorisation that was provided to them individually.

Q. Yes. And those authorised officers included a substantial number who had been authorised in respect of ensuring that hotel quarantine was being enforced and observed?

A. Some of them, I'm sure that would have been the case, absolutely, because the program was stood up at that time.

Q. So this request dated 29 March, even though broader than just hotel quarantine, was at least intended to capture, in part, hotel quarantine and the assistance it required?

A. Yes, I think the intention was to apply to authorised officers in the execution of their powers in whatever respect.

Q. Yes. And just finally, your evidence earlier, and I just want to see if it remains the same in respect of this now that you've been taken to it again, is that insofar as what the police would actually do within hotel quarantine after you've deployed this request, you left that to those that were running hotel quarantine to determine the extent of that involvement?

A. Yes, it's always the judgment of the authorised officer that they need to exercise their powers in accordance with the Victorian Charter of Human Rights and

Responsibilities, and within the limits of the delegated powers --- not delegated, the authorised powers under the Act specific to them.

Q. Yes, and if there was to be a role of Victoria Police presence on the ground at the hotels, that was a decision that you left to those running Operation Soteria to make in conjunction with the police?

A. Correct.

MR IHLE: Thank you, Professor. That concludes the questions I have for you. Madam Chair, unless there are --- of course, Ms Harris.

MS HARRIS QC: I'm very regretful to ask for leave to ask a question about one issue, Madam Chair. I know Professor Sutton has been in the chair giving evidence for a long time, but I would be quick and I imagine it might be preferable to coming back after lunch.

CHAIR: I imagine that's so. Is it, Professor Sutton? You'd rather complete your evidence now and be excused?

A. If at all possible, that would be great.

CHAIR: Yes.

MS HARRIS QC: Madam Chair, it just relates to a question that Professor Sutton was asked about the cohorting of COVID-positive individuals in a specific hotel.

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

MS HARRIS QC: Thank you.

CROSS-EXAMINATION BY MS HARRIS QC

MS HARRIS QC: Professor Sutton, I understand your evidence was that you were not involved in giving a recommendation about the cohorting of COVID-positive individuals in a hot hotel. I wanted to ask you about Dr Finn Romanes and his role as the Deputy Public Health Commander - Planning. Was that role intended to be a role under the Emergency Management Framework that had also a reporting line up to the State Controller with the Public Health Commander?

A. The Deputy Public Health Commanders, all four of them, reported to the Public Health Commander, who reported to me. So I wouldn't say that it's a report directly in to the State Controller, but Dr Romanes in particular was engaged in advice on policy and other guidance matters to Operation Soteria more than most. But it was a --- it was more in the liaison role than a direct line of command.

Q. And you're probably aware that Dr Romanes has given a statement, but that that has been tendered rather than him coming to give evidence orally. He gives some evidence about having been consulted about the idea of putting COVID-19-positive individuals within the Hotel Quarantine Program into a dedicated hotel from 30 March, and then subsequently being asked further questions about his views on cohorting. Was that the intended line of public health input into those questions, that Dr Romanes, if consulted, would be giving his views about those matters?

A. I'm not sure. I think Dr Romanes would probably have to respond to that directly. But as a public health physician like myself, he's qualified to give advice on that matter of cohorting, and I think it's well known that the idea of cohorting is one that helps to minimise risk in terms of those who might be exposed, both as cohorted individuals together, but also in the staff or clinical staff who look after them.

Q. Thank you, Professor Sutton. So really we should be looking --- in terms of the specific advice given, we can go to Dr Romanes' statement and that may not have been advice that you were copied into or involved in, if it was given in meetings, for example?

A. That's right. Dr Romanes and I discussed the idea of cohorting and agreed that as a general principle, it has public health merit.

MS HARRIS QC: Thank you. Thank you, Madam Chair, and thank you, Professor Sutton. Those are my questions.

A. Thank you.

CHAIR: Nothing further, Mr Ihle?

MR IHLE: No, there's not, Madam Chair, and can I apologise to Ms Harris for jumping in there. If there's nothing else, may we thank Professor Sutton for his work and for joining us today and excuse him.

A. Thank you, Mr Ihle. Thank you, Madam Chair. Thank you both.

CHAIR: Thank you, Professor Sutton, for your attendance. You are now excused. You can turn off your microphone and your camera. Thank you.

THE WITNESS WITHDREW

CHAIR: We will take a break now until 2.15, Mr Ihle.

MR IHLE: As the Board pleases.

ADJOURNED **[1.23 PM]**

RESUMED **[2.15 PM]**

CHAIR: Yes, Mr Ihle.

MR IHLE: Good afternoon, Madam Chair. I call Dr Annaliese van Diemen.

CHAIR: Dr van Diemen, I understand you wish to take the affirmation for the purpose of giving your evidence before the Board?

ANNALIESE VAN DIEMEN: Yes, Madam Chair.

CHAIR: All right. I will have my Associate administer the affirmation to you. Thank you.

DR ANNALIESE MAREE VAN DIEMEN, AFFIRMED

CHAIR: Thank you, Dr van Diemen. I'll hand you over to Mr Ihle now.

Thanks, Mr Ihle.

MR IHLE: Thank you, Madam Chair.

EXAMINATION BY MR IHLE

MR IHLE: Good afternoon, Doctor.

A. Good afternoon.

Q. Are you able to hear and see me okay?

A. Yes, I am.

Q. Excellent. Can we start with your full name, please.

A. Annaliese Maree van Diemen.

Q. And your current role?

A. Deputy Chief Health Officer, Department of Health and Human Services.

Q. Thank you. You're obviously aware that we're enquiring into the State's Hotel Quarantine Program. Do I understand correctly that for a period of time you were the Victorian Public Health Commander?

A. Yes, that's correct.

Q. And what was that period?

A. That period was from late February this year until approximately 19 or 20 July.

Q. Thank you. And just for the sake of clarity, you are a medical doctor?

A. Yes.

Q. You're a fellow of the Royal Australasian College of General Practitioners?

A. Yes.

Q. And a fellow of the Australian Faculty of Public Health Medicine which is a chapter of the Royal Australian College of Physicians?

A. Correct.

Q. Thank you. Dr van Diemen, you've provided a statement to this Inquiry as written evidence in answer to a number of questions that were posed to you. That statement is dated 9 September.

A. Correct.

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

A. I do.

Q. That statement is 33 pages long and has 150 paragraphs of information within it?

A. Yes.

Q. Are the contents of that statement both truthful and accurate?

A. Yes, they are.

MR IHLE: Madam Chair, I tender the statement of Dr van Diemen dated 9 September.

CHAIR: Exhibit 160.

EXHIBIT #160 - STATEMENT OF DR ANNALIESE VAN DIEMEN

MR IHLE: As the Board pleases.

Dr van Diemen, in preparing the answers to the questions that you have provided in your statement, did you have reference to and have you cited a number of other documents?

A. I have.

Q. And as far as you're aware, the documents that you've cited contain information that is both accurate and correct?

A. Yes, to the point in time that they were created, yes.

Q. Yes, thank you.

Madam Chair, I tender as a bundle all documents referred to in Dr van Diemen's statement.

CHAIR: Exhibit 161.

EXHIBIT #161 - ANNEXURES TO STATEMENT OF DR ANNALIESE VAN DIEMEN

MR IHLE: As the Board pleases.

Dr van Diemen, in your statement at paragraphs 2 and following, but specifically at paragraph 11, you outline a previous role that you --- or previous roles that you have had in your role as Deputy Chief Health Officer, including work done at the Victorian Arbor Virus Disease Control Program; is that right?

A. Yes, so the Victorian Arbor Virus Disease Control Program came under my purview as manager of Communicable Disease Prevention and Control.

Q. Yes, and one of the things I'm specifically interested in is that you say that you were engaged in look-back exercises, pandemic planning and emergency preparedness. Can you just talk us through what was involved in relation to the pandemic planning and emergency planning aspects of that role?

A. Certainly. So in my role as the manager of communicable disease prevention and control, I had a small team of project and program officers and one of those program

or project officers was the pandemic planning role. So that was the person who was responsible for updating our pandemic plans and had significant input into the exercise as discussed with Dr Sutton earlier, Professor Sutton earlier today, and was responsible for liaising with Emergency Management colleagues in respect to a wide range of planning exercises, including but not limited to some of the Concept of Operations plans that were also discussed this morning, and a variety of other activities.

Q. The work of that person who fell under your purview informed, to some degree, Operations Alchemy and Teapot?

A. Yes, yes. That person was less involved in Teapot, in the conceptualisation of Teapot by virtue of the type of disease that it was looking at, but certainly was very involved in Operation Alchemy. I was on parental leave at the time that Operation Alchemy occurred so I didn't have really any input into that particular operation or exercise.

Q. Yes. Are you aware in that role where you're overseeing or within your purview, to use the language you used, that someone was really primarily engaged in pandemic planning, was there any aspect of pandemic or emergency planning that touched upon the possibility of quarantining of large numbers of people?

A. No, not to my knowledge. The primary purpose of that role was to look at how we would implement the Australian Health Management Plan for Pandemic Influenza and the associated Victorian plan. At that point in time, there hadn't been either jurisdictional or national consideration to the large-scale quarantine of returned travellers. It was considered more in the realms of home-based quarantine for cases or contacts.

Q. Are you aware of any plans, either in Victoria or more broadly in this country, that envisaged the possibility of large-scale quarantining of persons in places other than their homes?

A. No, I'm not.

Q. So from that, do we take it that the first you turned your mind in a professional sense to that possibility was sometime in late March?

A. Yes.

Q. And specifically that period in late March, was it before or after the National Cabinet had announced that there would be a program now known as Hotel Quarantine Program?

A. My first recollection of discussion around Hotel Quarantine was the time that it was announced by National Cabinet and conversations immediately thereafter with Dr Sutton, that we would be implementing that decision.

Q. Okay. So just to be clear on that, it's not something you, in your role, had turned your mind to prior to it being announced by National Cabinet?

A. No. No.

Q. Okay. In your statement at paragraph 21, you make the observation that the Hotel Quarantine Program was not a public health function. You go on to say that it was an emergency function. Can you explain to us what you mean by making that distinction?

A. So the distinction would be in terms of the operations of the program was not a public health operational program. Obviously the entire response was of public health --- had public health oversight. However, the operation of the Hotel Quarantine was not under the public health purview, as opposed, I suppose, to, for example, case contact and outbreak management, which was an operational aspect of the public health response.

Q. Yes, we'll come back to that in a bit more detail later. But I just want to ask you about your role in the Hotel Quarantine Program, if I may. As I understand it, throughout the period --- and I know that there were periods where you were in specific roles and periods where you were not, for example Public Health Commander is one that we've already touched upon --- but insofar as it relevant, do you agree that your roles that had import or that had effect into the Hotel Quarantine Program first of all was that period you were the Public Health Commander, between February and June?

A. Yes.

Q. Sorry, July?

A. Yes.

Q. But you're also wearing the Deputy Chief Health Officer hat throughout that period as well?

A. Yes.

Q. And in your role as the Deputy Chief Health Officer, you were delegated powers by the Chief Health Officer?

A. Yes.

Q. And you issued a number of directions?

A. I did.

Q. And you were also wearing a third hat, if I can call it that, as an authorised officer yourself?

A. Yes. That was the hat under which I issued the directions, more so than as my role as Deputy Chief Health Officer. I could not, in my role as Deputy Chief Health Officer alone, have issued the directions.

Q. Yes. Were there directions that you issued as a Deputy Chief Health Officer or as delegate of the Chief Health Officer other than the Hotel Quarantine directions?

A. So all of the directions were issued as an authorised officer. The fact that I was Deputy Chief Health Officer was, I suppose, inconsequential to the issuing of directions, but as an authorised officer, yes, I did issue a large number of other directions both in terms of the primary issuing of the direction and in terms of re-issuing of directions as the State of Emergency was extended on a number of occasions.

Q. Yes. Did you ever in your capacity as Public Health Commander issue any directions?

A. Again, Public Health Commander is a role under SHERP, but isn't a role that is spelled out under the *Public Health and Wellbeing Act*, in terms of having the legal authority to issue directions, so as Public Health Commander, no, I didn't issue directions. All of the directions that I issued were under the auspices of being an authorised officer.

Q. Yes, so what was your role as the Public Health Commander under SHERP?

A. So the role of the Public Health Commander is to have oversight of the public health response of a health emergency, and that will differ depending on the particular emergency. In the case of communicable diseases, there are a number of major aspects to the public health response, namely operations, which in this scenario is primarily case contact and outbreak management, and planning, which in this aspect covered a very wide range of elements in terms of physical distancing planning, and planning around all forms of directions as they were put in place, and then revised, and then wound back as the first rounds of easing commenced, but also, planning had remit over the health management --- the health plans aspects and into various other ad hoc requests and requirements of planning across other areas of Government as they came in.

And the --- another major function is intelligence, so this is the team of epidemiologists and data officers and surveillance officers who gathered a large amount of the intelligence both from cases, contacts and national and international literature, and ensured that they were available in as rapid as possible a format.

And the final major component early on was the logistics function, really, of ensuring our response was being scaled up at the pace that was needed and finding

resources both human and physical to mount the response that we needed to.

Q. We've heard some evidence from Professor Sutton this morning in respect of the public health team, and he's also talked about the Public Health Incident Management Team.

A. Yes.

Q. Are they different concepts?

A. So the public health team in general, in, I suppose, business as usual, is as described in my statement: a number of different teams that sit in the communicable disease section of the Health Protection Branch. Incident management teams are stood up under an AIIMS structure generally for a time-limited incident and we frequently stand up incident management teams, and we stood up quite a number during the preceding year in response to measles outbreaks, and our colleagues in the environment section did similar for fires and other environmental incidents.

So an Incident Management Team is an Emergency Management structure that is stood up in response to an incident. In this particular respect, clearly it was stood up in response to an incident that continued and multiplied and became larger, and as such the team --- there was iterative versions of the Public Health Incident Management Team to adjust for the scale and the requirements of the emergency, and then that was phased into a more permanent structure akin more to a regular Government structure.

Q. Yes. You say in paragraph 20, in respect of describing your role as the Public Health Commander that --- and these are the final two sentences of that paragraph:

> *While SHERP contemplates that the [Public Health Commander] reports to the State Controller, in practice, I did not report to the State Controller.*

Why was that the case?

A. Well, really it was because the interpretation was that the Public Health Commander would report to the State Controller under the contemplation that the State Controller would be the Chief Health Officer, and that the Chief Health Officer was the lead figure in any public health response to a health emergency. So in respect that --- and therefore a State Controller would generally delegate Public Health Commander to another person. So, given that the Chief Health Officer was not the State Controller and that we were in the most part acting and undertaking the vast majority of our response under the *Public Health and Wellbeing Act*, under which the Chief Health Officer is the primary person, I reported directly to the Chief Health Officer because, (a) he is, in normal times, my line manager --- pardon me, my line manager; and (b) in discussions when the decisions were being made around who would be the State Controller, it was made clear that the Chief Health Officer, regardless of whether he was the State Controller, would retain control over and

ultimate responsibility for the public health response.

Q. Yes.

A. So that was the --

Q. You go on --- sorry, I apologise. I spoke over you.

A. I was just going to add that that was an agreed approach by everybody.

Q. Okay. You go on in the next sentence to say that you reported to the Chief Health Officer, and you've just described that, and say:

.... and filled an advisory role with the State Controller.

So, first of all, this advisory role with the State Controller, that's in your capacity as the Public Health Commander?

A. Yes, we spoke frequently.

Q. But specifically in respect of advice and giving advice, presumably that was advice directed to the health aspects of the response?

A. Yes. Yes. Often we would --- one or the other of us would call the other if something required us to provide advice to a certain aspect, be that something to do with industry or something else that had come up in the state control team --- or the State Coordination Team, sorry.

Q. And Professor Sutton has dealt with this in his evidence this morning. Do I also understand that the public health team or the Public Health Command obviously provided advice in a more formal way too, whether it be in respect of recommendations around infection prevention control and policy?

A. Yes, we did, we provided a large number of advice and policy positions around the public health response to COVID-19, specifically to hotel --- to the Operation Soteria Emergency Operations Centre, but also to more broader industries, and state-wide.

Q. And focusing down on the Hotel Quarantine Program, the advice and policies that were proliferated by your team and sent through to Operation Soteria included things like cleaning?

A. Yes.

Q. Included the use of PPE in the hotel quarantine environment?

A. Yes, although I will add at some point, I believe, in early April, a request was

made from the Operation Soteria team to the infection control --- I'll call it a team, but there was one infection prevention and control practitioner at that point, and that person, as I'm sure you would understand, was having a significant amount of requests in to them, so that person recommended that they didn't necessarily have the capacity to provide advice in the detail that was needed, so recommended an alternative source of advice, which was Infection Prevention Australia, and thus they were engaged by Operation Soteria. The advice that they provided was looked over by our internal team, but not necessarily created in its full by our internal team.

Q. And the advice that you provided through to the State Controller and through to Operation Soteria also included advice around welfare of those who were in quarantine?

A. Yes.

Q. You say in your statement at paragraph 67 that there was:

.... provision of regular welfare calls to all quarantined passengers ....

In respect of Operation Soteria plan 1, version 1. You go on to say:

.... which is what I understood was taking place ....

I want to just understand the basis of your understanding that regular welfare calls were taking place.

A. So for the first two weeks of the operation, I didn't have a detailed knowledge of how the day-to-day operations in the hotel were being undertaken. Over the Easter weekend, from the 10th to the 12th, I became aware in more detail of the exact procedures that were being undertaken at that time. And the detail of those were that there was daily calls being made by nurses for acute symptom checking and other --- and checking for other acute medical or social needs. So there was a daily check.

The checks that have been referred to in other testimony, specifically called the welfare checks, I understand to be a longer-form check that goes through a much more comprehensive, both physical health, social, emotional and mental health and other, I suppose, social and family circumstances, to see if there is additional assistance that people require throughout their stay. So those checks at the time of that weekend were occurring once at the beginning of people's stays and a shorter form again at the end of those stays. But there was certainly a daily check --- certainly a daily check by a health professional to each person in quarantine.

Q. And those daily checks were focused primarily on the symptoms of COVID; that's your understanding?

A. Yes, and any other --- yes, my understanding, exactly. I also understand that they did ask if there was any other needs that people had and, when identified, those were

referred to the appropriate team, whether that be the CART team or a general practitioner or concierge services.

Q. So just focusing on your advice capacity and these welfare checks, if I can, your understanding is that version 1 of the Operation Soteria plan had provision for regular welfare calls and, as you say at paragraph 67, that's what you understood was taking place?

A. Yes, but I wasn't involved in the drafting of version 1 of the plan. So that understanding was from verbal conversations only.

Q. Nor were you involved in actually implementing the advice itself. You provide the advice through to Operation Soteria and they implement it. Is that fair?

A. Yes, that is fair.

Q. So as far as the knowledge that you have and the knowledge that you had at each relevant time, that was based on what had been verbally relayed to you?

A. In those first two weeks, yes. There was more formal reporting in future weeks.

Q. And we know you've nominated that Easter weekend. That was the weekend of the incident that triggered --

A. Yes.

Q. --- the first Safer Care review, where a passenger in quarantine was found deceased?

A. Indeed.

Q. And you understand, don't you, in your role as Public Health Commander, that as part of that review, improvements were identified, opportunities for improvements were identified in respect of welfare calls?

A. Yes. And I believe a large number of those opportunities had been informally identified prior to the formal review being handed down and were in fact implemented reasonably quickly.

Q. Yes. Under the heading of "Welfare checks" on paragraph 66 of your statement, you say:

> *The AOs undertook checks and then there was a longer form health check after a few days with the objective of checking any health needs.*

We've dealt with those longer form checks already. But can you explain to us, what was your understanding about the AOs undertaking checks?

A. So my understanding early on was that the AOs were to be undertaking a daily check in order to fulfil the requirements of the 24-hour review. I believe that that became practically difficult to do, based on the number of AOs there were and their other compliance requirements; and that, given there were already --- there was at least a daily phone call and sometimes more frequent phone calls from other organisations, depending on the needs that had been identified, that it was determined that the AOs would undertake their daily reviews for the necessity to continue to detain people via a paper-based or a form, be that electronic or paper-based, and that the purpose of the AO daily check was really to determine that people were required to remain in quarantine or remain, in this case, in detention, as it was called, and that that is particularly relevant in other situations where the risk may have passed. But in this situation, as has been discussed previously, the 14-day quarantine requirement remained for the 14 days that people were there, unless they were able to be released because they'd already been infected and become non-infectious.

So there was very few instances where anybody would be being released. So it was determined that yet another daily phone call from an authorised officer, on top of the existing phone calls they were already getting, was an unnecessary impost both on the returning guests but also on the AOs who had other much more practically useful activities to be undertaking.

Q. Just so that I can understand that, very briefly, is it your evidence that, from your understanding, the AOs were the ones doing the initial daily phone checks but then later on, because that became impracticable, because of the number of AOs and the number of quarantined guests, that shifted somewhere else and the daily reviews were then done in a paper-based way?

A. So my understanding is that there were nurses undertaking checks daily from the beginning. I can't be certain at what point the AOs transitioned from speaking to guests daily to doing their check, that detention was still required via a form. I would have to get back to you on that one.

Q. There came a point fairly early on in the piece where you expressed some concern, along with Professor Sutton and Dr Romanes, about the governance of the program and specifically about what you perceived to be an absence of health-focused governance. Is that a fair summary?

A. Yes, that's a fair summary.

Q. And Professor Sutton this morning was taken to the email that Dr Romanes sent through to the State Controller and copied in a number of very senior people within Operation Soteria dated 9 April.

A. Yes, I'm aware of that email.

Q. And are you --- first of all, did you watch the evidence of Professor Sutton this morning?

A. Yes, I did.

Q. So you would have seen that I took him to that email?

A. Yes.

Q. And as I understand his evidence, by way of sort of broad compass, he said that many of these things were effectively brought to his attention by Dr Romanes and he had no reason not to accept them, and so endorsed the recommendations from Dr Romanes to send that email seeking an urgent review and implementation of an altered plan.

A. Yes.

Q. Did you --- was your position more closely aligned with Dr Romanes, in that you had personal things based on what you had observed or was yours more in line with Professor Sutton's, whereby you were relying on what you were told or was it a combination or somewhere between the two?

A. I would say it was a combination of the two. I was physically sat next to Dr Romanes at that time in the State Emergency Management Centre here at 50 Lonsdale, so I was more closely present to him when he was observing some of those issues through meetings and teleconferences. And I would say that I probably had more conversations with him about it as those --- as his concerns were forming in his mind and during his observations. And I would say that I, over the couple of days leading up to that, we --- Dr Romanes and I had more interactions personally with the lead officers in the compliance and enforcement section for whom some of the reports of how things were running on the ground were a bit more evident to us, and so I would say my position would be somewhere between those two things, that I had a little bit more knowledge of how things were going and of the fact that, in our opinion, there needed to be a little bit more structure around how some of the things were operating, mostly in terms of ensuring that the people who were operating in this very new, very unfamiliar environment had some clear reference material to go to when they needed to make decisions, to guide them.

Q. You endorsed that email when Dr Romanes sent it? You believed it was an appropriate email for him to send?

A. Yes. I would agree with Dr Sutton, though, that the timelines were perhaps slightly unrealistic. But the overall sentiment, I endorsed, yes.

Q. And it reflected the way you felt about the operation at that time?

A. Yes. I think we were all acutely aware, whilst fully supporting the need for

quarantine of returned travellers, we were also aware that we were detaining people and that there were inherent risks in that that we needed to be very, very cognisant of.

Q. And even now, on 16 September, when you look back, you would agree that it was a reasonable email for Dr Romanes to send with your and Professor Sutton's endorsement at that time?

A. Yes, I think so.

Q. And that email obviously speaks for itself, but it reflects the concerns that you had at the time about there being a lack of clear lead in relation to the operation?

A. Yes. Yes, it does.

Q. A lack of accountability in the operation?

A. I'm not certain that I would equate a lack of a clear lead with a lack of accountability. I think I would say that once the Emergency Operations Centre structure was stood up, it became a lot clearer to me who my go-to point was in that operation. But I would say it was always clear that the accountability ran through to the State Control Centre.

Q. In the email, and I'll read it to you --- we can bring it up if need be, Dr van Diemen --- it was stated:

There appears to be a lack of unified plan ....

A. Yes.

Q. That was reflective of your views at that time?

A. Yes. Yes. There was a desire that we could have a very clear understanding of what was intended, how the program was intended to run, and that that clear understanding was, as much as possible, in a single place and able to be accessed easily by people who needed to.

Q. And specifically one of the dot points, which Professor Sutton agreed was the minimum standards that you were calling for, was a direct line of accountability to you, the Deputy Chief Health Officer.

A. Yes. And that was primarily as the authorised officer who had signed the detention orders; and, as I say, I think we were all acutely cognisant of the gravity of that.

Q. And you were very clear, I suggest, in --- well, Dr Romanes was clear in his sentiment that there be a shift in focus to a more wellbeing and health focus and that

these structures might enable that to occur?

A. Yes.

Q. You say at paragraph 147 of your statement, Dr van Diemen, that:

> *I think we all could have treated the hotel quarantine program more as a health program than a logistics or compliance exercise and viewed the overarching principles more from a health lens than occurred at the time, including standards of care and infection control.*

That's a reflection that you make, isn't it, saying that, really, when you look back on this program, it was run as a logistics or compliance exercise?

A. So, yes. And I would, I think, caveat my response with, again, that is in retrospect and we know a lot more now than we did then. But as others have spoken to, I think the current model with healthcare services, particularly for the most part running the COVID-positive hotels, is a good one, and I think that's reasonably universally accepted, yes.

Q. You say that's a reflection in retrospect. But in essence that's really what is being said by Dr Romanes on 9 April, isn't it, that, "We really need more of a health focus here rather than just a logistics and compliance focus"?

A. Yes. So he was stating that it was important to incorporate more health principles into how the program was being run, and I believe that occurred through a series of subsequent iterations of the plan and insertions of a large number of other services into the plan. I think probably, even more so from that, we were very cognisant of health and wellbeing. But I think probably we --- clearly, in retrospect, we could have considered --- could have considered the broader elements of the Hotel Quarantine Program and all of the broader staffing to have warranted more health-qualified people to be undertaking it. But, again, that's a retrospective analysis of the scenario and upon reflection of how things have worked since we have transitioned --- since the transition was made to the Alfred running the second --- the COVID-positive hotel.

Q. Professor Sutton this morning referred in his evidence to the fact that a public health liaison position was created with Operation Soteria, I think at least in part due to the email that was sent on 9 April. First of all, do you agree that a public health liaison position was created in respect of Operation Soteria?

A. So, yes, in respect to the creation of the plans and policies around it. There were a number of members of my team who were on any given day the direct liaison points between the Operation Soteria team and the Public Health Team. It was more than one single formal role. There was in particular liaison into the planning team and liaison into the Case, Contact and Outbreak Management Team for the times when there were cases of more outbreaks in the hotels.

Q. Professor Sutton observed that even the creation or the observance of that role was really insufficient to give oversight in the way in which the program was being run in an operational sense. Would you agree with his observation in that regard?

A. Yes, I would. I would, I suppose, build on some of the testimony from Ms Skilbeck. In an ideal world, we would have placed multiple public health positions in both the Emergency Operations Centre and the State Control Centre. But the reality was there weren't enough to go around and we needed to determine where people would sit and many --- most of the public health positions in the response were covering more than one role at any given time.

CHAIR: Dr van Diemen, can I just ask you to clarify something for me just before you move on.

I'm just not clear, when you gave an answer earlier about the person with the expertise in infection control and prevention, you identified that as a position held by one person. Did I understand that correctly?

A. Yes.

CHAIR: Is that one person within the Incident Management Team or one person within the Public Health Team?

A. Both.

CHAIR: Or one --

A. Sorry.

CHAIR: Is it one person within the Department of Health?

A. All three. At the beginning of the pandemic, there was a single person who was employed as an infection prevention and control consultant for public health matters specifically in my team in communicable diseases. That person, obviously when COVID started, was primarily working or entirely working on COVID, and we have since employed a number of other people into the Incident Management Team or into the public health operations for COVID. But at that time there was a single person. I believe there's one other person in the Department who is an infection prevention and control consultant who joined us, and I would have to check at what point she did, but she wasn't employed as such in her substantive role in the Department. So hence at the time there was fairly large requirements on our infection prevention and control consultant's time, hence the recommendation that secondary advice be sought from Infection Prevention Australia.

CHAIR: Sorry, when you describe that person as a consultant, you're talking about a salaried position, though, a full-time salaried position inside the Department, are

you?

A. Yes. Apologies. The terminology --- the infection prevention and control consultants, that is what they call themselves. But they're not consultants in terms of the traditional Government understanding of a consultant who comes in.

CHAIR: Employment status.

A. This person is in fact employed by MDU, our Public Health Laboratory, in a shared capacity between them and the Department, but that is a very longstanding arrangement and they have effectively worked as a departmental employee for many years, as did their predecessor.

CHAIR: So just to be really clear about that, as at 27 March of this year, the Victorian Department of Health had one person fulfilling the role of infection prevention and control, one full-time position ---

A. Yes.

CHAIR: --- shared across the Department of Health and with the MDU?

A. Well, yes, shared between --- this person was primarily employed for public health elements of infection prevention and control, so didn't consult --- didn't work, for example, with the health and wellbeing division on infection prevention in hospitals. They worked primarily with my team around outbreak investigations and other infection control breaches in the community or that had a public health remit in terms of notifiable conditions.

CHAIR: Thank you. Thanks, Mr Ihle.

MR IHLE: Thank you, Madam Chair.

I just want to go back, Dr van Diemen, to something that you said a moment ago in response to a question I asked about the need for more of a health focus here rather than just a logistics and compliance focus, picking up on your statement. You said, amongst other things:

> *Clearly in retrospect we could have considered the broader elements of the Hotel Quarantine Program and all of the broader staffing to have warranted more health-qualified people to be undertaking it.*

By that comment, "more health-qualified people to be undertaking it", do you mean at all levels?

A. Yes. So in response to the outbreak at Rydges, one of the things we discussed was how we could consider using people who perhaps normally worked in health settings to do things like some of the security observing of passengers or the delivery

of meals or other things who were more used to doing the infection prevention and control requirements in a health setting. And again, I would agree with Dr Sutton that all of this is in retrospect and, even given more time to consider it at the time of inception, we may not have recommended that at the time and it may not, I suspect would not, have been practical at the time, given our health services were preparing for an enormous influx of patients as we had seen around the world.

Q. I'm not sure that Dr Sutton made that observation exclusively with the benefit of hindsight. You will recall that one of the matters he was taken to in his evidence was the decision that was made very early on in the piece, indeed before hotel quarantine was conceived, not to install him in the position of State Controller, notwithstanding that the SHERP assumed that to be the case or contemplates that that will usually be the case. That's another example, is it not, of someone with those types of qualifications being in --- remember I said "all levels" --- but at the top level?

A. Yes, it is.

Q. At the time that decision was made, did you have any views about the appropriateness of the Chief Health Officer not being installed as the State Controller in respect of the response to a pandemic?

A. My understanding --- I had an understanding of what the SHERP stated would normally be the case and I had an understanding of what the Concept of Operations had determined. I would agree with the sentiment that it would be --- I think it would have been perhaps more ideal to have somebody permanently installed in those places who had public health background and a greater communicable disease focus of that public health background.

But I would also, I think, agree with the sentiment that there was enormous requirements being made of everybody's time, and --- and can understand the reasoning that was given behind the appointment of the State Controllers. I have, I think, remained somewhat conflicted and on the fence about that, because I understand both --- both sets of logic and I'm not sure that there is an entirely correct decision in either respect at this point in time.

Q. Notwithstanding that, you observed:

> *.... we all could have treated the hotel quarantine program more as a health program than a logistics and compliance exercise.*

Do you agree that the decision to install the State Controller that was made may have in part contributed to the program being more of a logistics and compliance rather than one of having a health focus?

A. I think it may have done, yes.

Q. Yes. Have you read Dr Romanes' statement?

A. I have.

Q. You'd be familiar with the observation that Dr Romanes makes at paragraph 82 of his statement, where 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 may have been more embedded in the governance of the hotel quarantine program.*

I assume, based on the answer to the previous question, you agree with that sentiment?

A. I would agree that it's possible, yes.

Q. And indeed at paragraph 83 of your statement, you observe that you yourself --- whether it's in your capacity as Deputy Chief Health Officer or Public Health Commander, I'm unsure --- but you yourself advocated for a clinical lead in late April.

A. Yes.

Q. You say at 83:

> *I also advocated with the State Control Centre to have a clinical lead or liaison appointed to have this oversight ....*

That is, you were discussing the lack of oversight in the operational aspects of Operation Soteria rather than perhaps the advice and policy aspects. In late April, you were advocating for that position. There needed to be visibility of the Public Health Team over the operations that were being undertaken.

A. Yes, and I suppose visibility over the various elements of the health support being offered and provided to the detainees. So I think it was partly as you stated and partly to ensure that there was a clinically-based person who had oversight over the --- there was multiple --- general practice and nursing and complex care and other mental health services all being provided by various providers, and I thought it was important to have a person embedded in the Emergency Operations Centre who could be a single point of contact for those people.

Q. I understand, just going back to where we started here, you were in the Public Health Commander position until sometime in July?

A. That's correct.

Q. And your statement was sworn in September of this year?

A. That's correct.

Q. Notwithstanding you were advocating for such a position in late April, you conclude paragraph 83 saying:

I am unsure if this position was progressed or appointed.

A. Yes.

Q. So, notwithstanding again this drive from the Public Health Team, through you, to try and embed this clinical experience in the operation, at least as of July, when you finished being the Public Health Commander, that had not been activated?

A. I believe it had been, having heard other people's testimony now. But I couldn't recall having confirmation of that.

Q. And indeed in a statement that you've adopted today as truthful and accurate, you've said:

I am unsure if this position was progressed or appointed.

A. Yes. So at the time that I made my statement and at the time that I left the Public Health Command, I was unsure if that had been completed.

Q. In your statement at paragraph 147, again talking about perhaps more of a public health focus that could have been brought to this operation, you observed that in line with increasing the health lens over the program, there could have been regular external auditing and reporting on adherence to the standards set out in the overall Operation Soteria plan. First of all, did you hear the evidence of Ms Simone Alexander, the Chief Operating Officer of Alfred Health, who gave evidence last Tuesday?

A. I did not.

Q. She gave evidence that included regular auditing of infection prevention control where the Alfred had clinical responsibility; firstly, the Brady, and then subsequently rolled out to a number of other hotels. Is your observation at paragraph 147 essentially one which you make saying, "Well, perhaps because this was a logistics and accommodation program rather than a health program, we lost the opportunity to really conduct these external audits and reports on adherence to the IPC," that is, infection prevention and control standards, that you and your team have written?

A. Yes, in part. I suppose my observation in paragraph 148 is again a reflection in retrospect, knowing what we know now, and considering understandings and my previous experiences in healthcare settings where such audits do take place regularly, that that might have been an appropriate thing to institute earlier than has been done.

Q. And insofar as PPE was not appropriately used, insofar as social distancing was not adequately observed and insofar as infection prevention and control measures being other than what they should have been --- and by "should have been" I mean other than what you and your team had advised they ought to be by way of the policies --- that was something that came to your attention for the first time only after the outbreaks had occurred, wasn't it?

A. Yes.

Q. Can I come to the question of hotel detention. Prior to you issuing those notices as an authorised officer on 27-28 March onwards, there was --

A. Yes.

Q. --- already in Victoria a system whereby people were required to quarantine at home?

A. Yes, there was.

Q. And that was pursuant to directions that anyone who entered the country, into Victoria at least, had to isolate at home and, if they couldn't isolate at home, another facility was made available to them?

A. Yes, that's correct.

Q. You formed the view, notwithstanding that being the case, that it was necessary to change the location of that quarantining from people's own homes into hotels, didn't you?

A. I did.

Q. And on what basis did you form that view?

A. A number of bases, the first being the substantial risk to public health of a disease that we were observing, primarily through international experience, which spread extremely rapidly, which had very high, comparatively high fatality rates, particularly to other similarly spreading diseases such as influenza, with the understanding and knowledge that there was obviously no vaccine, that there was no treatment to mitigate the effects of the disease, and seeing the rapid increase of cases in the community occurring as people were returning from countries, even countries which were reporting relatively few cases.

So the first reason, which is the same reason behind the initial requirement for people to quarantine, is that we were observing that this was an exceedingly significant risk to public health, and at the rate of increase --- and at this point in time, if recall serves correctly, we were increasing our case numbers by four times every week,

week on week, from the first week of March. We had a fourfold increase every week, which put us on track to somewhere in the vicinity of 32,000 cases within a couple of weeks; and that every extra introduction to the State of Victoria then increased the exponential growth. So that was the first reasoning.

The second was that we had observed, through cases that were identified and subsequently interviewed and outbreaks had occurred, that there were people not adhering to the current requirements. Despite having signed the arrivals card when they got into the State to say that they would quarantine, that they had in fact not done that. And these were just the people who told us that they hadn't done that when they got diagnosed, not necessarily the ones that we didn't find out about because they were not diagnosed or the ones who decided not to tell us that they had not been adhering to the home quarantine.

So we had a reasonable amount of evidence, albeit over a short period of time, that people were not adhering to the home quarantine requirements as strictly as we needed them to do and there was an understanding that our window to stop the number of importations into the community was reasonably small at this point in time, but that action needed to occur quickly because for every introduction into the community, there was significant amounts of spread being seen.

Q. Prior to the standing up of the Hotel Quarantine Program, the power to make people quarantine or isolate in their own homes was a generalised direction?

A. Yes, it was.

Q. And following the commencement of the Hotel Quarantine Program, by contrast, there were individual Detention Notices given to people?

A. Yes, there was.

Q. Their name was specifically identified on the notice?

A. Yes, it was.

Q. As was the hotel in which they were required to spend the 14 days?

A. Yes.

Q. And indeed the specific room that they had been assigned?

A. Yes.

Q. And the breach for --- the consequences of breaching one of those notices was a fine in excess of $20,000?

A. Yes.

Q. Was there any thought given to issuing Detention Notices --- that is, specific, individualised Detention Notices --- detaining people in their own homes under threat of that $20,000 fine?

A. I can't speak to whether there was thought of that on 27 or 28 March, in the immediate time after the National Cabinet decision. At that particular time, both Dr Sutton and I agreed with the decision, and Victoria had been obviously party to the National Cabinet decision and in agreement with the National Cabinet decision.

In the times after that, as we were --- you know, ongoing discussions around how hotel quarantine worked, how this might be a long-term part of our COVID-normal future, for want of a better word, there were discussions around how this program might be further expanded or implemented differently. Those discussions included consideration of whether a group of people may be able to undertake their quarantine periods in their homes, particularly now that the general population did, in my belief, have a greater understanding of the significance and the ramifications of this condition. There were a number of discussions around a number of elements like that, none of which were pursued for a number of reasons, and part of the reason was an understanding that hotels may not be a long-term viable option for the future, by virtue of the fact that the State was beginning to open up and hotels may wish to accept other guests outside of hotel quarantine or instead of hotel quarantine.

I think there was an acute understanding that sometimes decisions were made very rapidly around the number of people coming into the State. So there were discussions around whether there were able to be other processes put in place in the event that we might receive --- be told that we're receiving 5,000 or 10,000 people in four days' time. So there was a large number of discussions around potential future, medium- or long-term future viable alternatives to hotel quarantine.

Q. I want to come back to the question, and perhaps I'll focus it specifically at a point in time.

On 27 or 28 March, at the time when you were issuing the Detention Notices for the first time, did you yourself give any consideration to individualised Detention Notices that would have committed people to their own homes for 14 days under threat of that $20,000 fine? Did you think about that?

A. I did think about that. But I was aware that there was a close to if not equal fine associated with the existing order, which did not appear to have deterred a large number --- a number of people from breaching that order. And I agreed with the requirement for hotel quarantine at that particular time, as opposed to home-based quarantine.

Q. I just wanted to ---

CHAIR: Sorry, Mr Ihle.

Doctor, can I just understand, when you gave evidence before about the signing of the arrivals card, can you just help me understand what exactly you understood took place as people arrived back into Melbourne?

A. Certainly. So when the initial requirement for people to home-quarantine was determined at national level, the --- I believe it was the Australian Border Force created a series of --- a card, an arrivals card akin to the card that you normally sign when you come in, but this was a specific quarantine card, which stated that people were required to undertake 14 days of quarantine. They were required, if memory serves, to put the address at which they would be undertaking their quarantine and to sign an agreement that they would undertake that quarantine. At some point those cards were provided to the Department. It wasn't immediately, but at some point later they were provided to the Department and those people were entered in as potentially at-risk people to our databases.

CHAIR: So when you say "at some point", what do you mean by that, the following day, the following week?

A. I would have to get back to you on that, Madam Chair. I believe it was in the first week or so, once those cards were instituted, that they were provided to the Department. But the numbers arriving --- this was before the borders were closed to all international arrivals --- were still very significant numbers of arrivals, so they were very large numbers of boxes of cards. So it did take a little while for those to be entered into our database. But at the time, everybody who arrived into the country was signing one of these. Again, I would have to get back to you. But my understanding is that there was also paper-based handouts for people, outlining the requirement to quarantine. And again, this is testing my recollection, but I do recall there being discussions about, you know, the electronic signs that are at the airport and having various languages of, you know, "You must quarantine for 14 days" going across those signs as people walked through the arrivals areas at the various international airports.

CHAIR: And at that time, was it members of the Australian Border Force who were making people aware that failure to comply with that direction put them at risk of a $20,000 fine?

A. I'm not certain if the Australian Border Force officers were discussing the State-based directions with arrivals. Certainly they were providing the cards and I believe the information sheets. I would have to go back and check to the exact detail of what was being provided in regards to the direction that was made. So the Victorian direction, the airport arrivals direction, was made on 18 March in Victoria, but that was in addition to there already being a national requirement for quarantine that was being communicated to passengers by the Australian Border Force.

CHAIR: So do you know if any official, State official, was warning people that failure to comply with the 14-day quarantine direction would put them at risk of

a $20,000 fine as they arrived back into Melbourne?

A. I know that was the case for cruise arrivals. We had a single cruise ship dock in Melbourne during that time period, and that everybody who got off that cruise was handed a notice of the direction and the accompanying penalty. I would have to come back to you as to whether the notice was being provided to airport arrivals of the State-based direction.

CHAIR: And when you give evidence about understanding that there were a number of people not complying, where do you get that evidence from?

A. So that came to light during the interviews of a number of cases who were diagnosed during that period of time. We then tracked the --- you know, during the contact tracing process, asked where they had been in the preceding days preceding their symptom onset, and a number of them stated that they had been out and about in public places, when they were under a quarantine order and should have been just at home.

CHAIR: And were those people subject to any form of action as a result of giving that information to the contact tracing team?

A. At the time, they were not. So they were not fined. It did lead to ongoing conversations about how the compliance and enforcement elements of this would be undertaken.

I think we were again acutely aware of the fine balance between the threat or the actualisation of large fines and maintaining trust and maintaining people's willingness to provide as accurate information as possible in terms of us being able to manage the public health risk. And that was still, again, very early in the piece in terms of working under the structure of these directions. So, no. It was considered. It was decided not to, at that point in time. But, as we have learned further throughout this outbreak and throughout this pandemic, some of those processes have changed.

CHAIR: So does it follow from what you've said that people who were testing positive --- and the notification thereafter would have been given to the Department of Health and Human Services --- that then the contact tracing team were getting in touch with that person who was testing positive and that person was then giving honest answers to what they had been doing and where they had been?

A. Yes. Yes, in some cases, yes. Obviously we're not sure whether there are people who were not honest at that point in time. There was also media reports of people breaking quarantine and being reported by others to media outlets.

CHAIR: Mr Ihle.

MR IHLE: Thank you, Madam Chair.

Ms van Diemen, I want to take you back to two answers that you gave in response to a question I posed and perhaps give you an opportunity to reconcile what might on the face be an inconsistency in those answers. A question asked of you at line 36 at page 1487 of the [draft] transcript was:

> *Question: Was there any thought given to issuing Detention Notices --- that is, specific, individualised Detention Notices --- detaining people in their own homes under threat of that $20,000 fine?*
>
> *Answer: I can't speak to whether there was thought of that on 27 or 28 March, in the immediate time after the National Cabinet decision.*

I then in the very next question said:

> *Question: I want to come back to the question, and perhaps I'll focus it specifically at a point in time.*
>
> *On 27 or 28 March, at the time when you were issuing the Detention Notices for the first time, did you yourself give any consideration to individualised Detention Notices that would have committed people to their own homes for 14 days under threat of that $20,000 fine? Did you think about that?*
>
> *Answer: I did think about that.*

Now, the first question I asked you whether there was any thought and you said, "I can't speak to any thought." The second question I asked whether you gave any thought, and you said that you did think about it. Do you see a tension between those two answers?

A. So to clarify, what I meant in the first answer is I can't speak to what National Cabinet were --- discussed or spoke about at the time when the decision was made at National Cabinet level that that would become national policy. I can't speak to whether they discussed the difference between increasing the requirements for people in their own homes versus hotel quarantine. I can speak to my own thoughts at the time when I was contemplating whether or not to sign the notices and the discussions that I had and the information that I had to hand, and that that was, on balance, at that particular time, the most appropriate thing was to require people to undertake their quarantine in a hotel scenario so that we could be absolutely certain that incoming importations were being contained in the hotel environment rather than having an opportunity to spread into the community with less control.

Q. You've articulated that in the context of it being the most appropriate. Of course, you would have been cognisant of your obligations under the Charter not only to find the most appropriate but indeed the least restrictive, would you not?

A. Yes.

Q. And do you consider that, based on the information you had at the time, issuing those notices to all returned passengers, no matter where they had come from and where their homes were within Victoria, was the least restrictive in relation to each of them?

A. Yes, I do. We considered this at --- I considered this at great length. I was not unaware of the significance of detaining people. However, I was acutely aware that as every day went by, we were seeing cases from countries who in some scenarios had not reported any cases yet, yet we were seeing cases in returned travellers from these countries. If memory serves, at one point Melbourne had more cases from Aspen, Colorado, than Aspen had reported, which just doesn't make any sense whatsoever.

So I was very aware that we could not rely on the reports out of many countries for what the level of infections were in those countries, and that this was spreading incredibly quickly. So therefore we needed to assume that every country at this point in time had significant numbers of infections and that it was taking off slowly in a lot of those countries --- slowly or quickly in a lot of those countries, without it necessarily being detected.

Q. So I take it from that answer, you say, "Well, it doesn't matter where people are from; this Detention Notice that I'm going to issue is, in my mind, the least restrictive imposition on every single returned passenger's rights when balanced against the public health concerns" that you were trying to mitigate?

A. Yes, and I think the second element of your statement there is the key one. It's when balanced against the public health implications of this pandemic. Now, clearly in a non-pandemic scenario, this would not be seen as the least restrictive measure by most people's standards. But we were not in a regular scenario and we were very, very aware of what we were seeing happen in many other jurisdictions and very aware of the epidemiological curve that we were seeing in Victoria and in Australia, and that we were quite literally weeks away from our systems being completely overwhelmed with thousands of cases.

Q. And you've explained that you factored into the calculus of that decision perhaps the obscurity as to what was happening overseas and the emerging picture of what was happening overseas. But did you take into account at the time you were issuing these --- I'll call them blanket notices --- a notice to everyone that's coming in, no matter where they had come from. Where indeed they were going to, once they returned to Victoria. For example, did you look at whether someone was moving into high-density living or living in a very rural and perhaps even remote place?

A. I didn't necessarily take into account where their next destination might be, because I didn't consider that any populations were less susceptible to this virus than any other. We knew this virus spread reasonably indiscriminately amongst the population. And somebody moving into a --- you know, going home to

a lower-density particular --- a lower-density living situation didn't necessarily pose less risk than somebody moving into a higher-density situation, because they could still have easily gone out and gone into a higher-density situation, like a supermarket or something else, and spread disease. So I didn't consider that people's living situations should necessitate that they were exempt from hotel quarantine. When we were --- (overspeaking)

Q. It's not a question of necessitating it. I think your answer is you didn't even factor it in. Is that fair?

A. We didn't factor in where each individual returned traveller might be going to live?

Q. Yes.

A. No, we didn't, because we had seen this spread from people in all forms of living situations.

Q. Were you aware at the time that you started issuing the Detention Notices that the AHPPC had neither endorsed nor agreed nor resolved in favour of a Hotel Quarantine Program?

A. I was not specifically aware that they hadn't provided formal advice to that effect. I was aware that Dr Sutton was supportive of the program and I was aware that our Premier was supportive of the program. So in that respect, for me, the major public health elements of it had been agreed to and, in terms of my representative at National Cabinet, that he was in agreement with that as well.

Q. When you say as far as you're aware, the major --- well, in that respect, the major public health elements had been agreed to, what were the major public health elements?

A. So, as we discussed, I think that this was necessary to mitigate a very significant public health risk to the community of Victoria and a risk that was unable to be mitigated by other pharmaceutical or vaccination processes, that spread rapidly and had a high, a relatively high mortality rate amongst cases, and for which we had very few other controls and for which there was no real delineation in terms of people being susceptible, that we had an entire population who was susceptible to it.

Q. They're sort of simple facts, aren't they, Dr van Diemen: that you've got a significant public health risk, they are unable to be mitigated by pharmaceutical and vaccination processes, a virus that spreads rapidly, has a relatively high mortality rate? Why do you go on to say that the public health elements had been agreed to? Who had agreed to the public health elements?

A. So Dr Sutton, as the Chief Health Officer, and the primary instrument, the primary person under the *Public Health and Wellbeing Act* under which these

directions were being made, was in agreement. So I'm aware that you discussed whether other Chief Health Officers were in agreement. And I suppose in terms of the Victorian situation, it was less relevant to me whether a Chief Health Officer in another jurisdiction was in agreement that this was necessary in their jurisdiction. As the Chief Health Officer of Victoria, Dr Sutton was in agreement that this was a necessary step for Victoria.

Q. And to what degree did the fact that, as you say, our Premier agreed and/or the National Cabinet, to what degree did their position inform your decision?

A. It played a part in my decision. Clearly a very large program such as this has very significant policy implications and I think it was important and reasonable that the major elected officials of our State are in agreement with a policy such as this. It wasn't the only factor by any stretch of the imagination, and I, in my consideration as to whether I would sign the order, took it into account but didn't --- it was not the completely driving factor that determined whether I would or wouldn't sign those orders.

Q. It sounds like, Dr van Diemen, that the decision that you made to make these orders to sign the Detention Notices was a decision that weighed quite heavily upon you. Is that fair to say?

A. Yes, it is fair to say.

Q. It was a complex decision which required you to take into account a number of competing factors?

A. Yes.

Q. Some of those factors were public health related factors and others were human rights related factors and legal freedoms?

A. Absolutely.

Q. Given the weight of that decision, or against the backdrop of the weight of that decision, are you able to tell us how many returned travellers were detained pursuant to the notices that you signed?

A. I believe it's in the order of 20,000.

Q. And these are orders that you signed in respect of people that you knew nothing about other than the fact that they were entering Australia from overseas?

A. Yes.

CHAIR: Ms Harris? Just before you answer that, Dr van Diemen. Ms Harris?

MS HARRIS QC: I regret an intervention at this point, but if this is a line of questioning that will have a more rhetorical impact rather than further evidence that probably is already in evidence before the Board, I would hope there might be some caution exercised in taking it further for any rhetorical purpose other than any new evidence that needs to be given.

MR IHLE: I'm not quite sure what that all means, Madam Chair. But I'm moving very swiftly to another topic or a related topic and that's the topic of daily reviews.

CHAIR: Yes.

MR IHLE: I assume, Dr van Diemen, that the fact of there being daily reviews required under the *Public Health and Wellbeing Act* afforded you some comfort in respect of the decision that you were making to issue Detention Notices to these people?

A. Yes.

Q. The fact that there would be someone, specifically an authorised officer, considering on a 24-hourly basis whether detention was warranted?

A. Yes.

Q. And you understand that those daily reviews are reviews required under the *Public Health and Wellbeing Act*?

A. Yes, I do.

Q. And they're daily reviews that must be informed by but are in and of themselves separate to the Charter requirements that exist in relation to public authorities and decision-making?

A. Yes.

Q. Are you aware of how those daily reviews were actually undertaken?

A. I think we discussed this earlier. My understanding is that, for the most part, they were undertaken by virtue of a paper- or form-based review of whether a particular detainee was required to stay in hotel detention, and that for the most part the answer to that generally was yes, if they had not completed their 14-day quarantine period, and that sometimes that was no, if a person had been determined to either meet the requirements for release because they had already contracted and been cleared from infectiousness of COVID, and in some cases people were released from hotel quarantine or detention for other health, medical or compassionate reasons.

Q. Mr Murray Smith gave evidence to this Inquiry --- now, he was the Commander of Endorsement and Compliance for a period that overlapped with the period where

you were the Public Health Commander. He explained at transcript page 1201, Madam Chair, that there was a sole criterion in relation to those daily reviews, and it was, as you've just articulated, whether the 14 days were up or not. Are you familiar with his evidence about that?

A. No, I wasn't able to watch that.

Q. Okay. So insofar as you say that you were afforded some comfort by the fact that there were going to be daily reviews, when they became a mere arithmetic exercise as to where in the 14 days someone sat, did that give you any less comfort in respect of the notices that you were issuing?

A. Not necessarily, because I was aware that there were also daily medical checks and a multitude of other checks being done on people, as well as opportunities for people to call out and request further either medical or mental health or other attention in addition to, you know, concierge and other facilities being offered.

Q. And they were, at least in that first fortnightly period, reviews that you thought were --- well, you understood to be done by authorised officers themselves, but then subsequently there were telephone calls made by nurses and the reviews were done on a paper-based, off-site basis?

A. That's my understanding, yes.

Q. Moving to the question of exemptions, you identify in paragraph 54, as part of the process of exemption --- you say:

> *At the end of April 2020, the following circumstances were generally recognised as justifying an exemption ....*

You talk about unaccompanied minors who need to transit or where a parent or guardian is unable to come into the hotel, et cetera, foreign diplomats, for example. Now, appreciating that foreign diplomats will have a certain status under international law, I want to take you specifically to the exemption that applied to air crew. By air crews, do you mean people who work on airlines on the plane?

A. Yes.

Q. So pilots, flight attendants and the like?

A. Yes.

Q. Is it your evidence at paragraph 54 that pilots and flight attendants were automatically exempted from detention in hotel quarantine?

A. Yes. There's a national policy that air crews were exempted from hotel quarantine, but not from quarantine. So they were required, and those requirements

were being very strictly monitored by their employers, that they were required to home quarantine between any flights for either a minimum of 14 days or until their next flight, whichever became --- whichever was earlier. That there was an acknowledgment early on that otherwise these particular individuals would spend their entire life either working on a plane or in hotel quarantine.

Q. Those people, though, that is, air crew, would have, by reason of their employment, been exposed to a number of places and lots of people overseas.

A. Yes.

Q. So what was it about their status that led you, in exercising your discretion as to whether to issue a notice or not, to conclude that they did not pose the same type of risk that others who were entering into Australia posed?

A. So there had been a number of discussions around this at national level and the various airlines had provided assurance that their employees were very well briefed on the ramifications or consequences of non-compliance with this policy, under threat of effectively losing their jobs, and those assurances were accepted by, I believe, AHPPC, and that was put into place across the country. So really it was an incentive-based decision that these particular individuals were very well briefed and very clear that, should they breach, that they would be immediately dismissed.

Q. Are you saying in that answer, Dr van Diemen, that that was a decision made by someone other than you?

A. I'm saying that Victoria participated in that decision, but that this was a national policy that Victoria determined to adopt as well.

Q. I'm asking you specifically, as the person who signed the Detention Notices for every other returned traveller, is that something that you felt --

A. I --

Q. --- unable to do or --

A. I agreed that this was a reasonable reason to exempt people, yes.

Q. Did you consider any other people, by reason of their profession, let's say, for example, medical professionals who may be expected to be well versed in infection prevention control and understand the need for rigorous adherence to quarantine and isolation, did you have any consideration about exempting that cohort of returned people?

A. We didn't consider medical professionals as a whole under that requirement. There were, I believe, a number of requests from medical professionals for exemption, and I believe those were declined, particularly given, whilst they should

have been well versed, that they didn't necessarily have the incentive that airline crews had in order to remain under home quarantine.

Q. Ms van Diemen, I just want to give you the opportunity to grapple with this. If it were to be suggested that you were effectively exercising powers that vested in you to do no more than give effect to a national policy position, what would you say about that?

A. I would say that that's untrue. There were national policies for which Victoria did not agree and that we exercised either increased --- I can't recall any scenarios where we exercised decreased restrictions, but certainly there were scenarios where we were stricter than what the national policy recommended.

Q. Coming to the big question about the purpose of the Hotel Quarantine Program, Ms Skilbeck explained in her answer, perhaps in the most succinct way, that the overarching objective of the enforced quarantine measure was to prevent transmission of COVID-19 to wider members of the community. Do you agree that that's a fairly succinct way of stating what the objective of hotel quarantine was?

A. Yes.

Q. There were a number of powers delegated to you by the Chief Health Officer in late 2019 and again were extended in June and July of this year. You accepted those delegations?

A. Yes.

Q. The delegation included the power that usually vests in his office but was delegated to you to make enforced examination and testing orders. You understand that to be the case, don't you?

A. I do.

Q. Did you at any time consider using those powers that had been delegated to you to ensure that people who were not COVID-positive were not released from detention?

A. I did consider it. I considered it when we were discussing implementing testing in the hotel program. I also considered it on a number of occasions early on, very early on, in the pandemic when there were returned travellers who were suspected cases of COVID and refused to be tested. And in those instances, they weren't required because the individuals decided that they would accept a test.

At the time of the --- when we were determining the next steps to ensure that all returned travellers were tested, it was decided that a less intrusive route would be to extend the quarantine requirements for a further 10 days for people who had refused testing, in order to ensure that should they continue to refuse a test, that they had completed both a full incubation period and a full infectiousness period, should they

happen to have become infectious at the end of their 14-day incubation period.

Q. If I understand your evidence before the Board today, you say that after the Hotel Quarantine Program was announced by National Cabinet and at the time of deciding whether to issue the Detention Notices, you specifically considered the possibility of enforced home detention and, at a number of junctures that you've just described, you specifically considered using the powers delegated to you in respect of enforced testing. Do I understand both of those things correctly?

A. Yes, we --- I considered --- I suppose I say "we" when I speak about myself and Brett and the broader public health physician team, because a lot of these things were party to many discussions, so certainly considered many, many options of the powers that were available to us.

Q. So insofar as there were discussions between yourself and the Chief Health Officer and yourself and other members of the Public Health Team, were any documents generated in respect of those considerations or were there any communications, whether they be by email or letter, that evidence the communications that you've told this Board that you'd had at those times?

A. Not to my knowledge of the very specific conversations around some of those aspects that we've discussed. There's certainly a very large brief of evidence that accompanied all of the directions that were made that was being updated regularly around the current situation of COVID-19, both nationally, locally and internationally. There may be email conversations around some of the testing issues that we've discussed.

Q. And the considering of detention in the home that you say you turned your mind to at the time of issuing the Detention Notices committing people to hotel quarantine, were there emails around that?

A. So there wouldn't be from the time around 27, 28 March. Those considerations were internal and via conversations. There are documents when we were actively considering how the program might be undertaken in a longer-term manner, you know, particularly over the coming months or perhaps even years. There were discussions and even options put forward regarding potential hybrid models or complete home quarantine or complete hotel quarantine models.

Q. And insofar as there are discussions within the Public Health Team about these things, were they ever noted or minuted?

A. No.

Q. So insofar as there may exist email correspondence or other documents evidencing these discussions and considerations, they'd be documents held by the Department of Health and Human Services, I assume?

A. Yes.

Q. Just finally, on the question of people --

CHAIR: Do you have a matter you want to --- no, it's all right. Sorry, Mr Ihle. Keep going.

MR IHLE: The question of exiting from quarantine. It's the case, is it not, that at the conclusion of the 14 days, after the 14 daily reviews, people were released from hotel quarantine whether they were COVID-positive or not?

A. In some instances, people who were residents of Victoria and had a home to go to in which they could appropriately isolate, they were released in the community. People who were either interstate residents or who did not have a home to return to in which they could appropriately isolate, they remained in hotel quarantine.

Q. What power allowed --- pursuant to what power or order did they remain in hotel quarantine?

A. They were under the isolation direction and the isolation direction required them to proceed directly to a place in which they could safely isolate, and therefore if they were not able to proceed directly to a place in which they could safely isolate, that meant that they required to continue safely isolating in their hotel room.

Q. That was for people who were confirmed as being COVID-positive but couldn't go safely to a place to isolate?

A. Yes. So --

Q. What about those whose status as to whether they were COVID-positive or not remained unknown as at the end of the 14-day period?

A. Because they hadn't had a test or because they were waiting for a test result?

Q. Either/or. Was there a difference?

A. So in the first few weeks, no jurisdictions were doing asymptomatic testing, so people were being tested when they reported any symptoms of COVID-19. The aim was always to ensure that people had a --- if they were waiting for a test result, that that test result was available prior to leaving. I'm aware that there were perhaps a small number of instances where people may have been released whilst they were waiting for a test result, due to before and when they were having asymptomatic testing on day 11, and that was a risk assessment that was undertaken to determine that there was still quite a low likelihood that they would come back positive, given that they had no symptoms at that point in time. However, the vast majority of people who were released into the community had the results of any tests that were undertaken.

So, just for clarity, prior to early May, only people who had symptoms were tested. And in early May, at approximately the same time as the testing blitz in Victoria occurred, we commenced asymptomatic testing of returned travellers on day 3 and day 11. And I believe we were certainly the first large jurisdiction on the eastern seaboard to undertake those tests. I think one of the smaller jurisdictions may have also been doing testing later in the quarantine period at that time.

Q. Given that you described, with the description of the overarching objective of the quarantine program as provided in Ms Skilbeck's evidence --- that is, to prevent transmission of COVID-19 to wider members of the community --- and that people who were known to be COVID-positive were released home, notwithstanding the fact that you knew they were COVID-positive at the end of the 14 days, do you see a tension between allowing those people to go home on the one hand and the overriding objective of the whole program on the other?

A. I see that a tension could be perceived. I believe that people's behaviour shifts significantly when they know that they have an infectious disease that is causing a worldwide pandemic, compared to when they have not been diagnosed with that condition, and that people --- most people don't believe they will get COVID until they get it, if that makes sense. I also know that the compliance and daily check activities around cases was significantly greater than for contacts and returned travellers before the Hotel Quarantine Program, simply by virtue of numbers. There was physically no way of calling every returned traveller who was coming into the country in early March; there was tens of thousands of them.

So that was a discussion that was had and there was a risk assessment that was undertaken in determining whether those people would be allowed to go home to quarantine. And one of the reasons for that was that we didn't want people to refuse to have a test because they knew that they would be kept in quarantine. So in part there was a degree of incentive there that, you know, if you have a test at day 10 or 11 and you're positive and you've got a safe place to go home to isolate and you're --- we can see that you're cooperative and you're receiving daily phone calls and you're being required to state that you are staying home in isolation, that that was an incentive to ensure that people did report when they had symptoms and ensure that a test was undertaken. I can see that there could be a tension perceived there.

MR IHLE: Thank you, Dr van Diemen. That covers the questions that I have for you.

I'm aware of one other interested party. And on cue, there we see Mr Moses, so I'll invite Mr Moses to make his application.

MR MOSES SC: Yes, thank you, Madam Chair. I just have two short matters to raise with the witness. The first is the witness' understanding of who within the Department was responsible for ensuring a safe detention environment in respect to the Hotel Quarantine Program; and the second issue relates to Exhibit 159, where the

witness is referred to by Professor Brendan Murphy as having raised a particular issue concerning the Hotel Quarantine Program. It should be less than five minutes, Madam Chair.

CHAIR: Yes, I'll grant you that leave, Mr Moses.

Dr van Diemen, Mr Moses appears on behalf of Unified Security.

A. Thank you.

CROSS-EXAMINATION BY MR MOSES

MR MOSES SC: Dr van Diemen, can I ask that you go to paragraph 103 of your statement, which appears on page 22, where you say:

> *In terms of responsibility for the implementation of [infection prevention and control] measures in hotels, I understood that I had responsibility for the availability of IPC advice and guidance but did not have accountability for its appropriate implementation.*

Do you see that?

A. Yes.

Q. Who did you understand within the Department of Health and Human Services had accountability for its appropriate implementation?

A. So my understanding of who had responsibility for the implementation of IPC in the program was the Emergency Operations Centre, which comprised of a number of representatives across a number of departments.

Q. I'm sorry, is that a serious answer to the question I've just asked you, Doctor?

A. Yes. So the Operation Soteria command structure in the Emergency Operating Centre were responsible for the implementation of infection prevention and control overall.

In terms of who was responsible on the floor in each hotel, I couldn't tell you. I didn't go to that level of granularity in terms of the day-to-day operations of Operation Soteria.

Q. Okay, thank you.

Madam Chair, we've notified Solicitors Assisting the Inquiry of the document. It's DOJ.501.001.9224_R. It's the redacted version of the "Operation Soteria Mandatory

Quarantine for all Victorian Arrivals", and it's page 7 that I'd like to draw the doctor's attention to.

If you go to 2.3, what it states there is:

> *The DHHS Commander COVID-19 Accommodation is responsible for ....*

And then it sets out a number of dot points. I want to draw your attention to the two dot points:

> *ensuring the safety and wellbeing of individuals in mandatory quarantine and DHHS staff;*
>
> *ensuring a safe detention environment at all times.*

Do you see that?

A. Yes.

Q. Do you accept, upon reading that, that in fact it was the DHHS Commander COVID-19 Accommodation who had accountability for the appropriate implementation of the IPC advice and guidance that you were responsible for, Doctor?

A. I think point 3 could be interpreted in multiple ways. I understand all three of the other points in this specifically pertains to individuals who were in mandatory detention, and DHHS staff, and all three specifically point to individuals in mandatory detention.

I think, looking at that point in retrospect, it could be interpreted that the DHHS Commander was responsible for the safe detention environment of individuals in hotel quarantine, or it could be interpreted that the Commander is responsible for the overarching hotel quarantine environment.

Q. But, Doctor, do you accept though, in retrospect, that when lives are on the line, these documents need to be crystal clear as to who has responsibility and accountability in respect of the implementation of a very critical public health policy? Do you accept that?

A. Yes. I would assert that everybody has responsibility in some way, shape or form, though, and that it was imperative for all people involved in the program to ensure that they were adhering to the standards and the policies that had been provided to them.

Q. But, Doctor, are you, by giving that answer, trying to blame others?

A. I'm not trying to blame anybody. And you will see at the end of my statement that

I also assert that it is my belief that there were probably a large number of small or less small actions or decisions undertaken by a large number of people that resulted in what we have seen as the second wave in Victoria. I would assert that I don't believe that any one individual is responsible for what occurred and that I think it is important for us to reflect on all of the processes that were at play at the time, and that I think it is imperative that we improve all of our processes. But I would not agree that there is necessarily any single person who has absolute responsibility for what has occurred as a result of the breaches in the hotel quarantine system.

Q. Doctor, that's not the point of my question. The point of my question was: do you accept, on reflection, given what has occurred here, that there was confusion within the Department of Health and Human Services as to who was responsible and accountable for the implementation of the infection prevention control advice and guidance that you say you were given. Do you say you accept that, on reflection of what you've seen?

MS HARRIS QC: No.

A. I accept the --

MS HARRIS QC: Can I just object to that question? It seems to me that Mr Moses was asking about guidance that Dr van Diemen was given. It might need to be clarified, with respect.

MR MOSES SC: That's exactly the question that I was asking and it was abundantly clear from the question I put, with all due respect to Ms Harris. With all due respect to her, I don't know what the point of that objection was about.

Do you understand the question, Doctor, "yes" or "no"?

A. Can you please repeat the question?

Q. Do you accept, on reflection, that there was confusion within the Department of Health and Human Services as to who was accountable for the appropriate implementation of the infection prevention control advice and guidance that you say you were responsible for? Do you accept that?

A. No. I --- I was clear that the responsibility for the implementation of that advice sat with the Commander of Operation Soteria. If by --- by extension of the question you are asking me whether that person was responsible for every single aspect of Operation Soteria on the ground in the hotels, I would accept that point 3 of the roles and responsibilities before me could have been better articulated, and I would assert that I did not have enough operational understanding of the agreements between different departments and different contractors to comment as to whether the DHHS Commander was responsible for all people in all agencies of this operation or whether they were solely responsibility for DHHS staff and the detainees.

Q. Doctor, just one final question I'll ask you on this point, before I go to Exhibit 159. The proposition I was putting to you was, as your role as a senior public servant, as to whether you accept, on reflection, matters could have been better articulated to ensure that there was no confusion as to who was accountable within the Department of Health and Human Services for the implementation of infection control, protection control advice that you were giving. And I just want to give you the opportunity as to whether you accept that proposition and ---

CHAIR: I thought you'd just put that question, Mr Moses.

MR MOSES SC: I did.

CHAIR: And Dr van Diemen has answered it.

MR MOSES SC: I understand, Madam Chair. I think it's best if I leave it to submissions. I think I've sufficiently put the proposition to the witness. I just wanted to be fair.

Could I just go to Exhibit 159, Madam Chair.

CHAIR: Yes.

MR MOSES SC: Thank you. This is the final point, Madam Chair. It's Exhibit 159. The document is DHS.5000.0034.6968, for the operator, and it's the third page, the last page of the document.

Doctor, is that you being referred to there by the Professor as Annaliese, that an issue had been raised by you on 19 June with Professor Brendan Murphy, it would appear, and others? Do you know whether that's a reference to you?

A. Yes, it is me. Yes.

Q. And in relation to the issue that you raise with Professor Brendan Murphy, was that in relation to a briefing that was being given by you in writing or orally?

A. Orally, yes.

Q. And was the issue that you were raising there related to information that had come to your attention about a hotel worker who --- that is, bearing in mind all I'm asking, so that my learned friend acting for Rydges doesn't get too excited and object, was in relation to this issue, is whether it was relayed to you that a hotel worker continued to work while symptomatic and didn't identify because of fear of income loss, that you were raising that issue as a matter of concern in a discussion with the Professor?

A. I do recall the discussions that you are mentioning. The individual I was referring to was actually a security guard, not a hotel worker. The specific scenario did involve a security guard. I pondered --- we discussed that one of the reasons behind

the continuance of work could be loss of income. That had not been stated as fact, but it was a conclusion that was drawn as a possibility for the person to continue to work while they had symptoms.

Q. That is, you were speculating on that being a possibility?

A. Yes. That was --- the reason was speculation, but the fact was that it was in fact a security guard, not a hotel employee specifically. But we often spoke of --- I think he was referring to hotel quarantine workers in generality, not by their specific roles.

Q. In relation to that --

A. I'm unsure whether I specified to Professor Murphy --- apologies. I'm unsure whether I specified to Professor Murphy whether this person was a security guard or not in the meeting, but I recall the specific situation very clearly and it was in fact a security guard.

Q. And in relation to that, was that information that came to your attention as an event post the second wave outbreak or was it something that occurred prior to the second wave outbreak.

A. It occurred during one of the outbreaks related to hotel quarantine.

Q. Thank you. And one final question: how did that [indistinct]? How did that information come to your attention, Doctor?

A. Oh, apologies, I didn't hear the question.

So that information came to our attention because the person had been identified as a close contact of another case, unrelated to the hotels, and had been tested as a result of being a close contact of what we thought was an entirely separate case. When the first notified case of that particular hotel outbreak occurred, lists of employees who had been present at that hotel on certain days was requested. That person's name was on one of those lists. The contact tracing team recognised the name as a close contact and recently diagnosed case related to an entirely separate case, and that is what prompted further investigation.

MR MOSES SC: Thank you. I have no further questions. Thank you, Madam Chair.

CHAIR: Thanks, Mr Moses. That document can come down, please.

Any other notifications to you, Mr Ihle?

MR IHLE: I've just had one in the last five minutes from counsel for Rydges but I'm not sure whether the answers to the questions that were just provided that issue or not. But I'll allow Mr Woods to address you on that.

MR WOODS: I'm sorry, I was in the process of contacting Mr Ihle. The issue that counsel for Unified suggested might excite me was squarely addressed by Dr van Diemen, so I don't press it, Madam Chair.

CHAIR: Thank you, Mr Woods.

Ms Harris, just before you do, perhaps I'll just raise a couple of matters with Dr van Diemen and then give you the opportunity to have any follow-up questions.

Just a couple of matters, Dr van Diemen, I just would like you to help me with.

One of them goes to an earlier answer that you gave with respect --- and made reference in the course of the answer to potential hybrid models or complete home quarantine models. So you were giving some answers to Mr Ihle about the various discussions that were had during the Hotel Quarantine Program about the potential for a variation, as I understood your answer anyway. Have I understood that correctly?

A. Yes, Madam Chair.

CHAIR: So could you elaborate on that for me, about those discussions about potential hybrid models or, indeed, complete home quarantine models, as best you can remember?

A. Certainly. So there were a number of contexts. As I mentioned, one was that various jurisdictions were decreasing their current restrictions, which meant that there was more domestic tourism starting to operate. There was a chance that hotels would in fact become unavailable. Secondly, there was an understanding that some form of quarantine was likely to be needed for a fairly significant amount of time. Thirdly, there was discussions at multiple levels that we may need or wish to accept increasing numbers of returned travellers into Victoria of varying cohorts, including potentially international students, be they secondary or tertiary, and potentially higher numbers of locally returning --- Australians returning, expatriates returning to the country.

So bearing all of those things in mind, there were a number of discussions around potential alternative mechanisms for hotel quarantine, and I think it was prudent that all potential options were considered. It became apparent very quickly that an entire --- a complete home-based quarantine system would not be feasible simply by virtue of the fact that we were receiving large numbers of interstate arrivals, and again a number of arrivals of individuals or families who had been out of Australia for a long time and therefore didn't have a home to go to. So it became apparent that there would always need to be a degree of hotel quarantine. And so then discussions moved to whether there was any opportunity to implement models that had combinations of people staying in hotels or going to other facilities. Things were considered such as if we were to get large cohorts of returning international students,

whether we could look at some of the international student accommodation that may be empty at the time, or people going into home quarantine.

All of this relied on rapid testing of people on arrival, which I believe Ms Skilbeck discussed, and was not going to be available as quickly as we had hoped. And some of this always was contingent on the consideration that we may be required to quarantine larger numbers of people than we were at the time. Again, that hasn't eventuated.

But I suppose the overarching theme is that there were a large number of things being considered across the board, including home-based quarantine and whether there was electronic means for compliance and enforcement. Again, we were aware --- and having had, by that point, quite a number of weeks of restrictions --- that a small minority of people, regardless of the fines at hand, were always at risk of not adhering to the quarantine requirements and that therefore there would need to be quite strict compliance and enforcement mechanisms in place; and that again one of the reasons why some of this was not progressed at the time was that those mechanisms were not well developed at the time.

So there was, I suppose, a tension between looking at systems which would potentially enable larger numbers of people to return to Australia, but also to maintain the high level of compliance and enforcement activity around quarantine that had come to be expected, and that I think that in some respects, the breaches that have resulted in the second wave of Victoria have demonstrated is necessary to prevent large subsequent waves of COVID-19 were very difficult to implement with many thousands of people quarantining at home.

So I'm not sure if that answers your question, Madam Chair.

CHAIR: So can I just focus for a moment on a complete home quarantine model. So you've ranged across a number of ideas. Let me just ask you to elaborate on that model, and you've spoken in that context about, for example, as I understood it, even discussions about the potential for some form of electronic monitoring in the home. Are you talking about discussions that took place very early into the Hotel Quarantine Program?

A. No.

CHAIR: No?

A. These were discussions that were happening in approximately May, I would say, as most jurisdictions were starting to open up and ease the varying restrictions that we had all had in place, and as there was discussions about potentially opening the borders to increased numbers of international arrivals and potentially even international arrivals of non-citizens, and in the context of knowing that we would probably be requiring some form of quarantine for quite some time to come. So it was in the vein of "How do we make this a sustainable yet safe and rigorous system

for the longer term?"

CHAIR: So just, for example, I'm endeavouring to understand --- you've given answers with respect to the release of people at the end of their 14-day period in circumstances where they had tested positive to COVID and they were released on the basis that they went home into self-quarantine.

A. Yes.

CHAIR: So what I infer from that is that that agreement, or that decision, I should say, to release that individual was based on a trust or a level of satisfaction that that person would indeed go home and comply with the direction to quarantine or self-isolate at home for the required period. Is that a correct assumption that I have?

A. Yes. But in addition to that, those people were receiving daily phone calls from the Case and Contact Management Team, they were receiving intermittent checks from police and they were also receiving daily text messages in which they were required to confirm that they were continuing to isolate at their address. So there were a number of compliance activities being undertaken for these particular people as well.

CHAIR: And did you have --- did you receive any notice from either the police or any of the case contacting people that there was a level of non-compliance from that cohort?

A. No, we did not.

CHAIR: So then one of the things I'm trying to understand then is, to use --- to take that case study, as it were, with the hypothetical person, although we know it to have happened, a person in hotel quarantine who tests positive on day 7 who's a permanent resident, who has an established home to return to, with those various aspects of compliance and enforcement in place, why was it decided that that person couldn't go home under the same conditions?

A. So there were discussions about that, and I think one of --- the major reason was that the 14-day period was a generous period for an incubation period. Many --- and as Ms Skilbeck noted, many of our positive cases came back on day 3 testing, which meant that they had been infected sometime, generally sometime prior to returning into hotel quarantine.

Part of the risk assessment that led to the decision that we would enable people who could go home to finish what was generally only a couple more days of their isolation period in a safe place in Victoria was that the chances of them still being infectious were in fact quite low, particularly for the ones who tested positive on asymptomatic testing. It was in all likelihood that they had actually had an infection prior to even returning to Australia. We have cases of people who have continued to shed for 80-plus days.

So part of the risk assessment in keeping people in the hotel quarantine for the 14 days was that the majority, if not all, of their infectious time would have been undertaken in the hotel quarantine, and so therefore releasing them home at the day 14 mark was generally significantly less risk than being infectious than it was should they have become symptomatic and tested positive on day 7.

CHAIR: So that decision then is not actually about a concern that a person wouldn't be compliant with the self-isolation?

A. No. No.

CHAIR: I see. Yes, all right. Thank you. Ms Harris.

MS HARRIS QC: Madam Chair, I wish to seek leave to ask some questions just to follow up. There were questions asked of Dr van Diemen about concerns raised on 9 April, and I wanted to ask her about the response to some of those concerns.

CHAIR: Yes.

MS HARRIS QC: And other related matters, not lengthy questions, but other related matters about the advice, the health and wellbeing advice that was provided by the public health division. I wanted to ask one brief question about the review process by AOs and I wanted to ask a question about something that Dr van Diemen was asked about AHPPC endorsement or otherwise of the 14-day quarantine period.

CHAIR: All right.

Are you able to bear with us, Dr van Diemen?

A. Absolutely.

CHAIR: Thank you. Yes, Ms Harris.

CROSS-EXAMINATION BY MS HARRIS

MS HARRIS QC: Thank you, Doctor.

If I can go to that AHPPC question first, you were asked a question about whether at the time of your giving the directions around 8 March, you were aware that the AHPPC had neither endorsed nor agreed nor resolved in favour of a Hotel Quarantine Program. You might be aware that Professor Sutton's statement refers to a statement made by the AHPPC on 26 June. Can you remember anything about a statement made by the AHPPC about hotel quarantine on that date? I can read it, if not, the relevant part.

A. If you could. I recall there were discussions around testing and recommendations for testing at about that time, but there may be something else.

Q. So the AHPPC's public statement referred to the fact that:

> *Since 28 March, Australia has required all incoming travellers to undertake 14 days quarantine in a hotel. AHPPC notes that this measure has been a key part of Australia's successful response to COVID-19.*
>
> *AHPPC recommends that all international travellers must continue to quarantine for 14 days after entry into Australia. The risk of COVID-19 in travellers returning from many countries is increasing, reinforcing the importance of quarantine as a protection measure. On the advice of the Communicable Diseases Network Australia (CDNA), AHPPC considered two options:*
>
> *1. Reducing the time of quarantine in a hotel for international travellers. This includes most spending part of the time in home quarantine; or*
>
> *2. Continuing the current model of 14 day quarantine in a hotel.*
>
> *AHPPC considered that there is not enough data to justify reducing the current need for hotel quarantine. AHPPC recommends that all international travellers continue to undertake 14 days quarantine in a supervised hotel.*

Were you aware of anything before that announcement on 26 June about the AHPPC's attitude, and their apparently continuing view to that effect, that 14 days in hotel quarantine had been an appropriate measure and continued to be, or was that something that was not the subject of announcements by the AHPPC?

A. I --- I don't have an immediate recollection of previous announcements by AHPPC. I did sit in a number of AHPPC meetings on days where Dr Sutton was not working and I recall that there was generally ongoing support for the Hotel Quarantine Program. But I couldn't speak to intimate details of any of those without minutes, and I believe, as Professor Sutton mentioned, that those are Cabinet-in-Confidence.

But my understanding is that after the implementation and general success of the program, that there was ongoing support of ongoing hotel quarantine from AHPPC.

Q. Thank you. I understand. I'll move to that issue of the matters that were raised by Dr Romanes with your support and that of Professor Sutton in an email on 9 April, with the State Controller at that time. In your statement, you went on to say at paragraph 68:

> *As an immediate response to that request, the State Controller advised that a*

new Public Health Liaison Officer reporting to me as PHC would be established to work across operational leads and to facilitate appropriate connection and support the PHC in relation to the operation.

And that you were also provided with a draft version of the Operation Soteria plan. Do you recall that?

A. Yes.

Q. And following the provision of that Operation Soteria plan, which you say included provision of regular welfare calls to all quarantined passengers and support to meet identified needs, was there further development of input from documents prepared by Dr Romanes and other members of the Public Health Team to Operation Soteria?

A. Yes, absolutely. So there was a series of meetings that occurred almost daily for the following several weeks, and then less frequently but still regularly after that. Myself, Dr Romanes and other members of the team attended those, pending other commitments, but members of the planning team continued to have ongoing involvement in the development of further iterations of what began as the health and wellbeing section of the Operation Soteria plan, the first version of which was ready for implementation on Saturday, I believe it was 18 March. So within a week of the first --- the incident, there was a new --

Q. If I could just ask one question. I think you said Saturday, 18 March, but you said it was within a week of the incident.

A. I'm sorry, April. Pardon me. I'm getting my months confused. Saturday, 18 April. So the first version of the health and wellbeing element of the Operation Soteria plan was ready by then, but that continued to be worked on and iterations were continued throughout the program as ongoing from public health.

Q. There's been some evidence from both the senior authorised officer and by a person who is in the position of Commander of COVID-19 Enforcement about policies and procedures provided. Was it always the intention that that would be what happened with those policies, that what input you were providing from the public health perspective would be provided through Operation Soteria to people like authorised officers and others involved in the plan, in the implementation of the program?

A. Yes.

Q. I won't take you through each of those, because that's already in evidence, and some of those documents are already referred to in your statement. But moving away from welfare, which you've just talked about, there was also --- I think you have referred to cleaning advice from your division.

A. Ye

s.

Q. And you refer in your statement to cleaning advice that was prepared with input from the Department's IPC consultant. Is that the employed person that you were talking about?

A. Yes.

Q. So the first advice there was available on the Department's website on 20 March 2020.

A. Yes.

Q. And again, there's been some evidence given about that being provided through Operation Soteria to DJPR, who was responsible for contracting. First, was that what the intention was, that you would provide those guidances and policy inputs and then that would be implemented by other parts of the Operation Soteria program?

A. Yes. In the same respect that particularly that cleaning advice was being implemented by various organisations across the state.

Q. And with infection control, you've mentioned that at some point because of the demands on that employed consultant's time, and I think the Board will be assisted in that you have also requested a statement by that consultant, so that may make some of these matters clear, Madam Chair, with the suggestion to Operation Soteria of a particular external consultant, Infection Prevention Australia, who made that suggestion and was it someone who had awareness of what services that entity could offer?

A. Yes. So that suggestion was made by our internal infection prevention and control consultant to the Operation Soteria team, and my understanding is that a person was engaged through that process and that they developed some bespoke infection prevention and control guidance which was reviewed by our team but developed by that external person specifically to the program.

Q. And did you understand that person from that external consultancy to have qualifications in infection prevention and control?

A. Yes.

Q. Now, you mentioned something about there being enormous demands on the employed infection prevention consultant's time. You may not have been aware of this evidence, but evidence was also given by Ms Alexander of Alfred Health about asking the DHHS to suggest infection prevention and control consultancy services. Do you know if there was any input from your division about suggesting the agency that the Alfred Health ultimately used?

A. No, I'm not aware of that particular request.

Q. Just moving on to a different issue, Dr van Diemen, with the reviews, the daily reviews that are required under the *Public Health and Wellbeing Act*, section 200, detention, you were asked some questions about the process of that review. Have you had an opportunity to look at Ms de Witts' statement, which does refer to that issue?

A. I have not yet, no.

Q. So what reporting relationship did you have to Ms de Witts around the time of the Detention Notices and directions that you gave at the end of March?

A. I had no reporting line to Ms de Witts at that time. At that time, Ms de Witts was general counsel for the Department, I believe.

Q. She refers to having obtained legal advice both from the Department and external counsel as to what would be required for a review, and about the review process that was adopted. Is that something that you were aware of or did become aware of?

A. It's not something I can recall. It may be something that I was made aware of via a conversation, but I can't specifically recall.

Q. Okay. I won't take that further, given that there's evidence from Ms de Witts about that matter. Madam Chair, I'm not sure I mentioned that I wanted to ask one question about this, but it relates to the difference between home detention and detention in a facility like a hotel.

CHAIR: Yes, I'll allow you to go there, Ms Harris.

MS HARRIS QC: Thank you.

Dr van Diemen, you were asked some questions about issues like whether people who were required prior to the Hotel Quarantine Program to quarantine at home after returning from overseas, whether they would have been made aware of the fines and other matters relating to the penalty that would apply for breaching quarantine requirement if served at home. Are there other matters that are relevant to compliance with a quarantine requirement, whether either served at home or in a detention environment like a hotel where there are security or other persons checking that you aren't leaving your room? Are there any other matters other than the prospect of a penalty that would be relevant to compliance, in your experience?

A. I think one of the elements is the requirement for authorised officers to undertake the compliance and enforcement checks, and that doing so for several thousand people spread across the state would be much more difficult than doing so for people who are congregated across a smaller number of locations that are proximate to one

another.

Q. And you gave some evidence about, as I understood it --- I might mis-paraphrase you, but the different attitudes people have when they know they're unwell and they know they're COVID-positive, compared to a person who may not, and we know that both people who are unwell or symptomatic and people who are not unwell and are asymptomatic but were required to serve the 14-day quarantine period, for a person who is asymptomatic and not unwell serving quarantine at home, are there any other matters that might make it less likely that they would comply with a detention requirement than if they were in a hotel environment with supervision?

A. So it is my opinion that in general, people who are in a hotel room with a security guard or other forms of compliance at the end of the hall or at the entryway, and being told that they must stay there, are much more likely to comply than somebody who is in their home and not being actively supervised and, you know, clearly this is not something in which we have Cochrane reviews of the evidence on. However, I think --- I don't think it would be fair to infer that because people weren't causing a huge fuss being in their hotel room, I don't think --- my opinion is that that does not equate to them not just popping out to the shops or popping out to very quickly get something or, "Oh, I'll just let somebody in for 10 minutes and it won't hurt" when they're at home. So I think that it is human nature to bend the rules somewhat when one is not being observed, and I think we are in a position and have seen the virulence and the rate of spread of this particular infection, that that is a dangerous thing when we are getting to a point where we have, you know, very, very tight suppression, as other states have seen and as we came very close to.

So, yes, I think there is a significant difference between people being required to home-quarantine and not, and I think we have seen clearly that it doesn't --- that it takes very few introductions into our community under the right or wrong, depending on how you look at it, circumstances for this particular virus to proliferate very quickly.

Q. And just one final matter arising out of a question from Mr Moses. He talked about issues of compliance with advice and guidance, and that was in part in the context, I think, of you being referred to the Operation Soteria plan. In a situation like this, where obviously compliance with public health advice about physical distancing and hand hygiene and related matters are very important, would it be your hope that people would not only comply with the Government-provided guidance but also guidance, for example, from their own employers about training and PPE and hand hygiene and physical distancing?

A. Yes. Yes, it would.

Q. So there's been quite a bit of detailed evidence given by security firms about very detailed training given to some of their staff about hand hygiene, physical distancing, use of PPE. Is that sort of reinforcement from an employer important, in your view, as well as the guidance that was provided through the Government program?

A. Yes, I think it is.

MS HARRIS QC: Thank you, Madam Chair. Those are my questions. Thank you, Dr van Diemen.

CHAIR: Nothing further, Mr Ihle?

MR IHLE: There's just two brief matters that pick up off the second-last question from Ms Harris, and also matters that you raised, Madam Chair, if I may.

RE-EXAMINATION BY MR IHLE

MR IHLE: Dr van Diemen, you've mentioned now twice in your evidence observations, conclusions, opinions you have about how people's behaviour might change when they know they actually have the disease or have the virus that's been responsible for a pandemic. Can you just expand a little bit on those changes in behaviour you've seen, and tell us whether they are COVID-specific observations or whether they're observations you've made as a public health expert in a more general sense?

A. I would say they're observations in a more general sense. I have managed the Communicable Disease Prevention Team or elements thereof since early 2016, and that involves many thousands of outbreaks a year, and I think it is fair to say that in general, when people know they have an infection that is likely to cause illness in others if they don't behave in a certain way, that they are much more likely to do so when they know they have the infection as opposed to when they know they are at risk of having the infection.

Q. So given that that comes from your general knowledge as a public health specialist, that's a view --- that is, the view about the impact on one's behaviour --- of knowing that they're positive to a disease or positive to an infection that could cause disease in others, that's something you would have known before 28 March?

A. Yes.

Q. Just picking up where Madam Chair left off in relation to what you described as perhaps a hybrid approach, do I understand that your evidence is that there was consideration around home detention, a hybrid approach, indeed electronic monitoring, as this Hotel Quarantine Program went on?

A. Yes, there was consideration to that.

Q. And discussion within the Public Health Team around how we might minimise or reduce the number of days people are spending in hotels and put them in their

homes?

A. Yes, there was discussion, and there was discussion as per the AHPPC statement, there was discussion at CDNA level, and I believe that was occurring across multiple jurisdictions.

Q. So those discussions would have been informed, at least in part, by what you knew to be the case as a public health specialist about the change in people's behaviour once they know they are carrying the pathogen that might cause the disease to others?

A. Yes. Yes, they would. That was one of the things that informed those discussions, yes.

Q. And you will recall that I asked you a number of questions before about other matters you said were considered throughout the course --- first of all, the considered possibility of enforced home detention that you turned your mind to around 27 and 28 March; the consideration of your using powers delegated to you under the *Public Health and Wellbeing Act*, and you will recall I asked you about the existence of documents?

A. Yes.

Q. Whether there were emails that passed between you and your colleagues when you were turning your mind to these things?

A. Yes.

Q. And whether there were notes of any meetings and the like, and I think you said if there were any such documents, they would be within the control of the Department. I want to ask you, in a similar vein, were the discussions and considerations that were had around the hybrid approach, the methods for electronic monitoring, types of influence that behaviour might have on people's behaviour as the program moved on, are they also things that would have found their way into emails?

A. So, yes, there will be documentation of some of those discussions because various options were written down as potential options moving forward. So, yes, there would be documentation of some of those discussions.

Q. Yes. We'd expect to find evidence of those in emails?

A. Yes.

Q. In notes?

A. Yes. It was a process being led by Ms Skilbeck and a project team related to Operation Soteria, so there was --- there will be documentation of those discussions.

Q. Including minutes of meetings?

A. I believe so, yes.

MR IHLE: Thank you, Dr van Diemen. That concludes the matters that I have for Dr van Diemen, Madam Chair.

CHAIR: Thanks, Mr Ihle. Dr van Diemen, just finally on that issue, your answer about a project team working to Ms Skilbeck, did that project team have a particular name?

A. So there was a coordinating cell who dealt with a very large remit of matters relating to COVID, in particular correspondence and various other things, and one of the members of that cell led this particular discussion, again in context of looking to really balance the risk and the sustainability and being acutely aware of the fact that we did not control borders or entry into Victoria, and with a view to being prepared for potentially --- you know, potentially being told that we were receiving 10,000 students in a week or something similar. So we were just aware that we needed to be prepared and have options on the table.

CHAIR: All right. So what you're talking about when you give those answers to Mr Ihle is a project officer whose responsibility it was to record what those various options were inside Ms Skilbeck's team?

A. Yes.

CHAIR: And to write the --- am I correct in assuming that those documents will contain a weighing up of --- an identification, first, of the positives and the negatives and a weighing up of those positives and negatives?

A. Yes, absolutely.

CHAIR: And then conclusions that have been given, I assume, to Ms Skilbeck; is that right?

A. Yes, I think there were some recommendations. I would have to look at the documents again. But yes, there were certainly options listed with positives and negatives and risks and benefits.

CHAIR: All right. Thank you. So I'm sure that the team will follow that up, Mr Ihle, with Ms Harris if there's any difficulty with respect to identifying those materials. Ms Harris?

MS HARRIS QC: Certainly. My instructors will be in communication with the Solicitors Assisting. There may already be some material provided, but certainly we will make sure it's identified clearly.

CHAIR: Thanks, Ms Harris. Thank you, Dr van Diemen. Thank you for your attendance at the Board, and I do apologise for having to have you wait around the other day and not be called until today. It's always regrettable when that happens. So, my apologies, and thank you for your attendance at the Board today. You are now excused.

A. Thank you.

CHAIR: You can turn your camera and microphone off. Thank you.

MR IHLE: Thank you, Dr van Diemen.

THE WITNESS WITHDREW

CHAIR: And indeed, Mr Ihle, to the two witnesses who were scheduled for this afternoon, it's obviously too late for Ms Spiteri and Mr Helps.

MR IHLE: Yes.

CHAIR: And hopefully someone has communicated that to those two witnesses, with our apologies.

MR IHLE: Yes, and I've made an enquiry as to their availability, and assuming that they are available, it's the current intention to call them at 2 pm tomorrow. There are already two witnesses scheduled for tomorrow morning, that is former Chief Commissioner Graham Ashton at 10 am, and current Chief Commissioner Patton at midday. The current best estimate is that they will be finished by lunchtime, so to ensure that we encroach upon Ms Spiteri and Mr Helps' time as little as possible, and again, assuming that they're available --- that's only an assumption that I make --- the intention is to call them at 2 pm tomorrow.

CHAIR: Thanks, Mr Ihle. So we will adjourn now until 10 tomorrow. Thank you.

MR IHLE: As the Board pleases.

HEARING ADJOURNED AT 5.00 PM UNTIL 10.00 AM ON THURSDAY, 16 SEPTEMBER 2020

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