TRANSCRIPT OF PROCEEDINGS

INQUIRY INTO THE COVID-19 HOTEL QUARANTINE PROGRAM

BOARD: THE HONOURABLE JENNIFER COATE AO

DAY 26

10.00 AM, MONDAY, 28 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

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

MS G. SCHOFF QC appears with MR A. SOLOMON-BRIDGE and MS K. BRAZENOR for the Hon. Jenny Mikakos MP, Minister for Health

DR S. McNICOL AM QC appears with MR E. NEKVAPIL and MR D. PORTEOUS for the Hon. Lisa Neville MP, Minister for Police and Emergency Services

MR D. COLLINS QC appears with MR N. WOOD and MS T. SKVORTSOVA for the Hon. Martin Pakula MP, Minister for Jobs, Precincts and Regions

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 Neal.

MR NEAL QC: Good morning, Madam Chair.

CHAIR: We are ready to proceed?

MR NEAL QC: We are.

CHAIR: Yes, you can commence, Mr Neal.

MR NEAL QC: Thank you, Madam Chair.

CLOSING SUBMISSIONS BY MR NEAL QC

MR NEAL QC: Madam Chair, with the close of the evidence on 25 September 2020, the task now falls to the Board to answer its Terms of Reference and make recommendations it considers appropriate, having regard to those terms. That means the Board will now need to consider the evidence before it and make findings that may lead to appropriate recommendations.

The Board's task is obviously a significant one and as the State continues to deal with the impact of COVID-19 on the Victorian community, with the eventual reopening of Victoria to international travel, whenever that may be, the potential impact of the Board's findings and recommendations will be even more significant. So much was made plain by the Premier in his evidence last Friday.

I, together with Ms Ellyard and Mr Ihle, now seek to assist the Board by making submissions on the evidence. We propose to raise the conclusions open to be drawn. The question of any recommendations is a logically subsequent matter for the Board to reflect upon, having regard to the submissions of all parties and having settled on its own findings.

Today we will be addressing you in four distinct stages, structured as follows: a first stage in which I will provide an overview and introduction. I propose to remind us all how it is that this Inquiry has progressed within the context of a COVID-19 pandemic and to draw attention once again to the context in which the decision to commit to a Hotel Quarantine Program was made. I propose to make very clear the matters which in our view the Board should see as uncontroversial, so that parties making submissions can be better informed of what the likely areas of contention truly are.

My learned junior, Ms Ellyard, will address you in a second stage; that is, on the decisions, participants, structure and implementation of the Hotel Quarantine Program within emergency management arrangements. My learned junior Mr Ihle will then address you in a third stage, focusing particularly on five discrete topics,

those topics being: firstly, pandemic planning and the absence of any plan for large-scale quarantining; secondly, the objectives of the Hotel Quarantine Program being preventing the further spread of COVID-19 from returning passengers into the community of Victoria; meeting the physical and mental needs of those detained in hotel quarantine, and securing a safe workplace for those undertaking duties within the Hotel Quarantine Program; thirdly, the structure of the Hotel Quarantine Program itself; fourthly, the health and welfare arrangements as were established within the Hotel Quarantine Program; and, fifthly, responsibility and accountability, the fundamental issue of a health response in a health emergency.

Finally, I will then be providing you with some concluding remarks and outline in express terms the key findings of those assisting you as we will be inviting you to make.

Submissions from Counsel Assisting are, of course, not the only submissions the Board will be receiving. By the Board's direction announced last week, parties with leave to appear or leave to make a submission will be required to file submissions by no later than 4.00 pm on Monday, 5 October. We understand that before the close today the Board may wish to clarify for the parties how best it might be assisted by their submissions.

For the assistance of other parties making submissions, those assisting you will provide at the end of today a detailed chronology of events and a standalone document of findings which we urge upon the Board. The chronology is a document which those assisting you say is populated with facts and events which are uncontroversial. It is intended that all parties make use of this document to avoid unnecessary rehearsal of those same facts and events in their own submissions.

To assist other parties to focus on issues emerging from the evidence, at least in the minds of those who are assisting you, we have been providing at the close of each phase of hearing a short summary of that hearing. Apart obviously from what we say today, we expect this will have given such parties a very clear foreshadowing of the matters on which submissions that they make should concentrate, if indeed they are to assist the Board's deliberations.

Before I turn to the framework for and context of this Inquiry, it is convenient to first say something about the course of the Inquiry itself. This Board was appointed by Order in Council on 2 July 2020. Since then, the Board has issued some 152 notices to appear or to produce documents to persons who might assist the Board's work. The Board has held public hearings, all virtual public hearings, over 25 days, between 20 July and 25 September 2020. The hearings have generated over 2,000 pages of transcript. The Board has granted leave to 27 parties to appear and participate in the Inquiry. In these hearings, 63 witnesses were called to give evidence directly to you. A further 27 witnesses' statements were tendered directly, without giving viva voce evidence before the Board. Purposely, those witnesses were drawn from every aspect of the Hotel Quarantine Program, from those who were the subject of detention within the program, those who designed and established

the program, those on the ground who delivered the program, all the way to those occupying the highest offices in the State. The Board has also heard evidence from health professionals, or a health professional in particular, to put the Hotel Quarantine Program in its appropriate human context; that is, it was a measure that was apt to have profound psychosocial impact on those who were involved in it.

By the time the first witness was called on 17 August, the Board had received in excess of 180,000 pages of documents. As at the close of evidence last week, the Board has received almost 290,000 pages of documents and received into evidence some 228 separate exhibits. All that has occurred against a backdrop of the declaration of a State of Disaster on 2 August and the introduction of Stage 4 restrictions applying in metropolitan Melbourne.

May I turn now, Madam Chair, to the Terms of Reference. It goes without saying that the Board's Terms of Reference express the findings and recommendations the Board may or should make. According to those terms, the Board may enquire into, report and make any recommendations that are considered appropriate, with respect to the following six matters: the first of those matters is the decisions and actions of Victorian Government agencies, hotel operators and private service providers, including their staff, contractors, and other relevant personnel involved in the Hotel Quarantine Program, each being called relevant personnel, relating to COVID-19 containment; second is communications between Victorian Government agencies, hotel operators and private service providers relating to COVID-19 containment; third is the contractual arrangements in place across Victorian Government agencies, hotel operators and private service providers to the extent that they relate to COVID-19 containment; the fourth is the information, guidance, training and equipment provided to relevant personnel for COVID-19 quarantine containment and whether such guidance and training was followed and such equipment properly used; fifth is the policies, protocols and procedures applied by relevant personnel for COVID-19 quarantine containment; and, lastly, any other matters necessary to satisfactorily resolve the matters set forth in the preceding five matters.

These Terms of Reference cannot be considered in isolation. There are areas where the subject matter of those issues overlap. Those assisting you do not propose to address the terms as discrete matters. They will be subsumed into the issues that we, as Counsel Assisting you, will be identifying directly.

Before proceeding further, it is appropriate to lend some perspective to the decision and the context in which the decision to set up a Hotel Quarantine Program was made. The Hotel Quarantine Program came into being in a very specific context, and that needs to be acknowledged. That context was a new disease that quickly became a serious global pandemic with disastrous consequences. In coming to the task of assessing what happened and what went wrong, it behooves us all to remember the particular circumstances in which the decision to set up the Hotel Quarantine Program was made.

Whilst necessarily there must be critiquing of the program and an analysis of its

shortcomings, the decision to enter into the Hotel Quarantine Program cannot be fairly assessed merely with the wisdom of hindsight. For that purpose, I wish to take the Board now to the timeline of the appearance of COVID-19 and of the events playing into the decision to take the radical step of entering into a Hotel Quarantine Program.

It is uncontroversial to say that the knowledge of COVID-19 has developed over time. By December 2019 the virus was first coming to world attention. On 31 December 2019 the World Health Organization's country office in the People's Republic of China picked up on reports of viral pneumonia cases in Wuhan, in Hubei province. On 25 January 2020, the Federal Government confirmed the first case of COVID-19 in Australia. On 30 January 2020, the Director General of the World Health Organization declared the novel coronavirus outbreak a public health emergency of international concern. On 11 March, the World Health Organization assessed that COVID-19 could be characterised as a pandemic.

May I now turn to the Australian and Victorian perspective on the pandemic. It was known that the virus was entering Australia from overseas through returning travellers. There were a number of countries around the world experiencing widespread infection rates, with relatively poor infection control measures in place. The Board will perhaps recall the COVID-19 outbreak on the Ruby Princess cruise ship that had disembarked in Sydney on the morning of 19 March. As to that outbreak, around 39 per cent of passengers from Australia on the Ruby Princess had actually contracted COVID-19. Around 17 per cent of the Ruby Princess' crew had contracted the disease as well and some 28 deaths were actually associated with passengers on that vessel. The passengers had been allowed to disembark, immeasurably compounding the task of tracing and of infection control. The Board may reasonably infer that Governments were keen to take action to avoid an outbreak similar to that of the Ruby Princess elsewhere in Australia.

The rapid rate of transmission was particularly concerning. By the start of 2020, Victoria's Deputy Chief Health Officer, Dr van Diemen, had been observing case numbers increasing fourfold each week, leading to an expectation of some 32,000 within a couple of weeks. Every introduction of COVID-19 would increase the exponential growth.

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

Furthermore, the Department of Health and Human Services had some evidence prior to 27 March of recent arrivals to Victoria who were thought not to be strictly complying with home quarantine requirements imposed upon them. Hence it was thought that Victoria had a small window to stop the number of virus importations into this community. Quick action was needed because with every introduction of

the virus to the community, the spread of that virus would be significant.

Globally, it is estimated that 943,343 people have actually lost their lives as a result of the pandemic. The personal, economic and social effects of the virus have been disastrous. Before the Board, Victoria's Chief Health Officer, Professor Brett Sutton, reflected that the pandemic is of the greatest severity we have seen for 100 years, probably since the Spanish flu. All of these factors would have led to a desire to swiftly and strictly prevent the virus entering the community from outside Victoria.

The Victorian and Commonwealth Governments were themselves responding in formal ways to the pandemic. On 1 February, by way of recognition of the growing threat posed by this human disease emergency, the State of Victoria appointed a State Controller pursuant to emergency arrangements under Victorian legislation. More will be said about that decision directly.

On 16 March this year, the Minister for Health declared a State of Emergency in Victoria under the *Public Health and Wellbeing Act*. That decision activated a range of public health and emergency measures. Acting under those powers on the same date, the Chief Health Officer issued a direction that:

> *A person who arrives at an airport in Victoria on a flight that originated from a place outside Australia or a connecting flight from a flight that originated from a place outside Australia must travel from the airport to a premises that is suitable for the person to reside in for a period of 14 days.*

Something we may refer to as a residential quarantine program.

On 18 March, the Deputy Chief Health Officer of Victoria issued a direction to people arriving in Victoria from overseas between 5.00 pm on 18 March 2020 and midnight on 13 April 2020 advising them that they must go into immediate compulsory isolation for 14 days at premises that are suitable for them to reside in for 14 days.

The direction also outlined that returnees must not leave their residence under any circumstances unless they have permission, returnees must not permit any other person to enter their room unless the person is authorised to be there for a specific purpose, for example, for food or medical reasons, hence we had a residential quarantine program, albeit in somewhat more explicit terms.

On 27 March this year there was a media release from the Prime Minister stating that the National Cabinet had agreed to returning travellers arriving back in Australia to undertake their mandatory 14 days self-isolation at designated premises, for example, a hotel. The Victorian Government was part of that decision. It was also tasked to implement and enforce mandatory quarantine under State legislation "with the support of the Australian Defence Force and the Australian Border Force where necessary".

On 28 March, the Victorian Deputy Chief Health Officer issued a further direction advising travellers returning to Australia on or after midnight on 28 March that they will be detained for a period of 14 days in a room at a designated hotel. Thus the Hotel Quarantine Program.

Amongst other conditions, that direction imposed this restriction:

> *Detainees must not leave their room under any circumstances unless they have permission. Detainees must not permit any other person to enter their room unless the person is authorised to be there for a specific purpose, for example, for food or medical reasons.*

It was in these circumstances, Madam Chair, that the decision to commit the State of Victoria to a Hotel Quarantine Program occurred and that decision has become the focus of this Inquiry.

By way of further perspective to the decision that was taken to commit Victoria to a Hotel Quarantine Inquiry, I draw attention to the evidence of what was known about the virus and of the principles of quarantining by 27 March. In doing so, I am largely drawing on the evidence of Professor Lindsay Grayson, an infectious disease expert at the Austin Hospital, called as the very first witness on the first day of this hearing.

What we knew about the coronavirus immediately before the decision was made to establish a program of hotel quarantine was as follows: COVID-19 is an infectious disease caused by a coronavirus, the severe acute respiratory syndrome coronavirus 2, or SARS coronavirus 2. It is highly infectious. Clinical symptoms are mainly related to respiratory illness. Symptoms of COVID-19 are likely to start within 14 days of exposure to the virus. That is not always the case. Some individuals may indeed continue to be symptomatic for up to 24 days after exposure. Testing, therefore, is critical to determine whether a person is infected with COVID-19, even if a period of 14 days may have elapsed, with or without symptoms being exhibited.

Importantly, COVID-19 can be transmitted before the onset of symptoms or even where an infectious person may be asymptomatic. COVID-19 is dangerous, particularly for those in the community with a compromised immune system. Older people in particular with certain comorbidities, such as diabetes or cardiac conditions, appear to experience conditions more rapidly.

The virus enters the body through the mucous membranes, including the conjunctiva of the eyes, the membrane of the nose and mouth and via the linings of the lungs. Critically, it can be transmitted through droplets, aerosols and fomites, fomites being the surfaces that become contaminated and serve as a vehicle for transmission. That means a person may be infected with COVID-19 virus directly through contact with infected people, such as inhaling droplets expelled through coughing, sneezing, talking or breathing, or indirectly by contact with surfaces in the immediate environment.

Human behaviour therefore has a strong link to the spread of COVID-19. Quarantine programs have often been used as a response to human disease pandemics. Quarantine involves keeping individuals who are either infected or potentially infected physically separated from others so that neither through droplet spread, airborne spread nor fomite spread they will infect others. Quarantine separates and restricts the movement of people. It is enforced. Quarantine efforts in pandemics usually occur in a health environment, such as a hospital, with correct oversight from people appropriately trained in infection control.

These matters set the context for the decision to set up a Hotel Quarantine Program in Victoria. Before proceeding to a substantive discussion of the issues, there are some matters which need to be acknowledged at the outset as matters which we submit to the Board should be accepted as uncontroversial.

Firstly, it is proper to acknowledge the magnitude and scale of the Hotel Quarantine Program itself. To establish and run a Hotel Quarantine Program involved a broad range of State and private organisations, all within the space of a weekend. Such an event would have been unheard of in almost any other context.

There had been no plan for mandatory mass quarantine programming that could have formed the basis of what eventually became Operation Soteria. The interval between the first phone call notifying the Department of Jobs, Precincts and Regions of the program and the first bus load of passengers was a mere 36 hours. As the Secretary of that Department, Mr Phemister, graphically noted to the Board, it was a day measured in minutes, not hours.

There was simply not the time to undertake the ordinary activities of translating a policy into a plan and then realising that plan. The circumstances facing Victoria were anything but ordinary and an extraordinary ask was made of those who were tasked to develop the program.

An enormous immediate unenviable burden was placed on those in public service to establish not one but a succession of infection control facilities in buildings clearly not designed for quarantine purposes. The pool of accommodation providers open to the Department of Jobs, Precincts and Regions comprised some 500 properties and more than 29,700 available rooms. 29 hotels were engaged for the Hotel Quarantine Program as its locations. Of those 29 hotels, 20 were actually used in the program.

As the program went on, the Department of Health and Human Services determined which hotels would commence operating in the program and the point in time at which that would occur. Hotels would need to be "stood up" quickly and to be staffed with security and other security guards --- security guards and other personnel, often at very short notice as to the composition and particular needs of the incoming group.

There will be no suggestion from those assisting you that those engaged in setting up this program worked other than with the best of intent and to the best of their ability.

Bad faith or corruption is not what the evidence shows.

Yet it is true that the hastily assembled program failed at two locations within approximately two and a half months and with disastrous consequences. It will not be suggested that a single decision or a single actor caused the Hotel Quarantine Program to fail in its objective of stopping the spread of COVID-19 into the broader community. Rather, the thoughts of Professor Euan Wallace, the Chief Executive Officer of Safer Care Victoria, are apt to recall, namely that complex systems fail in complex ways. The corollary of that idea is that eliminating one risk factor from a chain of events may reduce the risk of failure but does not guarantee a faultless system.

What the Board will hear in due course is that a multitude of decision, actions and inactions, many of which compounded the effect of the other, ultimately expressed itself in the outbreaks which subverted the very reason for the existence of a Hotel Quarantine Program.

May I make one final prefatory comment. Notwithstanding the number of witnesses, parties and sheer volume of documents involved in this Inquiry, it has become clear that the factual background giving rise to the Inquiry is generally not in dispute. Evidence from witnesses as to what occurred and when has generally not been the subject of significant challenge. What has been the subject of considerable dispute is who made some key decisions and the appropriateness of those decisions over the course of the Hotel Quarantine Program. Directly, my learned juniors will be expanding on those issues in some considerable detail.

Madam Chair, that concludes what I wish to say by way of introductory comments. I will now call upon my learned junior, Ms Ellyard, to address you further as to the detail of some issues.

CHAIR: Thanks, Mr Neal. We might just take a 10-minute break, to swap over counsel, as it were. So it is 10.30 now, we will take 10 minutes from here and resume at 10.40.

MR NEAL QC: If the Board pleases.

CHAIR: Thank you.

ADJOURNED **[10.31 AM]**

RESUMED **[10.40 AM]**

CLOSING SUBMISSIONS BY MS ELLYARD

CHAIR: Yes, Ms Ellyard.

MS ELLYARD: Thank you, Madam Chair.

I propose first to address you on the question of how the task of establishing the Hotel Quarantine Program was conceived of and understood. The decision to adopt a process of mandatory quarantine in facilities was taken by National Cabinet but it is quite clear that it had the support of Premier Andrews. It was a decision taken at a national level but, as Mr Neal has noted to you, it was going to depend for its implementation on State powers, including State enforcement powers.

From the time of the Premier's announcement of the program around 3 o'clock, a twofold rationale was put forward and appears consistent with the documentation that the Board now has. Firstly, it was said that travellers were an unacceptable risk, that an honesty basis was not going to be a sufficient basis on which to ensure that those returning from overseas quarantined to avoid the risk of transmission of the virus. And it might be thought that from the evidence of people like the Premier and also Ms Skilbeck, there was an assessment that there was a need for a strong public statement that questions of self-quarantine with going to be taken seriously and a strong unified response was going to be put in place. Secondly, it was clear from the earliest times that it was considered that the Hotel Quarantine Program might serve a dual purpose: not just public safety, but also some form of economic support for the Victorian economy. The Premier said in his earlier remarks that hotel accommodation was basically empty and that there were 5,000 rooms basically on standby. He said that it was not just an appropriate health response, it was also about Working for Victoria and repurposing people who perhaps had their hours cut.

In evidence before you last week, the Premier was plain that public health and jobs maintenance weren't, in his view, of equal importance. He said that public health was the clear priority, and certainly the public health objective appears first in relevant documentation, including submissions to the Crisis Council of Cabinet. But it is clear from those documents, as well as from public statements, that the financial and employment boost of a Hotel Quarantine Program was always a consideration too in the minds of those establishing it and running it.

As the Premier agreed in evidence last week, the decision to require returning travellers to quarantine in a hotel was taken on the basis that that would be less risky than to continue to trust them to quarantine at home. The Premier relied in his own view that it was too risky to leave things as they were on statements that he understood had been made by the then Chief Commissioner of Police, Mr Ashton, on 23 March and then on 25 March. He also thought that he had received formal briefings. Those briefings to the media from Mr Ashton were played in evidence and they don't suggest substantial noncompliance, and indeed in his evidence Mr Ashton seemed to suggest that to the extent that noncompliance had been identified by police, that was often due to the fact that the police did not have the correct address for where people were self-quarantining. So it might be thought that the evidence

that there was any substantial degree of noncompliance was relatively thin. But nevertheless the decision was taken that designated facilities, that is hotels, would be used. That meant the creation of a system, a risk mitigation system, that had its own risks. It was a very complex system, as Mr Neal has already addressed you on, and that complexity is revealed from the earliest stages in the mapping documents that were prepared first by the Department of Jobs, Precincts and Regions and then in the various versions of the Operation Soteria plan prepared within and distributed by the State Control Centre.

When one compares the first draft of that document from 27 March with its final iteration from May, it is clear how much detail was required and how many cogs there were in this very complicated machinery. It was much more complex than a quarantine-at-home model and while it might have been thought to have gained some things in administrative or compliance simplicity by bringing everyone together, it lost that because of the risks bringing those people together created both for those people themselves and for those who had to work with them. And those risk were clearly risks for the Government which had established the system to identify and manage. It had assumed responsibility for keeping those in quarantine as safe as they would have been if they had been trusted to quarantine at home and keeping the community at least as safe as if travellers had been permitted to quarantine at home.

As the evidence reveals, discharging that responsibility was going to require a workforce of thousands of people. This was a program that was going to run 24 hours a day, seven days a week and accommodate, as we now know, more than 20,000 but as at 27 March an unknown number of returning travellers.

As Mr Neal has already identified, the task of setting up the program was a task that had to be completed in an astonishingly short space of time. The Board may that you will that Professor Euan Wallace, the CEO of Safer Care Victoria, commented that they would never ask a health service to set up a program of this kind in two days. it was, as Mr Neal has acknowledged, a massive undertaking. It does seem that from the earliest stages, though, the only potential insuperable obstacle that was identified was whether or not there were going to be rooms. The Premier announced those rooms, as I've noted, in his press conference. In evidence before you, he agreed that having the rooms in place gave him confidence that everything else could be done. And so the existence of rooms seems to have been the basis on which it was assumed that Victoria could get this job done. That whole complex system only needed to be assured of locations for people to be quarantined in order for everything else, it was thought, to become possible.

What that means, we submit to you, is that this program began and continued on the basis that there was more focus given to logistical and concrete matters like places for them to be and buses for them to get there than to the public health elements of what was intended in fact to be a public health infection control response. Now, there was so much work required to be done to get passengers from the airport into hotel rooms and so much need for careful planning of multiple phases, as the documents reveal, that perhaps it's not surprising that that was the initial focus and

that there was less detailed planning about what would be done to keep people safe and to keep the environment safe once travellers had been placed in the rooms. The need for that work was always recognised but it appears that at first at least, primacy was given to logistical issues.

Over time the program evolved. Many people worked very hard to make it more responsive in a whole range of ways to the needs of those who were detained and to establish formal structures to prop up and standardise and expand the work that had to be done so quickly. But even though the program ultimately ran under the auspices of DHHS and was understood to be a part of a health response, a review indicates that it never got past that focus on logistics and compliance at the expense of public health. And the evidence establishes that the upper management of Operation Soteria, including senior personnel within the Department of Health and Human Services, were disproportionately focused over the life of the program on questions of compliance and control and logistical matters. This started with the decision prior to the establishment of the Hotel Quarantine Program about who was State Controller for the emergency and it continued through the absence of someone with appropriate public health expertise in a key role in the structure of the program.

It remained first and foremost a program for keeping people detained in hotels as a matter of logistics and compliance, rather than a health response that was designed to keep returning travellers safe and keep the community safe from the risks that might be posed by those travellers if they were COVID-positive. Of course, given the speed with which the program had to be set up and the undeniable logistic complexities that it had, that is not hard to understand and no criticism of is made of those who in the first couple of frenetic days were focused on all of the cogs in the machine. But the transfer of the program to DHHS and its continued evolving under their leadership should have been a reminder to everyone that this was always meant to be a public health response and in our submission the evidence suggests that, notwithstanding the best efforts of many people, that focus was always underdone. Thinking about that setup, you heard from Mr Eccles that he stepped out of the National Cabinet to set in train the program and he contacted Mr Phemister rather than Mr Crisp or Ms Peake because his primary thought was rooms. So he too, although he knew that there was a public health emergency in place and that DHHS was the control agency, had his mind go first to the logistics of rooms. And Mr Phemister understood from that conversation that it would be he who had responsibility for the end-to-end program and he gave evidence about the steps he took to put that into place.

It is certainly the case that it made sense for DJPR to be contacted in the first instance, they had been doing some work in obtaining hotel rooms for what became the Hotels for Heroes program but there was some substantial differences between that program and what became the Hotel Quarantine Program. Firstly, it was always intended to be voluntary, it wasn't ever going to be used to keep people against their will; and it was intended to be dispersed throughout Victoria, rather than being located solely in the CBD. And so there were different considerations in play. And so other than the mere allocation of hotel rooms, it is fair to say that there hadn't been

any work done to set up something that became a Hotel Quarantine Program and as Mr Neal said to you, there wasn't a plan off the shelf already about how such a program could be done.

Thinking about how tasks were allocated early on in that very busy first day when things were measured in minutes, Mr Phemister gave evidence that he had a very early conversation with his counterpart Ms Peake at the Department of Health and Human Services and he did that because he understood that DHHS would have the lead on health matters because it was a health operation. DHHS were represented at the early meeting at the State Control Centre and it appears from the recording of that meeting that DHHS representatives were very much alive to the health aspects of the program and their obligations in relation to it.

Mr Phemister allocated other tasks, firstly to Ms Febey, to lead the program and the Board had her evidence and the evidence in documents and recordings about what she did. There were other key tasks that were allocated on that first day that had great significance over the life of the program. Firstly the procuring of hotels and then, secondly, the function of sourcing private security firms, which was ultimately performed by Ms Currie, who was working in Working for Victoria at the time, a program established, harking back to the remarks the Premier had made, to assist people who had been dislocated by COVID-19.

There was also a strong involvement from the head of Global Victoria and some of her team to assist with logistical matters and it obviously made sense for DJPR to draw on the skills that it had in that area and to divert them to the monumental task of setting up the quarantine program.

Of course, none of those people from DJPR had any public health expertise, they didn't purport to. They all assumed that other people would be working on the health aspects and that assumption was a fair one and there was certainly work being done by other Departments on those parts of the program. But a couple of points to make perhaps before we go into more detail is, firstly, the absence, it would appear, of any period of reflection about whether this was all going to be possible. Once it was announced, everyone just assumed that they would have to do it and as Mr Neal has said, it reflects to their credit that so much was done over such a short space of time. Secondly, again, largely about logistics. How would it be done, rather than why are we doing it? Thirdly, there was from the earliest times an expectation that it would be for the Department of Health and Human Services to supply this huge logistical task with health expertise, even if in that early stage DJPR were conceived of as being the lead agency. Those are matters which we submit you could make findings about.

Of course, within 24 hours or so, a decision was made to shift lead responsibility for the program and to give the Department of Health and Human Services not just health expertise role but the overall control of the quarantine program. The evidence suggests that that followed discussions between Mr Crisp as Emergency Management Commissioner and Ms Falkingham of the Department of Justice and

Community Safety and then discussions amongst other Secretaries too about the desirability of this program being seen as part of the overall response to the public health emergency and as properly falling under emergency management arrangements as set out in the Emergency Management Manual. It is clear that was partly done for role clarity. Mr Crisp said in his evidence to you that, "It was important to put a control structure around this particular operation, and based on our experience of running operations, about having a control agency and then support agency, being really clear as to their role, is really important and useful in terms of achieving a good outcome." He went on to say it is really important to know who is in control. And the terms of control and command and coordinate were the subject of evidence and I'll say more about them. It is clear from the evidence that some of those meanings didn't have a uniform understanding across organisations.

It is clear under emergency management arrangements in place in Victoria that a pandemic of this kind, an infectious disease, qualifies as a human disease emergency under the Emergency Management Framework and the expectation is that that's a class 2 emergency, in respect of which the Department of Health and Human Services is the control agency. The Board can in our submission find that the Hotel Quarantine Program was properly identified as part of Victoria's response to that health emergency and it was reasonable for a decision to be taken to locate it inside the formal structures of the emergency response.

Locating it there meant placing it under control of the State Controller - Health, who had been appointed some weeks previously in early February by the Secretary to the Department of Health and Human Services. I want to say something about the role of the State Controller - Health as it is set out in the manual.

The role is set out more particularly in the State Health Emergency Response Plan, which is a subplan sitting under and contemplated by the overall State Emergency Response Plan. That health plan sets out the arrangements for managing specific emergencies and where those arrangements require more detail. It provides an overview of the arrangement for how all health emergencies in Victoria should be managed. It sets out the way in which DHHS' obligations as control agency are to be operationalised.

The State Controller - Health's role in this framework is firstly to lead and manage the State's response to a class 2 emergency; secondly, to establish a control structure for the class 2 emergency as appropriate and monitor it to ensure it suits the circumstances; thirdly, to support the Emergency Management Commissioner to identify current and emerging risks or threats in relation to the class 2 emergency and implement proactive response strategies; and fourthly, to support the Emergency Management Commissioner in the development of a strategic plan for managing that emergency.

The State Controller - Health in any health emergency sits above any particular incident and is responsible under the SHERP for the overall response to that emergency. Under the State Health Emergency Response Plan, the power to appoint

the Class 2 State Controller is given to the Secretary of the relevant Department, so here the Department of Health and Human Services. And the intention of that appointment is to enable there to be an adequate focus on managing the health consequences arising from the health emergency. The SHERP contemplates that where there's a public health emergency, the Public Health Commander will be appointed the State Controller - Health, and the Public Health Commander, as the Board will recall from the documentation, is assumed to be the Chief Health Officer or their delegate.

So it can be seen that there's a presumption in the State Health Emergency Response Plan that the Chief Health Officer will be the State Controller - Health. And in our submission there is good reason for that presumption. I draw on the evidence given to you in his witness statement by former Emergency Management Commissioner Mr Lapsley, who said:

> *It is logical in a pandemic that a Deputy Chief Health Officer or equivalent qualified person would carry out the Public Health Commander role. On first principles, it would be prudent to appoint a person with public health and medical qualifications, knowledge and expertise.*

That evidence assists you, in our submission, to conclude what is implicit in the emergency response planning, people with relevant expertise should hold relevant functions. But, as the evidence makes clear, and this is a decision made before the Hotel Quarantine Program, but influencing how that program then ran, a public health professional wasn't appointed in early February to lead the public health response to this public health emergency. Instead, two senior officers of DHHS, who both had backgrounds in emergency management, were appointed, and that's Mr Helps and Ms Spiteri.

The Board will recall the evidence given by Ms Skilbeck of DHHS and Ms Peake about why that was done. The reason why they said it was appropriate to choose Ms Spiteri and Mr Helps was because --- I'm quoting Ms Skilbeck here --- "to provide access to the needed State-level logistics and communication support rather than hazard control". So in our submission this was a missed opportunity and it really missed the point of why DHHS were the control agency here. The decision to appoint non-health professionals to be in charge of the response to a health emergency contributed to this ongoing misconception of the quarantine program, a discrete activity under that emergency heading, as fundamentally logistics and enforcement rather than fundamentally public health.

There were insufficient opportunities given to senior and qualified people from within the public health team in DHHS to have operational line of sight and to give direct guidance and advice into the program. And so to some extent the Hotel Quarantine Program inherited that early decision to give primacy to emergency management and logistics expertise over health expertise and the effect of that continued throughout the program. And that failure to first and foremost conceive of the quarantine program as a public health program created part of the context in

which further decisions were made and further deficiencies occurred.

In the light of that fact that the Emergency Management Framework which the Hotel Quarantine Program was placed under was a program that was being set up by DHHS and staffed by DHHS, it is perhaps useful to consider whether that Emergency Management Framework was useful, did it add to things or did it provide an unnecessary distraction or distract from other ways in which this emergency could have been managed? There was some DHHS evidence from witnesses to the effect that there were added complexities to this program because sitting over and above the Emergency Management Framework were State and national decision-making structures and so it was difficult, it was suggested by Mr Helps for example in his witness statement, sometimes to navigate and determine whether a decision or task came under emergency management arrangements or whether it was business as usual. And the involvement of National Cabinet and State processes was said to remove some of the control that State Controllers might otherwise have had. If this the case, and it's a matter for the Board to assess the evidence, it suggests that there was a lack of clarity in the arrangements and the whole benefit of an Emergency Management Framework is meant to facilitate clarity.

There's no time in the case of an unfolding emergency for there to be extensive dialogue between agencies and decisions made on the fly about where responsibilities should sit while an emergency is raging. And here, Mr Lapsley too noted that clear lines of command and control are of critical importance for an accountability perspective, so that agency and organisational commanders have a clear understanding of who is in control of the major emergency and who is responsible for coordinating. He said to you in his statement that there have been sadly in Victoria numerous examples of emergencies that were poorly managed because structures and accountabilities were poorly defined and understood and acted on. And so, should this program have been put into the Emergency Management Framework, as we submit it was proper to do, or might there have been some other way to manage it? Perhaps leaving it with DJPR, with input from DHHS, but without availing itself of emergency management structures.

Mr Crisp and Chief Commissioner Patton both gave evidence to you that they think the Emergency Management Framework is suitable for all emergencies, it's designed and intended through the benefit of recommendations made in earlier Inquiries to be scalable and flexible enough to accommodate any form of emergency. We invite you to accept that evidence. The Emergency Management Framework was appropriate, it was able to be applied with appropriate flexibility, both to the COVID-19 pandemic generally, unique as that pandemic is, and to this particular operation under the emergency management heading of Hotel Quarantine Program.

But the evidence also supports the view that the framework wasn't used as it was intended, so that to some extent it did become an example of a poorly managed emergency and the primary reason for that seems to be that DHHS did not sufficiently bring to its management of this public health emergency the health expertise which had been the basis of it being allocated as the control agency. And

in part we submit the evidence shows that's because the role and importance of a control agency was not properly understood within DHHS.

The concepts of control and command and coordination have all been well traversed in evidence before you, as I've noted, but as I've noted too, there wasn't unanimity about what they mean. We submit to you that the evidence is that the control agency as allocated under chapter 7 of the emergency response plan is responsible for leading the response to the emergency, the strategic direction, and it develops and executes management plans that involve all the supporting agencies. The control agency is responsible for directing the response to an emergency. Again, we reflect on Mr Lapsley's evidence that it is a fundamental premise to have a single agency that is in the position of leadership.

There was some evidence before you and one might anticipate some submissions about the emphasis on this being a complex emergency which had a multiagency response. It is no doubt true that this was complex, both generally and specifically, to the Hotel Quarantine Program, and there's no doubt too that there were a large number of departments and agencies involved. But however complex the emergency and how many agencies are involved, there still has to be a control agency. And there still has to be someone or an agency that understands that it has that function. The Emergency Management Manual describes that there may be some complex emergencies which require the consequences to be managed across agencies but there's never going to be a case where there doesn't have to be an agency in charge. And that agency is in relevant control, not merely the coordinator of what other people are doing.

So this was complex, this was multi-agency, but nevertheless, as Mr Crisp told you and as it seems to have been understood by most the ground, DHHS was the control agency, they were responsible for the response to the emergency across the State and they were responsible for this particular public health response, the Hotel Quarantine Program. And that's notwithstanding the very substantial role being played by a number of other agencies, including Department of Jobs, Precincts and Regions. They had their own substantial responsibilities and within their own command structure, they had obligations to carry out those responsibilities but they did it in their context as a support agency, accountable and relevantly controlled by DHHS as the control agency.

Of course, it is not disputed, as I understand the evidence, that DHHS was the control agency. What is the subject of some controversy and what may require some findings by the Board is what that means. Did it mean that DHHS were accountable or in control of the whole program or were they rather only in control of those parts which directly touched on their areas of expertise, for example, health and welfare and the detention arrangements? So, for example, Ms Skilbeck said in her evidence that the term control agency was a misnomer because really most of the activity was coordinating across the agencies. But in our submission and with respect to Ms Skilbeck, that misunderstands the difference between coordination and control. DHHS had a substantial role that they were being controlled by --- DJPR had a

substantial role but DHHS was in control.

It is relevant to note that in the emergency management hierarchy it seems to have been well understood that DHHS had that control function and indeed Mr Crisp said that the appointment of Mr Eagle as a Deputy State Controller - Health was intended to give further clarity and line of sight for the control agency in their control of this emergency response. He said that in his view it was quite clear, you go to the State Controller through a Deputy State Controller and to the Commander Hotel Accommodation to a team leader. That's the line of control. So State Controller - Health, Deputy State Controller for Operation Soteria, Agency Commander or the Hotel Commander and then down to the team leaders on the frontline. That was the way Mr Crisp understood the structure worked.

But the evidence of those performing some of those roles in that hierarchy was less clear. For example, thinking about the evidence given to you by Mr Helps and Ms Spiteri, who were the State Controllers - Health, they said they were in charge of certain parts of the response. Mr Helps said that he wasn't able to effectively meet some of the role functions because of those complex national arrangements and the suggestion was made that really the control function was in part being performed at a different level. They both said in their evidence that the Chief Health Officer and the Public Health Commander had "absolute control of the public health emergency" but in fact the structures show that the Chief Health Officer and the Public Health Commander weren't in the line of hierarchy in Operation Soteria, they were off to one side.

Mr Helps, as we understand the evidence, said that he wasn't leading the decision-making even though the State Controller would ordinarily perform that function of decision-making and leading. Mr Crisp had placed great reliance on the role of Mr Eagle and his off-sider, Mr Falconer, who shared the role. They were between them the controller for the particular operation. Mr Crisp said that Mr Eagle gave evidence that he understood his function to be quite a different one and in fact much more limited. He said that he had a coordination function in ensuring that questions and information were brought to DHHS' attention. He said that he was a coordinator between the agencies and the State Controller - Health. He said that whilst he did take some action on operational matters, he took no action other than to forward them on to DHHS if they were public health issues. He said he was an information flow. He made the point that he had no powers under relevant legislation, he only did things on the direction of the State Controller - Health. And so although his title had "health" in it, Deputy State Controller - Health, he was really also coordinating the logistical arrangements of the program, he wasn't engaged in any hands-on supervision of public health arrangements. Where there were public health issues, he sent them on to the State Controller or across to the Agency Commander leading the DHHS response. He said that he didn't have any knowledge or broad understanding of what that public health team or the public health component of DHHS were doing and he didn't have oversight or an understanding of what authorised officers were doing.

So that suggests that this structure which could have been helpful to DHHS was less helpful than it otherwise would have been. DHHS as the control agency had staffed these positions, they picked the State Controllers - Health, they had the power to and did pick the Deputy State Controller, and they filled both those hierarchy levels with people who were emergency management experts undeniably but not public health experts. So that top two tiers of the response to this emergency, as it related to the Hotel Quarantine Program, didn't have public health expertise in it. It is in that context that we submit to you that DHHS didn't understand its control agency function and didn't properly perform it, notwithstanding the great deal of work that was done by a great many people. Even despite the evidence of Mr Helps and contemporaneous emails from him in which he clearly identified DHHS as being in control of the operation, the Board will recall that in the evidence of Ms Peake she too was at pains to suggest that it was not actually control of the whole operation at all but something more nuanced than that. She seems to have seen the DHHS role as control agency as being much narrower. She said that it was primarily with respect to the authorisation of directives, including Directions and Detention Notices, and the authorisation of AOs to exercise roles on site. A much narrower role. Similarly the evidence of senior authorised officer Mr Cleaves gave evidence that he was warned off, as an authorised officer, to "stay in our lane", to deal with legal detention process.

Of course, the Board will recall receiving evidence from Dr van Diemen who observed with the benefit of hindsight that the whole program was run as a logistics and compliance operation when there should have been more of a health focus. The evidence of Mr Sutton and Dr Romanes is to a similar effect. It may well be that the relative infrequency of public health emergencies of this style and scale meant that how the emergency management arrangements worked for such an emergency was not properly understood. Victoria has regrettably had many recent instances where class 1 emergencies have occurred and everyone understands and has acted many times on their obligations for class 1 emergencies. DHHS, for example, has very substantial recovery activity operations responsibilities for class 1 emergencies. It is less often, as we understand the evidence, responsible for control where large class 2 emergencies are concerned. Indeed the Board may well find that Victoria didn't have the benefit of recent direct experience in managing major public health emergencies through this Emergency Management Framework, in comparison with its experience in class 1 emergencies. And perhaps that framework didn't properly or sufficiently contemplate the particular guidance and role that should be given --- should be played in health emergencies.

The question of what plans and other tools were available is going to be touched on by Mr Ihle later. I also note in the evidence of Commissioner Crisp there is a suggestion that there is in fact a review of emergency management operations underway and the Board has sought some information to better understand whether that review will touch on any of these matters.

But it is clear, before I move to another topic, and we invite the Board to find that DHHS' role as the control agency was a control agency role as that is contemplated

in the Emergency Management Framework. They were in control of the whole operation.

Might I turn then to the separate question of enforcement. As returned travellers were going to be required to remain in their place of quarantine for 14 days, one component of the Hotel Quarantine Program was the establishment of appropriate arrangements to keep them there. And it is a matter of record that DJPR contracted ultimately with three security providers to assist in enforcing the detention of returned travellers and that they played the frontline security role until their replacement by Corrections staff in early July.

Now, there is no doubt that those companies were selected by DJPR, that the contracts were negotiated by DJPR officers, they were signed by Mr Phemister, and that invoices rendered by the security companies were received and paid within DJPR. There has never been any dispute, for example, about whose name is on the contract or who signed the cheques. That's not the level about which there is any confusion in this area of private security. The question is: who decided that private security officers needed to be engaged and that they would be playing the role that they played? And that question is quite astonishingly still unable to be answered, it would seem, in any direct way, despite the calling of witnesses who ought to have relevant knowledge or recollection and who may well have been potential sources of that decision. No accountability has been accepted by Ministers, Secretaries or any other officials for that decision being made.

Now, obviously, the private security companies were used and the suggestion might be, well, given they were used, does it really matter who made the actual decision? We know a decision was made because contracts were entered into and payments were made. But it is a question of critical importance, we submit to you, because of the impact that decision ended up having. It is trite to say and my learned leader has already taken you to the Terms of Reference, that this Board was established to inquire into the Hotel Quarantine Program, to work out what happened and why. So Government decision-making is part of your remit, and as I put to Mr Eccles and as he agreed, this decision to engage private security, that is the decision as a matter of principle, not the operational decisions about who signed contracts, this decision ended up employing thousands of people and costing tens of millions of dollars and as a matter of proper governance we ought to be able to say who is accountable for that decision. It ought to be able to be identified.

Now, what can be said as we try to search for the origins of this outcome is that it doesn't seem that the involvement of private security was at all controversial on 27 March or afterwards. Similarly, there doesn't seem to have been any controversy that there should be at least some role for Victoria Police and there is indeed a suggestion in the evidence that the use of private security freed up what might otherwise have been police officers from hotel security to do other coronavirus-related work. It is true too from the evidence that private security appear to be commonly used in various areas of public life and to work regularly alongside police in a range of actives, and Chief Commissioner Patton told you that properly trained and governed

supervised private security work very well with police.

Now, the Board has heard evidence from a number of people who might have been the decision makers or who might have contributed and none of them said they made it but each of them thought it had been made either by someone else or somewhere else or some time other than where they were involved. So perhaps to touch briefly on that evidence, Mr Ashton says, assisted in his recollection by a text message that he sent, that he understood that private security were going to be used and he seems to have communicated that understanding to Commissioner Kershaw of the Australian Federal Police. That text exchange also suggests that Mr Ashton at the time he sent those texts thought it was the Department of Premier and Cabinet who had set up that deal. He couldn't remember in evidence what his source of information was but it seems he texted that understanding at that time. Mr Eccles, the Secretary of the Department of Premier and Cabinet, told you that he didn't know about any such deal at that time, the Premier told you something else, and there's no documents that the Board has seen that would suggest there was any such plan in place at that early time of 1.30.

By 2.00 pm, the issue, it appears, is the subject of some discussion in a meeting at which Minister Neville, Mr Crisp and Mr Ashton are all present. Mr Ashton says that in that meeting Mr Crisp said that private security would be the frontline. Mr Crisp doesn't think he knew that at the time to be able to say himself. Minister Neville's best recollection, she said, was that Mr Crisp raised the question of private security, and there are some notes but they don't assist one way or the other in determining the origin of remarks and precisely what was said.

By 3.00 pm when the Premier made his remarks, the involvement of private security is identified by him. He couldn't explain in his evidence to you why he said that or what he might have meant by that. But that public announcement was noted by people including Minister Neville and it was certainly made prior to the initial State Control Centre meeting, which occurred at about 4.30. Around about that same time, as the Board knows, the Victorian Secretaries Board were also meeting and it seems there was some discussion about enforcement arrangements at both the meetings. Mr Ashton says to you that at the Secretaries Board meeting, he clarified that private security was the first security option. That doesn't appear in the formal minutes but in the notes it does appear that firstly he posed a question about the potential role of police and private security, and then later on there's reference in an exchange between him and Mr Eccles to there being a challenge posed by Victoria Police having a static presence over a long period of time, and there's discussion between Mr Ashton and Mr Eccles that a private contractor might be involved.

Then we move to the State Control Centre meeting at 4.30, a recording of which the Board has and parts of which have been played. That recording suggests that in that meeting the first mention of private security was from Assistant Commissioner Grainger, in response to a request for comments about resourcing security. In those initial comments, Assistant Commissioner Grainger refers to security arrangements as being multilayered. He refers to, amongst other things, private security at

locations and police may have a role. The recording then reveals that Ms Febey responded, acknowledging the potential need for increased private security at hotels and asking how Victoria Police saw its role. It appears there was an agreement at that time that they would take that discussion offline. But then later in the same meeting, Mr Crisp, who hadn't been present for that exchange, comes back into the room and directly asks Assistant Commissioner Grainger, by way of confirmation, whether it's Victoria Police's preference that private security be the first line, and police respond as required, and in response, Assistant Commissioner Grainger is recorded as saying, "Absolutely, that's our preference." What we know from evidence is that immediately prior it would seem to that exchange inside the room, Mr Crisp had left the room and had a conversation with Mr Ashton and as a result of that conversation he had sent a text message to Mr Grainger stating that Mr Ashton had made it clear in the conversation, that he had made it clear in VSB that private security is the first security option. So the sequence of events seems to be the issue is raised early on in the meeting and a general view is sought from Victoria Police and a general answer given, with private security mentioned; then Mr Crisp has a conversation with Mr Ashton, as a result of which he sends a text to Mr Grainger, and then the issues raised in the meeting and the preference of Victoria Police is attached.

Mr Ashton said in evidence that any such conversation between him and Mr Crisp would just have been him reporting on what was agreed rather than himself expressing a view or a preference. He denied that he had any view, he denied he had made any recommendation. He said that the decision was presented to him before 2 o'clock or at 2 o'clock by Mr Crisp as having already been made, and he disavowed any suggestion in an email that was sent by a Superintendent of Police that this had been his or VicPol's recommendation that private security be used. Certainly it would appear that Victoria Police would resist the suggestion that any preference or recommendation had an impact on the decision to engage private security, a decision which as I understand it they suggest through Mr Ashton's evidence was made before 2 o'clock. You will recall that Mr Phemister, the one who ultimately had the job of engaging private security, said that he thought it was most unlikely a decision had been made that early because if it had he would have known about it and he would have acted on it. You will recall too that Ms Febey went into the meeting at State Control Centre with a "working assumption" that security might be required but left the meeting with a later understanding that she had been given that job to do. So that is the context. No evidence of anyone disagreeing with it, no one claiming it as their decision.

Perhaps building on some evidence that has been given by witnesses when this issue has been raised with them, it could be argued that perhaps this was a group decision, made in the context of multiple departments and agencies gathered together. But the Victorian public would rightly expect that those making such a decision in a group would know they were making the decision and would accept responsibility for it. If it was a group decision then the group is responsible. But it seems that if the decision was made in that State Control Centre meeting, no one knew they were making it and no one wanted to own it. It is for that reason that we submit to you the

use of private security is not really a decision at all. It is a conclusion that was arrived at by way of a creeping assumption, that took hold over a period perhaps of a couple of hours, and that wasn't questioned by anyone. And inviting you to that conclusion, we do suggest that some findings were open to you. Firstly, we invite you to find that the decision or the conclusion or the outcome that private security would be the first tier of enforcement was not made before the State Control Centre meeting. Apart from that one text from Mr Ashton, the source of which he can't recall, there is no evidence of a deal or a final decision that early. Mr Ashton's certainty the decision had been made and communicated with him is at odds with the understandings of everyone else at that State Control Centre meeting. It is odd that it wasn't mentioned that a decision had been taken if indeed it had been. It is at odds with the way it appears Mr Ashton framed questions at the Victorian Secretaries Board meeting, it is at odds with Mr Crisp's text to Assistant Commissioner Grainger. And so it may well be that Mr Ashton is misremembering the sequence of events. But in our submission the Board should not take the view that a final decision had been made either at 2 o'clock or at any time prior to the State Control Centre meeting.

But it is also clear, and you can find that by the end of that first State Control Centre meeting, the creeping consensus was everyone's and while no one person made a decision, by the end of that State Control Centre meeting it was understood by all present that that was what was going to happen.

But that's not is to suggest that there weren't any influences on that creeping consensus. It wasn't Victoria Police's decision, we don't put it that highly, but Victoria Police's clear position expressed in that meeting, that private security would be, in its view or its preference, the appropriate first line of enforcement, has to be understood as a substantial contributing factor to that creeping consensus. Victoria Police were the law enforcement experts, they were present at that meeting by reason of their law enforcement expertise. The Chief Commissioner of Police can't be directed by anyone on operational matters. The police decide what they do in matters of this kind. So in those circumstances and in the context of this meeting, the expression of a preference can readily be understood to have given the clear impression that police weren't going to do it and there needed to be an alternative. It was understandable and reasonable for Ms Febey to have left that meeting with the understanding that a decision had been taken. Now, it may well be that the Premier's remarks had contributed to that general creeping assumption that private security would be used, and it may well be that people's knowledge that private security are regularly used also contributed to that creeping assumption. No one seems to have thought it was strange or odd. But what can be said is that the nature of that private security role as being the frontline role, that consensus was influenced and strongly influenced, we would say, by everyone at that meeting understanding what Victoria Police's preference was. Their preference became the outcome.

So what that means is that there wasn't any specific decision, there wasn't any specific decision by an individual or by a group. It was a creeping assumption that became the reality. And the absence of clarity, certainty and active engagement with

that question on whether it was appropriate or not has to be understood as a failure of decision-making. Because it follows from no one being the decision maker that there is no evidence that any one person or group of people actually turned their mind to whether it was appropriate to rely so heavily on private security. This wasn't a sporting event or another kind of voluntary activity, where police and private security worked together. This was an infection prevention detention program and no one, it seems, on the material we have gave any specific consideration to that and the suitability of private security for that function.

What is clear is that once that consensus had become the agreed understanding of everyone, it endured. Private security were engaged and no one revisited the suitability of them as the frontline workforce until after the two outbreaks at Rydges and Stamford and two investigations which had reveal the vulnerabilities of that private security workforce, which is something I'll say a little bit more on shortly.

As the Hotel Quarantine Program developed and the roles allocated to private security evolved, no one turned their mind to whether they remained a suitable workforce because no one understood themselves to have made the decision about their use in the first place. So that is where this decision becomes crucial and the absence of an owner of the decision turns out to be so potentially dangerous to the success of this program. Because to the extent that it was reasonable for someone on 27 March to have agreed on the use of private security as the frontline security, that decision would have rested on assumptions about precisely what they were going to do, what the skill set would be, how they would be supervised and what other arrangements were going to be in place for, for example, infection control and training. And because no one owned the decision to use them, no one had the responsibility for monitoring whether the assumptions that must have sat behind the decision were correct assumptions. And indeed one can see from the evidence of people like Mr Ashton that there were starting assumptions about what the job would be. He thought it would be static guarding, monitoring points of entry and exit, doing standard work outside rooms, making sure people didn't go in or go out. If that was all the job was, that might help us explain more readily why everyone participated in this consensus that private security should be used. But in fact, knowing as the Board now does what this program became and what the role of private security became, those assisting you call on you to make a finding that absent very clear oversight from persons who had infection control expertise, absent continued training, absent continued supervision, it was not appropriate for private security to be the frontline in enforcement at the hotels.

We say that for a variety of reasons, none of which are intended to reflect on the inherent capacities of private security guards generally or the ones who actually worked here. It is more to do with what the program was and what the risks of the program were and the extent to which they were understood. So perhaps before going into detail about some of those matters, may I just touch on another related issue, which is the extent to which there was or should have been an ongoing police presence. Once the consensus was reached that private security would be used as the front tier, the question became, well, what would the police role be? It is clear that

some people thought that role should be a 24/7 presence at all hotels and that views were expressed by Ms Febey and some others that that would have been desirable or indeed necessary, and in some of the evidence the Board has received there has been evidence that other people had that view from time to time, that police would have been useful and appropriate.

It is also clear that no formal request for 24/7 police attendance was ever received by police. And the Board can find that that's the case. Whatever might have been the views of some within the planning and operations sector about the desirability of police being there all the time, those views never found their way in a formal request that could have then been assessed by Victoria Police. We do have some sense of how Victoria Police might have assessed such a request if it had been made through the evidence of Commander Tully. He was asked to reflect on whether it might have been useful to have police there all the time and he pointed to the relatively low number of call-outs for attending police and suggested to you that it wouldn't have been an efficient use of police resources to have police there all of the time. It is true that the number of those call-outs seemed relatively low and that some of the risks of poor behaviour or aggressive behaviour or resisting behaviour that were anticipated by those setting up the program didn't eventuate. Nevertheless it is also relevant to note that in the model currently operating at health hotels, police are there all of the time, and it is relevant for the Board to consider, and I will touch on this perhaps after I invite the Board to take a short break, about the way in which the presence of police on site might have served other functions, not least the function of ensuring that there was an appropriate focus on health and safety matters on site. I say that because when one looks to the documentation that has been provided by Chief Commissioner Patton about the circumstances under which police are providing services at health hotels, it's very clear that there's a great deal of planning and work that has been done to ensure a safe environment for those police officers: full-time safety officers, extensive briefings, very detailed protocols. And there is some evidence before the Board to suggest that concerns were expressed from time to time in the life of the Hotel Quarantine Program by security companies and guards about their own workplace safety or by others about whether the workplaces were being monitored in the same way. It is perhaps instructive to note that once the police were on board, their employer, the Government, gave very careful attention to those matters in a way that perhaps wasn't given early on. To that extent perhaps police might have made a difference but those assisting you don't invite you to conclude that there should have been for enforcement purposes necessarily a 24/7 presence by Victoria Police.

Madam Chair, I am going to move on to some new topics. I have been making everyone listen to me for more than 45 minutes, so I wonder if it might be convenient to take a short break. I estimate that I am about halfway through.

CHAIR: All right, we will take a break, Ms Ellyard. We will take 10 minutes.

MS ELLYARD: If the Board pleases.

ADJOURNED **[11.38 AM]**

RESUMED **[11.48 AM]**

CHAIR: Yes, Ms Ellyard.

MS ELLYARD: Thank you, Madam Chair.

I want to turn now to consider some other aspects of what flowed from the use of private security providers in the Hotel Quarantine Program and perhaps picking up on what was said by Mr Neal about this being a complex system with no one clear event but rather a whole combination of factors that create vulnerabilities and which bore fruit regrettably here. There are a number of issues that arise once one gets past of the point of private security being engaged about how they were engaged and what they were used for. Part of that too, it seems to those assisting you, arises from the fundamental misapprehension or lack of focus on this being a public health response and instead consideration of it as an ordinary enforcement or compliance activity. It also appears too that perhaps not inappropriately but relevantly the approach to private security was also an approach which took account of the possibility of job creation and that it was seen as a useful benefit that this would create some jobs in an industry that like many industries were being affected by COVID-19 restrictions.

It is important to reiterate, again building on what Mr Neal said, that the risks posed by the decision to use private security guards or the concerns that those assisting you invite you to hold about that decision don't arise from my suggestion that security guards are inherently badly behaved or that they were badly behaved here or that there was any widespread misconduct or misbehaviour. There is some evidence before the Board of instances where there were complaints about security guards. There were some allegations of inappropriate contact with guests, sleeping on the job, rudeness, misuse of PPE and so forth and certainly those matters of personal behaviour are unacceptable and it plainly had an impact on the welfare of those in quarantine who witnessed it and placed people at risk. But it doesn't appear that personal misbehaviour was systemic or widespread and it does seem that instances of personal misbehaviour were dealt with by contractors when they were raised.

The risk that was posed by the security guard workforce was of a different kind. Sitting alongside that assumption that we have discussed that security would be used were, as I've indicated, assumptions about what their role would be. Perhaps tritely, their role was originally conceived as a security services role. On that first weekend it was understood that they would be engaged to support the work of authorised officers who would have the power to detain, and the first documentation prepared by the Department of Jobs, Precincts and Regions over that first weekend reflects that focus.

The contracts that were later signed are slightly less clear in the line of accountability and are more expansive in the likely duties. But even beyond that, over time it is clear that the Department of Jobs, Precincts and Regions called upon security guards as a more flexible resource that were used to perform a range of non-security related tasks, escorting people for breaks, doing some work in sanitising of facilities, delivering food and parcels, going to the shops to purchase toys, delivering Easter eggs, a whole range of other activities. That gradual function creep, if I might use that expression, for security guards posed a risk for transmission of infection --- infection transmission because we submit that security guards, whatever might have been their proper role in static guarding, were not the appropriate cohort to perform that more expanded role and that suite of roles that were more likely to bring them into contact with people who might be COVID-positive or to move through areas where the infection might be present.

In our submission, it is open to you to find that that increased reliance on security guards to perform non strictly security functions was not a considered decision and led to certain functions being performed by those who didn't have the necessary expertise.

Professor Sutton gave you some evidence on what he now understood to have been some particular risks posed by the demographics of those who are engaged in the private security industry. He relevantly noted the relevance of casualised labour force, which can mean that workers are less inclined to reveal if they are ill or to take time off and they will often work more than one job, because of the low wages that are payable in the security industry. He also noted from his own observation, and this was with hindsight, the existence of language and cultural barriers that might impede understanding and acceptance of infection prevention and control measures.

A number of those matters are matters that were traversed in the issues paper that I took the Premier to on Friday. That document came into existence after the decision to use security was made but the issues contained in it were well known to the Government well before.

So there are some things that can be said that make security guards as a cohort a potentially vulnerable cohort. Firstly, the fact that the work is season and unpredictable, even more so in a COVID pandemic context where many regular jobs of security guards have been lost, and it is reasonable to infer that the vulnerability of workers and the reduced availability of work would lead to security companies and their workers being willing to accept work, even work going beyond their strict skill set rather than risk losing the court or losing the hours. One notes, perhaps by example, the fact that sometimes guards needed to be available on a one or two hours' notice. If the numbers required per day rose or fell as a particular hotel, contractors and then subcontractors had to find new people with astonishing rapidity, and the vulnerability of a workforce that has to be available on a moment's notice of that kind but then is vulnerable to being sent home after four hours if it turns out they weren't needed, really raises the question of whether that is the people you wanted

performing what was really a frontline infection prevention job. It wasn't actually, as it turned out, a pure security job at all.

Secondly, it is relevant to note that perhaps in comparison with other workforces, including the workforces now performing roles at the health hotels, security guards are relatively less organised in terms of having less or reduced access to formal union arrangements, although of course there is a union that provides assistance to some of them. They are less likely than other cohorts, particularly fully employed cohorts, to assert their right to proper standards of work and health arrangements, and there is a clear, we would submit to you, potential for there to be an imbalance of power between the contractors and those who they are employing.

Indeed, the evidence before the Board supports the view that not only is there a lack of power between the end security guard and their employer, where security guards might have felt reluctant to say no or reluctant to disclose issues that might make them unemployable in the future, there is also, given the tiered hierarchy that existed here, a clear imbalance of power, we would say, between head contractors and subcontractors. Reflecting on the evidence that was given by the panel of subcontractors, it is quite clear that it would have been in some cases difficult for subcontractors to make much by way of a complaint if their head contractor required things of them that were unusual or unsafe. The nature of the industry as such is to very much consolidate power higher up the chain. Again, that can be contrasted with the arrangements that are now in place in health hotels. The Board will recall that we have looked at documentation clearly showing that as Government cohorts of workers, whether from Corrections or police or otherwise have moved into these workforces, there have been detailed policies about health and safety, there has been extensive consultation with relevant unions, and it has been clearly understood that there's a need to focus on workplace safety matters.

All of those things are things which were less likely to be present or reliably present in the use of a private security workforce, without meaning to suggest in any way that the employers of security guards are indifferent to those things. But there is no evidence before the Board to suggest that all of these issues, the demographics of those who are security guards, the relatively flexible and less stable way in which they are employed, their personal characteristics and levels of experience and understanding, there is no suggestion that any of those things were considered when the role of security guards were discussed and certainly no discussion that they were considered as the role of security guards expanded, even though the Government must have been in possession, noting the existence of that issues paper, with relevant information about those things.

Now, had someone owned the original decision to engage private security, they would have been better placed to know if they needed to revise the decision. Security guards were essential to the success of this program, not just because they were at the door in case someone tried to do a runner but because they were moving through and around the environment and having, as it turned out, closer contact than had been anticipated with people and items and locations that might be

COVID-positive. And so it seems that it wasn't understood in the way that it should have been how much on the frontline as essential frontline workers the private security guards were.

And so the issue isn't so much about individual instances of misconduct, it's more about a systemic issue about whether this casualised workforce, with all of the compounding issues connected with potentially poor literacy in English, limited access to health information, vulnerability potentially to exploitation, all of those things create a systemic issue about whether or not they were the right cohort here, whether they were going to be able to be sufficiently trained and retrained, bearing in mind Professor Grayson said that you have got to keep on reinforcing training. This workforce was changing every day, they were all very casualised, coming and going. Was that the right workforce for work this of this kind? We submit to you it can be seen that it was not the right cohort, and if it was going to be the right cohort it was going to need a very substantial and ongoing structure to provide supervision and training.

That raises the question of what other alternative workforces there might have been. There has been some evidence given about the extent to which the ADF might have been a suitable alternative. Certainly outside of the Board's hearing room, there has been a lot of attention on that as well. It is uncontroversial that there is a plan in place and an arrangement in place pursuant to which where the State has exhausted its resources or otherwise requires assistance, it can seek assistance from the ADF, and there is evidence that Victoria has done that on multiple occasions, including on multiple occasions this year with reference to coronavirus responses, and that included relevantly for our purposes the role of ADF personnel who were in the State Control Centre and assisting with planning for Operation Soteria.

The question is to what extent was considering given to the use of ADF in any frontline or boots-on-the-ground function. The evidence of Commissioner Crisp on this point is quite clear. He didn't seek ADF assistance for frontline work, he didn't see a need for boots on the ground. He knew that he could ask for it if he needed it but it appears that in that first meeting, understanding that private security was going to be engaged after the expression of Victoria Police's preference, as I have already outlined, he thought that the matter would be handled within Victoria, and ADF boots on the ground weren't required. Leaving aside all of the issues that are raised about the means by which use of private security was settled on, we submit to you that it was a reasonable conclusion for Mr Crisp to come to on that day that resourcing was available for the various aspects of the program so that there wasn't a need to request boots on the ground from the ADF.

Later, of course, on or about 24 June, a request was submitted by Commissioner Crisp for 850 personnel to do that boots-on-the-ground work. This was made after DHHS had formed the view, as you have heard in evidence, that the private security workforce needed to be replaced and 850 was seen as the number of ADF personnel that were necessary.

Ultimately, as you heard in evidence, that request, although it was granted, was rescinded, after decisions were made to explore other options and within a very short space of time, only a couple of days, a decision was taken by the Crisis Council of Cabinet to indeed replace private security but with a Corrections-based workforce rather than with ADF people.

So again, it appears that those decisions about the use or non-use of ADF were reasonable and open and no criticism we say should be directed to those who made those operational decisions about whether frontline ADF were needed in the hotels.

Of course, there is the question of whether or not they were needed, whether they might have been better. They certainly would have been cheaper, given the evidence is it would have been in-kind support for which no financial payment needed to be made by the State. And there is an argument that perhaps in some respects, the ADF people might have been better trained for the job. There is no suggestion that they had specific training for quarantine programs, they certainly didn't have and wouldn't have had any more legal power than private security guards did, and again, if the security job had remained a static job of standing outside doors, perhaps the comparison would have reflected appropriately with private security being left in the job. But there are features of the ADF cohort that again, in comparison with the private security cohort, might have made a difference to the extent to which that role as a frontline infection prevention role was understood. Certainly the ADF by virtue of their work are engaged in the service of the public, they are very familiar with a command and control model that would have lent itself to the expectation of clear lines of accountability and follow-up if they weren't in place, and it might well have been because of their background and training, they were better placed to understand the infection risks or to be ready recipients or training and information made available to you. And these infection control risks associated with, for example, assisting passengers for fresh air walks and things of that kind, those are things that might have best been done, for example, by ADF officers who had some background themselves in matters of infection control or clinical expertise.

So, and first, they would have been people who were seconded to the role, being paid, not vulnerable to the risk of losing their job if they were unavailable for a particular shift, readily contactable in the event of any illness that required contact tracing, a much more permanent and stable potentially workforce.

So it might well be that the Board considers that had ADF had that frontline role, there would have been some advantages in the extent to which infection control measures were implemented and understood and the speed with which issues could have been followed up if issues arose. But we don't invite you to find and indeed we say it is not open you to find that the ADF should have been engaged. Again, the issue is about systemic risk and control issues and the expansion of the security officer role beyond what would have been the function of someone performing a private security function.

We do invite you to find that the officers --- offers of assistance made or available to

be made to Victoria by the ADF should have been raised with the Premier, thinking particularly about the apparent availability of in-kind personnel in early April. The evidence is that that was not brought to the attention of the Premier. The Premier says it wasn't. Mr Eccles can't recall whether he did. And there is no documentation to assist Mr Eccles, as I understand it, in that recollection. It would have been appropriate for the Premier to have been made aware of that, although it is not possible to speculate on what the outcome would have been.

But otherwise we submit that the decision to not use the ADF and to, at the start, keep the Victoria Police in an as-needs responsive role only were both appropriate decisions that were open. But as the role of security expanded there should have been a revisiting of whether or not they remained the appropriate people to perform the role.

Can I turn then to the way in which the security companies were identified and engaged. The Board is aware that ultimately three security companies were contracted with for ongoing provision of private security services: MSS Security Pty Ltd, Wilson Security Pty Ltd and Unified Security Group Australia Pty Ltd. Mr Phemister said that his view was that services should be procured from firms who had a track record of working with Government, who were good employers, who were able to scale up, because flights were going to continue to come in, and who could provide their own PPE, given that PPE was at the time in late March in short supply. What the evidence reveals is that ultimately through a descending allocation of responsibilities, staff within the Working for Victoria team, who were themselves at least in part on secondment from the Employee Engagement Program, consulted amongst themselves via WhatsApp on which companies might be suitable. It doesn't seem that any of them knew that there was in fact a State Purchase Contract for the provision of security services and that there were publicly available details, including email and mobile numbers, on a website. It appears from the WhatsApp messages that those thinking about who to suggest as potential security providers had some general ideas about the security industry but they don't seem to have had any knowledge of security contracting and no knowledge at all --- and this isn't a criticism of them --- of what the role in the Hotel Quarantine Program was going to look like. To the extent that they were working late at night trying to identify names of people and then contact details of people, they were, and again without criticism of them, being called upon to somewhat reinvent the wheel because all of the work of identifying relevant and appropriate security companies for Government work had been done through the purchase contract arrangements and those details would have been available to them had they known where to look.

Instead, what seems to have happened is that they were placing weight on their personal knowledge as security companies, including their knowledge of them as employers and recipients of placements, rather than any assessment of whether or not those companies had what was required to provide frontline security services in a quarantine program.

The evidence of Ms Currie about her role can be accepted. She received the advice

from her team, which had been gathered in the way we have discussed. She sent out two emails very late at night and the first one to answer the next morning was the one who got the gig, they were the one who were engaged to attend the initial walk-through and to provide services at the first hotel, and history shows that was Unified Security. Over that weekend, Ms Currie engaged Unified and also Wilson on an informal basis. She had contact with MSS, who were subsequently contracted on a formal basis. Her evidence is, and this isn't disputed, that she described to each of the three contractors the role as best she understood it, she asked for how many people they could stand up. She didn't have herself any sense or any reason to have a sense of ultimately how many people would be required, or what the ultimate job description would be.

As the Board now knows, two of those security providers, MSS and Wilson, were, as it turns out, on that panel under the purchase contract for security services. Unified wasn't. It had applied to join but it has not been selected. Ms Currie didn't know that and given the role that she ordinarily held in the Department, there is no reason why she should have and no criticism is made of her for not nothing that. It appears if the evidence that Unified attended the dry run at Crown on the 28th. They were there for the first arrivals. In fact, although one of the concerns had been to find people who were good employers and who could scale up, as at that time of the first call between Ms Currie and a representative of Unified, Unified had very few employees in Australia and --- I'm sorry, in Victoria and indeed Mr Nagi, who came on as the operations manager, didn't himself start work until after that contact had been made. The teams of guards they provided on that first day were largely through subcontracting arrangements, and I'll come back to that.

What is clear from the evidence and the documents the Board has is that over that first frenzied weekend, Unified were there and worked very closely in the establishment of what the model was going to be and very closely with the DJPR team from Global Victoria and others who are working on the ground to establish this very complicated logistical exercise. It is clear that those DJPR staff found Unified staff to be supportive and helpful and that a relationship of what I'm going to call professional reliance developed in which Unified saw its role to be as helpful as possible to DJPR, even going beyond ordinary security duties, and DJPR indeed experienced Unified as helpful and responsive to their needs.

On the Monday, 30 March, Wilson Security did its first walk-through at what would become its first hotel. The documentation suggests that somehow on or around that time Wilson were perceived as not being helpful in the way that Unified were helpful, although the Board might perceive that Wilson's approach which was perceived as unhelpful was perhaps driven by a greater experience and understanding of the logistical complexity of this operation and a greater sense perhaps of the risks that it posed to staff. In any event, all three were subsequently engaged, Unified and Wilson informally, over the weekend.

The process by which Unified came to be the first contractor on the ground is certainly explicable and understandable by reason of the short timeframe and the fact

that Ms Currie was presented with information in circumstances where she had no time to check it and no knowledge that there might have been an easy means by which to understand who the Government's preferred providers were. The placing of this task, this initial task of identifying security companies with the Working for Victoria team does suggest an understanding from the earliest days that this would in part be a job creation scheme.

But we mean no criticism of that team when we say that the task of identifying security services was not appropriately allocated to them. This was the contracting of crucial frontline service in a quarantine program. It wasn't an employment scheme or an inclusion scheme, as important as those things are. So those staff did the best they could but they weren't the people who should have been given that job.

Again, leaving aside the decisions of that first frenetic weekend and understanding why the initial companies were selected as they were, a separate question then arises about who the State decided to enter into longer-term contracts with. Procurement policies are in existence and those policies meant that firms on the panel should have been given preference. There was a critical incident exemption under which it was permissible to engage a non-panel firm like Unified but --- and certainly the initial weekend more than qualifies as a critical incident. But it is not really an explanation, in our submission, for why once that initial panic was passed and there was time to pause and there was an understanding within DJPR of the existence of the purchase contract arrangement, why DJPR didn't take the advice of its own procurement people and confine longer-term contracts to firms which had been vetted through a proper process and included on the panel. Indeed, the email traffic suggests for a time they did intend they would confine Unified to its initial engagement, on the basis it would be disruptive to change, and that they were otherwise going to use preferred providers. But for reasons which are unclear but which do seem to have included those direct relationships of professional support that had been formed between Unified staff and DJPR staff, it was only a few days after that email traffic that Unified were allocated a string of additional hotels and a final contract having been entered into.

It is open to conclude that if there had been a concentration and a proper reliance on firms that were part of the security services panel, then the criteria for selecting security guards, the key criteria against which security companies should have been selected, would have been better understood rather than there being a risk of or at least a perception of a risk of subjectivity in decision-making and reliance on personal professional connections rather than the objective process that had led to the establishment of the panel.

As has been noted in evidence, Unified ultimately received a substantial percentage of the security work across the hotel program, including the crucial hot hotel at Rydges. That was in circumstances where although there were well regarded by people on the ground, they hadn't satisfactorily demonstrated their ability and skills to provide security services in the way that panel members had. In fact, as we know, Unified was almost entirely reliant on subcontractors from the very first day. It

seems to have had a very small Victorian infrastructure and in turn appears to have been drawing on quite small subcontracting companies. This can be illustrated just by one example. In late May, when the Rydges outbreak occurred, a single subcontractor, Sterling, which appears to have been a two-director company, which without the substantial infrastructure of larger firms, was providing hundreds of guards a day across six hotels for Unified. And at that same time Wilson itself, a large operation, only had two hotels in total to staff and MSS only had three. So that is a particular risk for the success of this program, occasioned by so much responsibility ending up on the shoulders of a small subcontracting firm for the identification and supply of hundreds of staff who had to be appropriately trained and resourced, at a time when there were other larger companies who were not being called upon in the same way.

This particular risk partly arose because Unified, although on the documentation it seems to have been slightly more expensive, was, because of its small Victorian footprint, much more reliant than Wilson and MSS were on the advice and assistance of DHHS with regards to matters of infection control. So that increased the risk. They were less self-sufficient, the evidence suggests, than the larger companies, yet they were getting more of the work, including that crucial hot hotel.

It also appears from the way decisions were made about contracting that those entering into the contracts on behalf of DJPR didn't really understand how common subcontracting was. It is obvious from the contracts that it was anticipated. And subcontracting presented very particular challenges to the quarantine program, which were then a further flow-on risk from the decision firstly to use private security and then secondly to engage the companies that were engaged.

As I've said, each of the contracts provided for subcontracting but there was a requirement that DJPR provide written approval or that they otherwise be notified in advance of the use of subcontractors. It appears from the materials the Board has received that Wilson and MSS, largely though not entirely complied with these obligations and it seems there were some process issues about the timing in some respects of that compliance. But by contract, it doesn't appear that Unified gave formal notice, as opposed to informal notice, of any of its subcontractor use.

The statement of the Principal Policy Officer and other documentation suggest that over time, DJPR did become aware that subcontractors were being used but nothing was done to follow up the need to approve them or have formal notice of them. One is left, in our submission, with the impression that although they were relying so heavily on Unified the program, DJPR did not really understand the extent to which Unified in turn was relying on subcontractors. By way of one example, the Board will recall that in early May, after a complaint about the conduct of some guards at Rydges, Unified removed the subcontractor who had been there. Documentation prepared by DJPR at the time suggest that DJPR thought that Unified had replaced that subcontractor with Unified employees. But in fact it was another subcontractor, it was Mr Aggarwal of Sterling who stood up a team, as he told us, on a few hours' notice. I asked Mr Phemister about these matters and he gave evidence that there

had subsequently been a procurement review which had revealed that approval would have been given for those various subcontracting arrangements if they had been brought to DJPR's attention. But the problem remains, whether or not that's right, DJPR placed more than half the hotels in this program with a company which was using nearly entirely subcontracted labour, which wasn't on the panel, and which was using that labour without active knowledge and oversight by DJPR.

Minister Pakula agreed that it is best to keep contractual relationships close here. We should acknowledge that the evidence is clear that given the seasonal nature of some security work and the large number of staff that were required for this program, it was perhaps inevitable that there would be subcontracting. But the Board should conclude that DJPR didn't have adequate oversight of the use of subcontractors in the program and didn't consider when apportioning work between the three contractors the extent to which those contractors had access to appropriately trained staff, whether directly or through subcontracting arrangements, and this was, we submit, a failure of contract management on the part of DJPR. It ignored a mechanism which was designed to protect the safety of subcontractors and returned travellers alike.

This became a real issue because of a separate decision that had been made in that cascading line of decisions about the terms of contracts. That was the extent to which there was a contracting out of responsibility for infection prevention education and PPE usage.

It is trite to say that hotel quarantine was a risky place to work because it exposed those working there to the risk of becoming infected. The security contracts expressly refer to the likelihood that security guards will come into contact with people who may or may potentially have COVID-19 and obligations were imposed in the contracts that security providers had to ensure compliance with PPE usage and COVID-19 training requirements.

So the risks of those matters were placed on the security companies and the same was true for hotels. And that in our submission ought not to have occurred. Ms Currie gave evidence that she was aware of and identified the Commonwealth COVID-19 training program and that subsequently found its way into the contracts as a requirement that all staff should undertake. It doesn't appear that she identified it based on DHHS public health advice and ultimately, as the Board knows, that training wasn't sufficiently specific for a quarantine program and was, and the evidence of Professor Grayson, quite clearly misleading. Ms Currie didn't have relevant expertise about public health, she shouldn't have been put in the position of identifying for herself what the relevant criteria were, and she seems to have understood from things she said to at least one contractor that there wouldn't be COVID-positive people in the hotels and that's entirely consistent with the role she was playing at a very early stage in the program. but those entering into signed contracts knew full well that there would be COVID-19-positive people in the hotels, and they were placed to make rational and considered decisions about where responsibility for PPE usage and infection training should reside.

On the face of the contracts, they elected to allocate that responsibility entirely to the contractors. So responsibility for ensuring that staff wear PPE, responsibility for ensuring that staff received adequate training in security workplace health and safety, customer service and risk management as applicable to the provision of security services and in relation to COVID-19. And one might comment that those requirements are quite vague. What's to be made of, for example, the term in the contracts to "all necessary personal protective equipment that complies with the relevant public health standards including but not limited to in relation to COVID-19"? If as we apprehended at the time these contracts were entered into, DJPR didn't know itself what was precisely in that standard or what precisely the quarantine environment required, it was certainly unreasonable to expect that private providers would know and certainly quite unreasonable to divest the State's responsibility on to those private providers. DJPR had its own obligations under the contracts since it had imposed these conditions to monitor them, but since DJPR don't seem to have known for themselves what those requirements were, it follows that they didn't and weren't in a position to monitor the extent to which staff were in fact properly trained, did in fact receive appropriate guidance and did in fact have access to appropriate PPE use.

We invite the Board to find that it was not appropriate that the State, through DJPR, divest responsibility for training, infection control and PPE for private security guards, that frontline service. All of the evidence at the time was that this was a highly contagious virus. It was true that much was still unknown about its behaviour, and the risks of transmission and methods of transmission were still being debated, but enough was known to know that strict attention to infection prevention was required, because there was just too much at stake. This was the frontline of defence for COVID-19 reaching the Victorian community through overseas travellers.

If as the DJPR Secretary Mr Phemister and Minister Pakula suggested in their evidence, DJPR had an expectation or an intention that the State, through DHHS, would in fact provide on-the-ground training and guidance to supplement the contractual obligations placed on security companies, then one would have expected to see that expectation documented and enforced. Instead what the documents suggest is that from time to time DJPR did seek or raise the question of the sufficiency of infection control training and so forth. But they appear to have to some extent regarded themselves as the passive recipient of advice from DHHS rather than seeking out and obtaining what they required.

Further, I think it is appropriate to perhaps note that another reason why it was inappropriate to outsource this obligation to security companies is because the ordinary functions of those who provide security services don't readily align with the function of managing infection prevention and control. Security guards work in a variety of locations but what they do there is security work. They are not the best cohort of professionals to take on responsibility for training for infection control purposes. It is not reasonable to expect that they would have access to expertise if the State didn't. And what can be seen is that contractual terms of this kind left the

State to the mercy of how the contractors themselves chose do educate themselves, their staff and their subcontractors, and across the three head contractors there were varying approaches. The evidence is, for example, that Wilson engaged its own medical expert, it introduced temperature testing at its hotels months before that became standard. MSS too seems to have prepared and provided its own training on these matters. Whereas by contrast Unified seems, of the three, to have been the most reliant on guidance and advice coming from the State and therefore to have been the most vulnerable if that guidance and advice were not provided.

So the Board is invited by those assisting you to make a firm finding that responsibility for the managing the risk of infection and providing for the safety of those involved in the quarantine program should have remained with the State. No contract should have purported to outsource those matters. The same is true for hotels. There were similar provisions in place requiring hotels to take responsibility for those matters in relation to their staff and in relation to the hotel environment, including cleaning. The evidence is that hotels were left at first to work out for themselves the policies and procedures that should apply for infection prevention and control. They weren't given clear directions. The evidence was about what applicable infection prevention measures were and the evidence of the hotel managers that you heard was that they all did the best they could and there was later some guidance and training provided, and you may be addressed further on that in due course, but it does appear there was never a uniform standard across hotels, and it doesn't appear that DJPR, as the holder of contracts which had purported to outsource those things, was ever checking in on a regular basis to check that infection prevention measures were being complied with. So whether or not ultimate responsible for these things is found to rest with DJPR or DHHS, what can be said is that the State did not take sufficient or sufficiency early steps to ensure that the risk of infections at hotels and in hotel environments was appropriately managed. Again, it should have remained with the State. It was just too important a responsibility to be outsourced.

The final point to make on this point, Madam Chair, is that it is a matter of some significance in our submission that these important decisions about the outsourcing of risk, about the outsourcing of responsibility for infection prevention and control measures, appear to have been made on legal advice within Departments and not been the subject of specific consideration or assessment as to whether that was an appropriate allocation of risk as between the Government and private providers.

It certainly doesn't seem it was the subject of any consideration by Mr Phemister. He signed the contracts but we don't understand his evidence to have been that he was across the detail. And Minister Pakula it seems knew even less, even though he readily agreed that contracts for hotels, private security and cleaners represented three crucial aspects of any successful quarantine program.
His evidence was that it wouldn't usually be the case that he would be aware of specific contracts, even contracts that were very substantial in scope or dollar value.

To the extent that it is common practice in Government for contracts of this size or scale to be entered into without Ministerial or Secretarial oversight or approval, that is a matter well beyond the Board's Terms of Reference and I do not address you on those matters as a matter of general principle. But I would say that, whatever be the standard that applies more generally, that wasn't the standard to be applied here. It wasn't the standard to be applied in relation to the outsourcing of substantial components of a quarantine system that was designed to prevent the spread of this virus into the community. It shouldn't have happened without appropriate Ministerial consultation and knowledge, it shouldn't have happened without appropriate and specific consideration at the highest levels of the department, it shouldn't have been left for those who were doing their job properly to mitigate risks to the Government but who weren't in a position to understand really what those risks were and where responsibility for them should have resided.

May I turn then to the final topic that I want to address you on, Madam Chair, which is about issues of confusion that arose on the ground and the extent to which those arose as a result of contractual arrangements and misunderstandings.

I have made submissions to you that as a general proposition the contracts didn't properly allocate the risk as between Government and private providers. And those assisting you will also be making a submission that in the context of those private providers, particularly security but not just security, there wasn't proper early and appropriate training and supervision for them, particularly with regard to infection control. And whether that is a failure of contractual management or a failure of provision of services by DHHS is a matter for the Board to determine on the evidence.

It is clear, as we have said earlier, that this was a complicated operation and the apportionment of roles between DHHS and DJPR is clearly on the evidence a matter that created confusion at multiple levels within the program, including right up to Ministerial level, about whether or not there was sole or shared accountability.

The Board heard multiple examples of frontline experiences where it wasn't quite clear where responsibility for things were. One obvious example is the distinction between the view that infection control had been contracted out and was therefore a matter for contractual management, versus the view that it was a DHHS responsibility with DHHS powers and obligations to intervene. There seem to have been expectations that training would be done. There was evidence that to some extent it wasn't to the perception of those involved appropriately or sufficiently done and there is evidence about the concerns about the extent to which there was proper information made available and whose job it was to supply that information.

This issue particularly arose with security guards because they were on the ground at hotels and they were subject to contract management from DJPR but, on a day-to-day basis, subject to directives from DHHS or required to work within arrangements made by DHHS. And this it seems led to confusion for hotel staff, for passengers who didn't know who was in charge of what, and for security as well.

So it is quite clear in our submission that the continued responsibility for contract management resting with DJPR sat ill with the frontline role being played by DHHS and the better opportunity it had to observe and direct and identify concerns with the performance of frontline operators like hotels and security guards.

This raises a more fundamental issue, which is one of the threads that arises from that decision all the way back or that assumption all the way back to engage private security. It is clear that when the original conclusion was reached that private security would be used, it was understood by DJPR that private security were going to be under the direction of authorised officers, and early documentation suggests that. It seems that at least some authorised officers didn't understand that to be their role, they didn't see themselves as having any means of directing the work of private security guards, and to that extent there was a failure of on the ground management because both Departments thought the other one was monitoring security guards. There was also then the risk that they might both seek to direct security guards in contradictory ways, for example, with regard to the use of PPE where there was a contractual obligation to wear it all of the time but varying directions from DHHS through team leaders and authorised officers about whether or not they should use it or not. And security guards were placed in a bind about whether to follow the contractual obligations that the company had signed up to or the directions being given by the person they knew was in power on site.

Of course, more fundamentally, to the extent that there were failures to comply by security guards or hotels, DJPR weren't on the ground to observe them. They had contracted for the services and they were present from time to time but they weren't there day in and day out, the way DHHS were. They had a safety manager to whom some issues were escalated but it appears that they didn't see themselves as being the ones ultimately responsible for directing security guards on a day-to-day basis or at least there was the potential for confusion about who should have that role.

And so what we say to you is that, for the sake of clarity, consistency and efficiency, the beneficiary of contracted services should also have been the manager and supervisor of those services. What in practice that means is that all of these contracts should have rested with DHHS as the control agency. It doesn't mean DHHS couldn't have taken advantage of the work done by DJPR to establish contracts but it would have been prudent and appropriate for them all to have been handed over far sooner than they were.

The Board will recall that in the weeks and months that followed, it appears that there was some consideration given to the possibility of contract transfer. Ms Mikakos and Ms Peake both understood that it would have been open for DHHS to seek those contracts of private security to be pulled across to DHHS; they didn't do it. Ms Peake said she was grateful that DJPR were performing that role and it was of assistance, and certainly as a support agency that was a role that DJPR could and did perform. But, as Mr Phemister said, perhaps with hindsight, it would have been more appropriate for all of those contracts to rest in the one place. It would have

removed the risk that the proper oversight and supervision of security guards fell between the two stools of who was the contract manager and who was the on-site management.

And so we invite a finding that reflects what is now the position, where all contracts and arrangements are held with one Department under the new model. We invite a finding that the transfer of private contracts for security and hotels should have occurred to DHHS much sooner; that that would have ensured clear lines of accountability and responsibility and supervision, an ongoing review of whether those contracts were suitable and whether the tasks being performed were being done in an appropriate way. Again, as we note, it appears that that view that we urge upon you was anticipated by the Government and was part of the arrangements and changes that were made in July, when the whole program was transferred to the Department of Justice.

If the Board pleases, those are the matters upon which I wish to address you.

Noting the time, I would invite the Board either to take a short break or indeed perhaps to take the luncheon break, before resuming with Mr Ihle's submissions. We are all in the Board's hands about that.

CHAIR: Yes, thanks, Ms Ellyard. Given the time, it seems sensible to take the lunch break. Perhaps we will take the lunch break between 12.45 and 1.45, so we will resume at 1.45.

MS ELLYARD: If the Board pleases.

CHAIR: Thank you.

ADJOURNED **[12.38 PM]**

RESUMED **[1.45 PM]**

CLOSING SUBMISSIONS BY MR IHLE

CHAIR: Good afternoon, Mr Ihle.

MR IHLE: Good afternoon, Madam Chair.

CHAIR: Ready to proceed, Mr Ihle?

MR IHLE: I am. If the Board pleases, today the submissions I make will be directed broadly to five major topics. As foreshadowed by Mr Neal, those topics are as

follows. The first is the state of pandemic planning and specifically the absence of any plan which envisaged or addressed the large-scale quarantining of persons as part of the health response to a pandemic. Secondly, the objective of the Hotel Quarantine Program in this State, what the evidence suggests they were and what they were professed to be, namely, prevent the further spread of COVID-19 from returned passengers into the community in Victoria. Under this subheading, I will address the evidence concerning the state of knowledge about COVID at particular times, what was known about the outbreaks that occurred and what can be made of the evidence as to the likely transmission event or events and the factors that contributed to them.

I will also deal with those aspects of the program which were directed to meeting the physical and mental health needs of those detained in hotel quarantine and the need to secure a safe workplace for those undertaking duties within the program itself.

The third major topic I'll be touching upon this afternoon will address the structure of the program as it was established and how it came to be over time, conceivable problems that arose with that structure and, as they were implemented, why those problems arose. Fourthly, I will deal with the health and welfare arrangements as were established within the Hotel Quarantine Program and make submissions regarding their adequacy and the consequences that arose from them. Finally, I will make submissions concerning the concepts of responsibility and accountability. I will address the Board on these issues as they have emerged from the evidence.

After my part of the submissions, Madam Chair, Mr Neal will provide a summary in conclusion and will wrap up the formal submissions part from the Counsel Assisting team.

I turn to my first point, the state of pandemic planning as at the time the Hotel Quarantine Program was first implemented.

In Victoria, and more broadly in Australia and indeed around the world, Governments have been required from time to time to respond to different human disease pandemics. Take, for example, avian influenza, the swine flu, SARS and MERS, of which we have all heard evidence. As the very first witness in this Inquiry, Professor Grayson, observed, and I quote:

> *Given the previous history of the Spanish flu a century ago, and more recent outbreaks of avian influenza and swine flu, most pandemic planning has logically focused on strategies aimed at influenza ....*

Although in his opinion, that is, Professor Grayson's opinion:

> *The principles and operational frameworks of those plans are known to be very applicable to other respiratory viral infections, and that includes COVID-19.*

Prior to the advent of COVID-19, Victoria had in place plans to deal with pandemic

risks and also general plans to guide responses to infectious diseases. The Board has heard that evidence that in broad compass they were, firstly, the Victorian Health Management Plan for Pandemic Influenza, a document from 2014. This plan is consistent with its Commonwealth counterpart, the Australian Health Management Plan for Pandemic Influenza. And secondly, the Victorian Action Plan for Pandemic Influenza, which is a 2015 document. I will refer to that as the Victorian Action Plan.

Specifically, and in relation to COVID-19, on 10 March this year the COVID-19 pandemic plan for the Victorian health sector was published. The response to COVID-19 in that plan was said to have been guided by plans including the Commonwealth Australia Health Sector Emergency Response Plan for the Novel Coronavirus COVID-19. Importantly, prior to the announcement of National Cabinet on 27 March, there was no health response plan in Victoria that envisaged large-scale quarantine, nor was there one at Commonwealth level. Before this Board, Victoria's Deputy Chief Health Officer, Dr Annaliese van Diemen, stated that prior to late March, and specifically the announcement on 27 March, she had never even turned her mind to such a concept. She only did so for the very first time following the National Cabinet decision.

Reflecting back, the Board has heard evidence that in 2011 the Commonwealth Department of Health and Ageing published its review of Australia's health sector response to pandemic H1N1 in the wake of the swine flu epidemic. The document is entitled "Lessons Identified". The States' and Territories' Health Departments contributed to that review.

Against the backdrop of the global swine flu pandemic, that review contained a number of findings as to issues that presented at that time and proffered a number of recommendations that were designed to address the issues identified. At its core, the need for "effective communication, robust science-based decision-making and a flexible public health response" were identified. Specifically in respect of quarantine, the review identified that a pandemic may require quarantining of large numbers of people after their arrival in Australia. This resulted in the following observation being made:

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

The review went 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.*

History to some degree at least has been repeated. Although this pandemic has been

variously described as a once-in-a-100-year event, had those involved in designing the Hotel Quarantine Program been alive to the review and the issues identified by it, those lessons of the past may well have assisted them in the development of the program. It appears they were not so alive to those issues and were not so assisted by these recommendations.

Perhaps at least in part, for this reason, role clarity, accommodation needs and the welfare of those within the program were not, in our respectful submission, given the significant focus that they deserved. There was a lost opportunity in the years between 2011 and 2020 for which there has not been any adequate or satisfactory explanation.

Although, Victoria's Health Management Plan for Pandemic Influenza was updated in 2014 --- that is, three years after the Commonwealth Department of Health's review --- the updated plan made no provision nor had any regard to those aspects of the review identifying the need for quarantine pre-planning. Nor did the Victorian Action Plan for Pandemic Influenza, which was published the following year, in 2015.

Professor Sutton in his evidence to the Board agreed that a pre-existing, ready-to-stand-up program would have been of great assistance compared to the situation that the State of Victoria faced; that was, setting up a program de novo. Professor Sutton stated that in his view and seemingly with the benefit of hindsight, that there was insufficient consideration of the pandemic potential of coronavirus and no explicit consideration of a program of quarantine to keep the jurisdiction entirely free of the virus. Rather, it appears that it was always an assumption that such a virus would reach every country and quarantine was merely a mechanism designed to minimise the peak of the pandemic and thus the resulting pressures on the health system. The effect of this evidence was that pandemic planning was directed to minimising transmission, not creating a water-tight system of quarantine.

As the Board is well aware, Professor Sutton is a member of the Australian Health Protection Principal Committee, the AHPPC. He confirmed that the idea of quarantining all returned travellers at hotels or other designated facilities was not an idea endorsed by the AHPPC prior to nor immediately following the announcement by the Prime Minister on 27 March. Indeed, the evidence before the Board demonstrates that the AHPPC's advice to National Cabinet was that only so-called high-risk cases should be placed in an enforced quarantine in facilities such as hotels.

The advice actually given to National Cabinet is consistent with the versions of the draft advice passing from Professor Sutton to Ms Peake on the evening 26 March and the early morning of 27 March. Professor Sutton has told this Inquiry that, notwithstanding the recommendation of the AHPPC to National Cabinet, his personal view as at 27 March was that all returning travellers should be placed in enforced quarantine in a designated facility and for a period of 14 days. However, it is apparent that this was not the position of the AHPPC either before the announcement of National Cabinet nor in its immediate aftermath.

During the course of the hearings, several witnesses spoke about the fact that there was no off-the-shelf plan for mass quarantine, and that accordingly, after the announcement of National Cabinet, the program needed to be stood up in a mere 36 hours. This necessarily meant that decisions were made under enormous time pressure and plans were developed in haste. That did not have to be the case. In our submission, proper, thoughtful and considered pandemic planning, at least insofar as this State is concerned, should have included plans for mass quarantine. This was recognised at least in part by the 2011 review of the responses to swine flu pandemic. For reasons that remain unexplained, those findings and recommendations were not heeded.

In our submission, the Board will have no difficulty in making the following findings: prior to 27 March the Victorian Government and its Departments had no plan for large-scale quarantine. The lack of plan meant that the Hotel Quarantine Program had to be conceived of and implemented from scratch and within a very short period of time. This placed an incredible strain on the resources of the State and more specifically on those Departments and the people required to give effect to the decision of the National Cabinet.

However, in our submission, what was established was necessarily untested and thus prudence dictated that the program should have been accompanied by intensive ongoing monitoring and auditing. The Victorian Government failed to adequately ensure that this was done.

The Board can find that these failures contributed, along with others, to the difficulty of the implementation and the operation of the Hotel Quarantine Program in this State and overall contributed to an increased risk or at least contributed to a failure to adequately mitigate the risks that the virus would be transmitted from returned travellers into the community.

I turn now to the objectives of the Hotel Quarantine Program. The evidence demonstrates that the understanding in late March 2020 was that the major form of transmission of COVID-19 in Australia at this time was from returned travellers. That is a direct quote from the evidence of Ms Peake. As described by Pam Williams, one of the Commanders of Operation Soteria, the Hotel Quarantine Program's primary purpose was to contain the COVID-19 virus by keeping people who are returned from international travel in a room for 14 days. She described a secondary purpose being to keep guests safe and comfortable for 14 days within their room.

The other Operation Soteria Commander, Ms Merrin Bamert, described the role of the operation as being to "operationalise public health where the outcome was to protect the Australian public, and suppress the transmission of a virus for which we still knew very little about while balancing this with supporting the over 20,000 returning passengers who were detained."

In our submission, the Hotel Quarantine Program had three key objectives for it to meet to be successful. Each of those objectives was plainly a health and human objective. The primary objective of the Hotel Quarantine Program was the prevention of the further spread of COVID-19 from returned passengers. A secondary but in our submission no less important objective of the program was to meet the health and other needs of those detained in quarantine. The third but by no means less important than the second or first objective of the program should be one that was implicitly acknowledged by some who were part of its command and coordination but not all, that was to ensure the safety of those working in the program, including clinical and nonclinical staff.

Proper infection control, outbreak management, healthcare, welfare and human services are core to the work of the Department of Health and Human Services. As the Board has heard through the submissions and the evidence, that was the Department that was the control agency for this operation. In our submission, the evidence demonstrates that there were critical and fundamental shortcomings with the Victorian Hotel Quarantine Program. Those deficiencies were in its structure and focus, specifically in the areas of governance, infection control, outbreak management, healthcare, welfare and human services.

Looking at the first objective, that is preventing the further spread of the disease, one reflects upon the fundamental purpose of any quarantine program as described by Professor Grayson. In his evidence, he said:

> *Quarantine is a public health measure by which people who have or may have an infectious disease are isolated to prevent the spread of that disease. It is a method designed to ensure observation of those who may be infected or present a higher than usual probability of being infected so as to prevent further spreading of the disease.*

We know that there were outbreaks of COVID-19 from two quarantine hotels, the Rydges Hotel in Carlton and the Stamford Plaza hotel in the CBD. But the mere fact that a pathogen, sought to be contained, breaks through the lines of quarantine does not of itself bespeak errors or shortcomings. Even in well-designed, organised and supervised environments, it is difficult to completely guard against infection.

However, and notwithstanding, we invite the Board to find many of the problems that have been evident here were present, identifiable and preventable. Had those problems been actually identified and addressed in a timely and thorough way, many of the risks which subsequently materialised would have been mitigated. Put another way, in our submission, the inadequacies of the program overall increased or at least failed to appropriately mitigate against the risks that the virus would be transmitted from returned travellers and into the community. That is a risk that we now know did eventuate and had devastating consequences.

The Board has heard that the Rydges Hotel was a designated COVID-19-positive or so-called hot hotel from early April 2020. On 25 May, three individuals who worked

at the Rydges Hotel began to experience symptoms consistent with COVID-19. They were each subsequently diagnosed by way of testing. By 29 May, the Department had identified seven people who had worked at the Rydges Hotel, each of whom had contracted the virus.

In total, between 26 May and 18 June, cases of COVID-19 were epidemiologically linked with the Rydges Hotel outbreak. The scientific evidence now strongly suggests and we submit that the Board can comfortably find that 90 per cent of positive cases in Victoria since are attributable to that initial outbreak at the Rydges in late May.

The Stamford. The Stamford Plaza Hotel was not a hot hotel. It accommodated returned travellers whose COVID status was unknown. In that sense it was a typical quarantine environment, and prudence dictated that everyone be treated as being suspected of being COVID-19-positive. A security workers from the Stamford Hotel became symptomatic on 10 June and tested positive on 14 June. Investigations revealed that 26 security guards who worked at the Stamford Hotel along with one healthcare worker who also work there became infected as a result of that outbreak.

By 13 July, 46 positive cases were epidemiologically linked to the Stamford Plaza outbreak. The scientific evidence now strongly suggests and we submit that the Board can comfortably find that just under 10 per cent of positive cases in Victoria since that time are attributable to the outbreak at the Stamford.

As Mr Neal has already identified, through a combination of genomic sequencing and epidemiological investigation, it has been ascertained that the movement of the virus through the barriers of quarantine is responsible for 99 per cent of the recent COVID-19 infections in Victoria.

On 23 May, Victoria's COVID-19 death toll was 19 people. There were no deaths attributable to COVID infection between that date and 4 June. Of course, by the latter date the Rydges outbreak was just shy of a month old and the Stamford outbreak about a week. As of today, the total number of COVID-related deaths in Victoria is 787. As at 15 June, Victoria had recorded 1,732 confirmed cases of COVID-19. As at today, that number is at 20,150. In light of the epidemiological, genomic sequencing, positive case data and mortality rates, the failure by the Hotel Quarantine Program to contain this virus is, as at today's date, responsible for the deaths of 768 people and the infection of some 18,418 others.

One only needs to pause and to reflect on those figures to appreciate the full scope of devastation and despair occasioned as a result of the outbreak. This was a program which failed to meet its primary objective to keep us safe from the virus. In our submission, the Board will comfortably find that the Hotel Quarantine Program in Victoria failed to achieve its primary objective. The program that was intended to contain the disease was instead a seeding ground for the spread of COVID-19 into the community.

The DHHS outbreak management team investigated each outbreak and prepared outbreak management plan reports. The outbreak team identified that in respect of Rydges, a designated COVID hot hotel, there was "a high risk of transmission from COVID-positive cases being detained in the hotel to the staff members working at the hotel. This is due to the inadequate education and cleaning procedures that are currently in place. The cleaning duties of communal areas were the responsibility of the security staff, specifically for the elevators used to transport COVID-positive cases. Because of this there was a high likelihood of fomite spread from poor cleaning products being utilised, poor PPE used by security staff, and the lack of education surrounding cleaning practices. At-risk populations include staff members from the hotel, DHHS staff, nurses and other various healthcare workers that were on site to attend to people in hotel detention. Outside of the hotel, there has been onward household transmission to partners and housemates."

In respect of the Stamford Hotel, the outbreak control squad nurses who visited the site advised the hotel and security staff are not adequately educated in hand hygiene and PPE and that their work was not visibly zoned for safe containment of COVID-19 case, suspected cases and quarantine close contact. They identified that there was there, therefore, a risk of fomite and person-to-person cross-contamination. For reasons that have not been completely explained, these issues remained up until and even after the outbreaks.

The evidence before the Board as to transmission events is indirect. Other than the epidemiological and genomic sequencing evidence which provides a very close if not direct link between those workers who became infected and those returned travellers who were the original sources of the virus, there is no evidence which could conclusively prove from a scientific perspective the precise circumstances in which the virus made its way from the infected travellers to the workers. But this Inquiry is not to be conducted on the basis of scientific certainty. Facts are to be found on the balance of probability with regard to the well-known principles in Briginshaw. In circumstances where there is no evidence that those workers who became infected at the Rydges had any direct contact with the passengers to whom their positive tests could be genomically linked, and in light of what was known about infection prevention and control measures, it is open to the Board to arrive at a conclusion about the likely method of transfer at that hotel.

The evidence in respect of the Stamford is more diffuse. It does not permit, in our respectful submission, the favouring of one mode of transmission over another. We invite the Board to have regard to the evidence of Dr Sarah McGuinness in this respect. In her statement, Dr McGuinness said the following in respect of Rydges:

> *Ultimately, the Deputy Public Health Commanders and I were unable to draw a firm conclusion about the transmission events that precipitated the outbreak. In my opinion, the possibility that the outbreak was precipitated by person-to-person transmission is less likely than the outbreak being precipitated by an environmental source.*

Clearly Dr McGuinness was proffering a preference as to what was the likely transmission event, at least in respect of its nature. By way of contrast, one can refer to Dr McGuinness' statement and what she said about the Stamford Plaza outbreak. I quote:

> *Genomic data suggests that the virus was introduced to hotel staff by one or more returned travellers from overseas. Transmission from COVID-19-positive cases in quarantine may have occurred directly through person-to-person transmission or via fomites. There is insufficient evidence to support one mode of transmission over the other and both are possible.*

In our submission, it is open to the Board to find that in respect of the Rydges Hotel, especially in light of what is now known about the lack of compliance with prudent infection prevention and control measures, including poor PPE use, nonobservance of social distancing measures, drastically inappropriate cleaning measures and poor training of frontline staff, especially in light of the fact that it was a designated hot hotel, that it is more likely than not that the outbreaks primarily occurred as a result of environmental contamination rather than person-to-person contact. Furthermore, it is open to the Board to find that poor training and education of frontline staff, delays in cleaning the common areas of the hotel and delays in quarantining of all staff were additional failures which contributed to the further proliferation of the virus into the community.

By way of contrast, the evidence does not permit the Board to find, in our respectful submission, on balance that the transmission event or events at the Stamford was or were environmental over the equally possible event that it resulted from person-to-person contact.

The Board is able to find, in our submission, that notwithstanding the considerably higher number of frontline staff who became infected at the Stamford, an almost fourfold number of the number of workers at the Rydges who were infected, the measures taken, whether by way of prompt or appropriate cleaning or because of the immediate and swift quarantining of all staff or a combination of both those factors were more effective in preventing the spread of the virus into the community than they were at Rydges.

CHAIR: Mr Ihle, I might get you to repeat that last sentence. There was a short interruption of transmission and I think the stenographer missed that last sentence, so for the purposes of transcript I ask you to repeat it, please.

MR IHLE: Certainly. The Board is able to find that, notwithstanding the considerably higher number of frontline staff who became infected at the Stamford, that was an almost fourfold number when compared with the number of workers at the Rydges who were infected, the measures taken, whether by way of prompt and appropriate cleaning or because of the immediate and swift quarantining of all staff, or a combination of both, were more effective in preventing the spread of the virus into the community than the measures that were undertaken at the Rydges.

The decision to designate the Rydges as a hot hotel has been the subject of some evidence. According to Dr van Diemen, the decision to establish the Rydges as a hot hotel was a decision made by the Emergency Operations Centre. Dr Simon Crouch, from whom you heard, Madam Chair, was a senior adviser in the communicable diseases section of the Health Protection Branch of the DHHS. He gave evidence to this Inquiry and stated, while it was not discussed with him prior to its implementation, in his opinion it was not unreasonable to have a hot hotel in order to minimise the risk of further transmission to others in quarantine. While any returned traveller should be managed as a suspected positive case, he explained, this model --- that is, the cohorting or hot hotel model --- provided the best oversight and public health management option. However, Dr Crouch clarified that his opinion depended on a number of assumptions around the safety of such an environment. Those assumptions included the following: firstly, that the staff managing those in quarantine are trained appropriately to manage the confirmed cases; and secondly, that they have the knowledge and skills to do that effectively.

Dr Crouch, whose evidence echoed Professor Grayson, explained that in his opinion a hot hotel should have had the same standard as any quarantine facility. That is because all quarantine facilities, to be effective and appropriate, should operate on the assumption that everyone is infected. Thus, expanding on Dr Crouch's evidence, it must be the case that he expected that all staff in all quarantine hotels were appropriately trained in infection prevention and control, that all staff in all hotels were aware of the symptoms consistent with COVID-19, that all staff in all hotels understand the need to get tested and do get tested when necessary, and that all staff in all hotels understand appropriate PPE usage and physical distancing. He would also have expectations around appropriate cleaning and the preference to not have staff working across multiple sites and he said as much at page 1067 of the transcript.

It is a matter ultimately for the Board to consider as to whether the setup at the Rydges complied with what in our respectful submission were reasonable expectations for Dr Crouch as a public health expert to have in respect of the Hotel Quarantine Program. Dr Crouch's views were, we submit, consistent with those views expressed by Professors Grayson and Sutton in this regard.

Professor Grayson explained that:

> *An efficacious and appropriate quarantine environment fundamentally starts from a position of assuming that all those who are in quarantine are potentially infected until proven otherwise.*

The idea of a hot hotel was not discussed with Professor Sutton prior to the decision being made. Whilst the evidence shows that as a concept Dr Romanes, the Deputy Public Health Commander, had approved it in principle, there is no evidence to suggest that he nor any other member of the Public Health Team were specifically consulted about the need for particular measures or assurances at the hot hotel, beyond the way the program operated in general. Dr van Diemen agreed that

cohorting of positive COVID-19 cases, preferably in a single location, is a recognised preventive public health measure.

However, in our submission, the evidence demonstrates that the appreciable increased risks presented by cohorting COVID-positive detainees in one location increased the risk of transmission from that group to those working at the location. Logic would dictate that that would be so. This was a crucial decision. It was not wrong in principle but in our submission the Board should find that it was poor in delivery.

The Board received evidence that on 11 April, the Department decided that all hotel staff at the Rydges, including security, would do a "short tutorial on infection prevention organised by DHHS". That comes from the statement of Ms Peake, paragraph 229. Ms Bamert, on the other hand, described this briefing as a PPE briefing arranged "for GPs and nurses working at the Rydges Hotel". Ms Bamert's description is at paragraph 28 of her statement.

Whether the briefing was to nursing and medical staff only or, on the other hand, whether it was delivered more widely to hotel and security staff, it is clear in our submission that the beneficial effect of this training insofar as security was concerned was shortly lost to the Rydges site. This is because on 13 May, as a result of complacent behaviours of security guards, the head security contractor stood down the entire subcontracted security team at the hotel and replaced them with their own security personnel brought from locations other than the Rydges.

Additionally, in our submission, it should be observed that the external infection prevention and control consultant engaged by the DHHS made a recommendation some time later that a request be provided to the nursing agency provider to ensure that the same staff are rostered at the same hotel for a minimum of 14 days to cover the entire quarantine period. It appears that that didn't occur. At least up until the outbreak at the Rydges, the people who received the training arranged on 11 April were not continuously working there and in many respects may not have been working at the Rydges Hotel at all.

In any case, all that worked in the program worked in shifts and not continuously at any single hotel. Thus it might be observed that a single training session provided on a particular date could not and did not provide adequate coverage of the workforce at that hotel. This was an unsatisfactory state of affairs. It can be contrasted with the observations made by Professor Grayson about the need for proper education, constant reinforcement when it comes to infection prevention and control and the use of PPE.

He said that:

> *People must understand the potential danger of infection in order to appreciate the importance of adhering to the training.*

In our submission, it is clear that the plainly ad hoc training in PPE usage and infection prevention and control which was administered was insufficient. Specifically it was insufficient to manage the risk of transmission at the Rydges, which was increased by reason of it being a designated hot hotel.

In our further submission, it behoved the Department of Health and Human Services to ensure that all staff who worked at the Rydges at all times received the benefits of face-to-face training, even if only by way of what was described as a short tutorial on infection prevention. This did not occur.

In our submission, the idea of cohorting positive COVID-19 cases together in a single location or a hot hotel appears to have made sense as a sound public health measure. It was a recognised and endorsed method to ensure those in quarantine who were not infected had a reduced chance of being infected by reason of their quarantine. However, once the decision was made to establish a hot hotel, it behoved those involved in deciding to implement that concept to pay particular attention to the infection prevention and control measures deployed at that location and to have particular regard to the make-up of the workforce undertaking duties there. The consequences of not doing so were foreseeable, even from before the time that decision was made. Those foreseeable consequences came to pass.

In our submission, it is open to the Board to find, and we submit that the Board should find, that at the time the decision was made to cohort COVID-positive cases at the Rydges Hotel, insufficient regard has paid to the increased risk patent upon concentrating those cases in one location. There was no convincing evidence led to prove that the decision was accompanied by any particular attention to the increased risk of infection.

Furthermore, in our submission, the Board should find that this shortcoming increased or at least substantially failed to mitigate the obvious risks presented by the hot hotel model.

As to what was known about COVID-19 at the time the decision was made to cohort patients in a --- returned travellers in a hot hotel, Dr McGuinness, who the Board heard evidence from, is a senior medical adviser who is seconded to the DHHS for a period between March and May of this year. In that role she performed a number of duties, including as an outbreak team leader. Dr McGuinness gave evidence as to the state of scientific and medical knowledge about the transmission of the virus as at 1 May 2020 and indeed earlier. She referred in her statement to the relevant portion of the World Health Organization guidance which was dated 29 March, a time before the decision was made to establish the hot hotel. That guidance provides as follows:

> *According to current evidence, the COVID-19 virus is primarily transmitted between people through respiratory droplets and contact routes. Transmission may also occur through fomites in the immediate environment around the infected person. Therefore transmission of the COVID-19 virus can occur by direct contact with infected people and indirect contact with surfaces in the*

immediate environment or with objects used on the infected person.

Notwithstanding the above, and notwithstanding the fact that it was designated as a COVID-positive hotel, the cleaning of the common areas at the Rydges Hotel was at all relevant times prior to the detection of the outbreak and even for a period of 48 hours thereafter undertaken by hotel and security staff utilising inappropriate cleaning products and practices.

The outbreak management squad therefore specifically identified that there was a high likelihood of fomite spread from those poor cleaning products being utilised, which was a factor in addition to poor PPE use by security staff and a lack of education surrounding cleaning practices, and thus concluded that the Rydges site presented a high risk of transmission from COVID-positive cases being detained in the hotel to the staff members who were working there.

In addition, prior to the establishment of the Brady Hotel in mid-June, none of the hotel quarantine properties, and that includes the Rydges hot hotel, had any suitably qualified person, indeed any person at all, with the responsibility for ensuring appropriate observance of infection prevention and control standard, including the use of appropriate PPE on site.

Professor Sutton explained that had he been consulted prior to the establishment of the Rydges as a hot hotel, he would have recommended:

> *Specific infection prevention and control measures to be adopted to take into account the increased risk.*

That risk of which he spoke was the increased risk created by the cohorting of COVID-positive patients in one location.

It was readily apparent to Professor Sutton, as it was to others, such as Ms Williams, that a hot hotel necessarily posed a greater risk of transmission. Whilst not himself an infection prevention and control expert, Professor Sutton outlined the various measures that were appropriate in his view for such a setting. His evidence on that can be found at page 1499 of the transcript.

He said he would have obtained specific input from the DHHS infection prevention and control team, which the evidence shows at that time comprised only of a single infection control consultant that was shared with the Department of Health and the Microbiological Diagnostic Unit Public Health Laboratory, as well as broader groups, regarding the infrastructural and structural elements so as to minimise the risk. He went on that this would have included oversight of all training, auditing, review and revision. In our submission, it is of little surprise that the site of the first and the most damaging outbreak from the Hotel Quarantine Program was the hot hotel designated to receive all COVID-positive cases from within the program itself.

Based on what was known about the nature of the virus at the time, and the purposes for wh

ich by definition any quarantine program is established, it is open to the Board, and we submit the Board should find, infection prevention and control measures were inadequate not only at the Rydges but across the entire Hotel Quarantine Program. Those inadequacies continued right up until the health hotel model was implemented with the Brady in mid-June.

Inadequacies in the management of the infection prevention and control and the Hotel Quarantine Program included the following: the misuse and insufficiency of personal protective equipment; the lack of compliance monitoring, such as an on-site supervisor and the use of appropriately trained people and regular independent safety audits; poor infection prevention and control measures in general; generally unfit-for-purpose logistical and cleaning practices; and interventions which were only episodic and inconsistent, that were not sufficiently overseen on the hotel side.

In short, in our submission, the program did not match the expectations of what a proper quarantine setting should look like, where the goal of the whole program is infection control. The Board heard evidence from returned traveller Liliana Radcliffe, who herself holds a masters of public health degree. She gave uncontested evidence of her observations made while she was detained at the Stamford Plaza Hotel during May of 2020. Ms Radcliffe observed that the approach to infection control processes were, as she described them, "not right" and that the approach was "so different to her experience working in hospitals".

In our submission, it is no answer to these observations to tritely if not inappositely observe the Hotel Quarantine Program was established as an alternative to isolation in the community. With all due respect, this kind of comparison misses the point entirely of the purpose of the program. That is, to prevent the spread of infection.

In that regard, a hospital infectious diseases ward is the best analogue from which to draw guidance. The apparent approach that this was a system providing mere accommodation and base-level logistical support, including food and the likes, lies at the heart of the problems evidenced through the material before this Inquiry. There was, in our submission, inadequate focus on the need for rigorous infection prevention and control measures and thus a lack of corresponding --- a corresponding culture of wariness.

By virtue of the intention behind quarantining individuals, the hotels were a health setting and needed to be treated as such, akin to the infectious diseases wards of a hospital, not an ordinary community setting. The capacity to protect against the dangers posed by the environment created by this program was further underlined by the way in which the contracts were set up, and the Board has already heard submissions from Ms Ellyard on this point. The contractual terms placed primary responsibility for infection prevention and control on private providers. In our submission, that was inappropriate. That was a difficulty and a problem with the structure of the program itself. In our submission, there are several salient features of the structure of the Hotel Quarantine Program that increased or at least did not sufficiently guard against the risk of transmission of COVID-19 from the program

into the community.

These are features that applied generally and specifically were evident at the Rydges and Stamford in particular when it came to the outbreaks. They are, firstly, mischaracterisation of the program as mainly a logistical and compliance operation; secondly, the failure to adequately engage and embed public health and infection prevention and control experts in the operational aspects of the program; thirdly, inadequate testing of detainees; and, fourthly, deficiencies in cleaning processes and performance.

I will deal with these each in turn. The failure to adequately engage public health experts. In our submission, one consequence that flowed from the poor characterisation of the Hotel Quarantine Program was primarily a logistical and compliance operation was a patent failure to adequately engage with public health experts in the implementation and in the observation of compliance with health-based policies. Within the DHHS, the Deputy Secretaries who had responsibility for the program were primarily Melissa Skilbeck, an economist by training, and Ms de Witts, a person with significant legal expertise. Neither has any health or medical qualification, nor do either have clinical experience.

Professor Sutton is and was the Chief Health Officer of Victoria. As referred to earlier by Ms Ellyard, under the SHERP, the Chief Health Officer would ordinarily be the State Controller - Health and the Public Health Commander. As observed, Professor Sutton was not appointed to either role. Andrea Spiteri and Jason Helps, both of the DHHS, were instead appointed as State Controllers. That appointment was made by Ms Peake on the advice of Deputy Secretary Skilbeck. Ms Skilbeck advised Ms Peake not to appoint Professor Sutton as the State Controller. During her evidence before the Board she explained her reasons for that advice. She said that she viewed the Hotel Quarantine Program --- I withdrew that. She viewed the response to COVID-19, of which the Hotel Quarantine Program proved to be a part over time, as primarily a significant logistics program that required logistical expertise rather than public health knowledge.

She also referred to the other responsibilities that were falling to the Chief Health Officer at the time. She gave evidence, that is Ms Skilbeck gave evidence, that it was discussed with Professor Sutton and that he expressed his disagreement with her decision and recommendation. She stood by that decision, even with the benefit of hindsight. Professor Sutton, when he gave evidence before you, and at any time before that it would seem, did not add his voice to the view that his other duties deprived him of the ability to perform the role of State Controller. In short, he said that from his perspective it was preferable that he be appointed and given that role.

It was Professor Sutton's view that the State Controller position would have vested him with line of sight --- his term --- over operational elements of the pandemic response but given that he was not so appointed, he was deprived of that visibility.

Furthermore, he explained that as he was responsible for the people who were the

subject of the powers he was exercising or authorising, it was important for him to understand the practical effect of those directions and the controls that they were enforcing. This was clearly a health emergency, both from Professor Sutton's perspective, and we submit the Board should agree that it was preferable, if not necessary, these that he be appointed, or someone with sufficient and equal qualifications.

Documents tendered to the Board demonstrated that a mere three days after appointing Ms Spiteri as State Controller and at the same time that Ms Peake made Mr Helps the State Controller, an instrument of appointment that was dated 7 February also appointed Professor Sutton to that role. There is no evidence that Professor Sutton was advised of the fact of his appointment.

In light of Professor Sutton's evidence on this issue, the evidence of Ms Skilbeck, Mr Helps and Ms Spiteri, and in light of the fact that the Department has not led any evidence to the contrary, the Board may readily infer that Professor Sutton was not informed of the fact of his appointment as State Controller on 7 February.

That leaves the Board with a difficult situation. It must grapple with an entire unsatisfactory explanation as to why that was the case, especially in light of the discussion and preference that Professor Sutton had expressed to Ms Skilbeck and perhaps also to Ms Peake. Both Professor Sutton and Dr Romanes expressed their concerns that those in the leadership roles of the Hotel Quarantine Program were people without significant public health experience. In her evidence, Dr van Diemen agreed with that sentiment and agreed that it would have been preferable to have someone with communicable disease focus as the State Controller. She agreed that the decision regarding the choice of State Controller may have contributed to there having been a focus on logistics rather than health. However, she balanced this by stating that she believed she understood the reasoning behind the appointments that were effected.

Nevertheless, Dr van Diemen agreed in her evidence with the statement of Dr Romanes that the public health --- that to have public health more embedded within the operation could have been arrived at by the appointment of the Chief Health Officer or someone appropriately qualified with similar background and experience performing the role of State Controller.

The Department of Health and Human Services, which had only one infection prevention and control expert as an employee at the outset of this program, did engage an external consultant. The Board has heard evidence that that consultant was from Infection Prevention Australia and that person was engaged to advise on infection control measures within the hotels. The Department also engaged nursing agencies to provide nursing services and a newly created company to provide general medical practitioners. On the ground, DHHS team leaders were present at quarantine hotels to "coordinate and problem-solve". Their position seemed to be one focused mainly on liaison, perhaps another coordinator in the system. It was explained in evidence that if there was a problem with security, the team leader who raise it with

the security manager. If there was a problem with the hotel, the team leader would raise it with the hotel manager. And if a problem needed to be escalated beyond security or hotel management, it would be escalated to the DJPR.

No one has sought to ascribe responsibility for managing infection prevention and control, welfare services, or the delivery of clinical care to the DHHS team leaders. In fact, it appears that there was no one on the ground at the hotels with that responsibility. Dr van Diemen's evidence was that there should have been a clinically based person with oversight over the multiple services delivered by various providers within the Hotel Quarantine Program. She observed, and in her words, that "we all could have treated the Hotel Quarantine Program more as a health program than a logistics or compliance exercise and viewed the overarching principles more from a health leaning than occurred at the time, including standards of care and infection control". This would have included regular external auditing and reporting on adherence standards. These things were self-evidently not done.

The Board will also be cognisant of the email sent on 9 April by the Public Health Team, specifically by the Deputy Public Health Commander, Dr Romanes, send to the upper end of the management of the Operation Soteria program that:

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

Both the Chief Health Officer and the Deputy Chief Health Officer said that it was appropriate for them to have sent that email. They stand by their reasons for doing so, even today. There were problems of which they were aware that required immediate and substantial attention.

In response to the email sent by Dr Romanes, a Public Health Command liaison position was established between Operation Soteria and Public Health Command. However, even that, in Professor Sutton's opinion, was still not an optimal way of getting line of sight into the operation of the program with respect to health and welfare.

I am just conscious of the time, Madam Chair.

CHAIR: Yes, you have been going --- you have been speaking for an hour, Mr Ihle. It seems to me appropriate to take a short break, for both you and those listening and indeed for the stenographers and operating staff. We will take 10 minutes.

MR IHLE: If the Board pleases.

ADJOURNED **[2.44 PM]**

RESUMED **[2.54 PM]**

CHAIR: Yes, Mr Ihle.

MR IHLE: Thank you, Madam Chair.

As the Board is aware, the Department's Public Health Team had the role of creating policies and guidance regarding health, welfare and infection prevention and control. However, it was left to others bearing the primary responsibility, including private organisations, some with little or no expertise in the subject matter of those policies, to implement them. This structure, which segregated those with specific health expertise from the operation of infection prevention and control policies, created a diffusion of responsibility and a dilution in understanding. This created inherent risks and was especially dangerous given the pernicious nature of the virus to which the whole response was directed.

Dr van Diemen gave evidence that the whole public health program was not a public health driven program. She distinguished the Hotel Quarantine Program from the case contact tracing in this respect. She observed the latter as having the necessary characteristics of an operational public health response where public health professionals were embedded in the policy, development and delivery of the activity.

I want to deal briefly with the topic of daily checks. In our submission, the disproportionate focus on compliance and enforcement was reflected in the manner in which the statutory requirement of daily reviews or daily checks were undertaken. In no way did these reviews, we submit, accord with what would be expected in a health-driven or health-focused response. Now, whilst it is not incumbent upon this Board of Inquiry to make legal conclusions as to the lawfulness of what was undertaken, it is suffice to observe that serious questions arise as to the sufficiency of those reviews. As the Board is aware, under section 200(6) of the *Public Health and Wellbeing Act* it was a requirement for daily reviews to be conducted in respect of the ongoing detention of each individual in hotel quarantine. Ongoing lawful detention is probably dependent on those reviews being appropriately conducted, as the DHHS sought and received legal advice from independent counsel as to how such a review could be carried out. That advice included four main elements to it. And I quote:

> *The advice was that a authorised officer must ask themselves, is the continued detention of this person reasonably necessary to eliminate or reduce the serious risk to public health? Secondly, in doing so, the authorised officer must engage in an active intellectual process. Thirdly, this need not be time-consuming because the question in 1 [that is, is the continued detention of the person reasonably necessary to eliminate or reduce the serious risk to public health] will be a simple one to answer if the medical advice is clear about what is necessary to reduce the risk that travellers returning from overseas pose to public health. they are entitled to rely on that advice in conducting the review.*

But importantly the fourth limb of the advice goes as follows: it could involve reviewing the information on a database that identifies where a person has come from, when they arrived in Australia, whether they had any symptoms when they arrived, whether they have a COVID-19 diagnosis. The database should have a field, the advice goes on, in which those collecting information note any other relevant information about the person, for example, have they had COVID in the past and recovered, been cleared overseas, for example.

Notwithstanding that above advice, Mr Murray Smith, who the Board will recall was the Commander of COVID-19 enforcement and compliance in the Department of Health and Human Services, with the responsibility to supervise AOs, senior AOs and team leaders, gave evidence that there was only one criterion considered in the daily review: whether the person had completed the required 14-day period of quarantine. He said that the daily reviews were done en masse by simply looking at where in the 14-day period a person sat. On that evidence, it is clear that the daily reviews were not conducted in accordance with the advice the Department received.

In a similar respect, the Board will recall the evidence of Mr Hugh de Kretser, who was detained with his wife and children at the Rydges Hotel in Carlton from 27 June. Mr de Kretser is an experienced lawyer and human rights advocate, and he gave evidence that during the two weeks of his quarantine:

> *I asked three different people who I was told were the DHHS authorised officers or team leaders whether our detention was being reviewed daily. One officer seemed surprised by the question and told me we were being detained for 14 days. Another told me that the nurses do the review, presumably referring to the daily nurse welfare check, and another told me that detention "wasn't really reviewed".*

Mr de Kretser said that those conversations led him at least to believe that a number of the DHHS authorised officers seemed to be completely unaware of the legislative requirement to review detention daily and therefore that this requirement was not being complied with in his opinion. On the basis of the evidence before the Board there is doubt as to whether there was any active intellectual process applied to consider whether the detention was reasonably necessary to eliminate or reduce the serious risk to public health. Whilst it more properly falls to other bodies on other occasions considering different legal questions to determine whether the daily reviews were conducted in accordance with section 200(6) and the impact of that analysis on the lawfulness of ongoing periods of detention, this evidence is nevertheless of high probative force to the issues under the Board's Terms of Reference. It strongly supports other evidence suggesting that the focus adopted by the Department of Health and Human Services was one of enforcement and compliance, rather than one of health and wellbeing, the latter being the focus called for, in our submission, under the Act.

This analysis falls, draws further support from the evidence around the testing of

detainees. True it is that the knowledge about the novel virus has developed over time. Mr Neal has already canvassed the evidence given by Professor Grayson in this respect. But for the purposes of the submissions that I advance, it is worth noting that it is a known feature of the virus that people can infect others, even if they are themselves not symptomatic. Recently it is accepted asymptomatic infection has been observed and understood as a more common feature of the virus than was first appreciated. Nevertheless, even prior to the outbreaks at Rydges it was well understood that people may be infectious for some time before demonstrating symptoms. It was also understood that some people infected with COVID-19 showed only very mild symptoms. As such, in our submission, there was knowledge of the fact of asymptomatic and presymptomatic transmission before the Hotel Quarantine Program commenced. Indeed, as early as 29 January this year the AHPPC published a statement on the virus indicating that it was aware of "very recent cases of novel coronavirus who are asymptomatic or minimally symptomatic". The advice went on:

> *Reports of one case of probable transmission from a presymptomatic case to other people two days prior to the onset of symptoms was observed.*

I hasten to add that the AHPPC in this advice cautioned that the data was very limited and preliminary and that the AHPPC still believed at that time most infections are transmitted by people with symptomatic disease. Nevertheless, it is clear that the possibility of asymptomatic or presymptomatic transmission was something that was being identified by a peak advisory body in this country at the very least.

In our submission, the possibility of asymptomatic or presymptomatic transmission underscored the importance for testing of COVID-19 within the Hotel Quarantine Program. Such testing would allow for evidence-based decision-making, based on known facts, rather than uninformed guesswork.

In his statement, Professor Grayson said that:

> *It would be sensible to test all people at the end of their quarantine period to see whether they are infected with the virus, irrespective of symptoms. If the criteria that people are not showing symptoms after 14 days is used it is the sole determinant for whether people are released from quarantine, a proportion of those who are infected with the virus and potentially infectious but who remain asymptomatic could be released into the community.*

That risk, the one identified by Professor Grayson, actually came to fruition in the Hotel Quarantine Program. The outbreak team identified that a person held in quarantine at the Stamford Plaza was released at the end of his 14 days without knowing that he had COVID. He was released into the community and infected the very first person he came into contact with, being the person who drove him away from the hotel. Between 28 March and 28 June, consistent with the public health advice at the time and the then current public health directions, all detainees were

permitted to exit quarantine after the 14-day quarantine period. In the event that a returned traveller had tested positive during their stay in hotel quarantine, they were still permitted to depart, provided they could safely self-isolate as required by the isolation diagnosis direction that existed at the time and consistent with the requirements that applied to all other members of the community who tested positive.

Submitting to testing for COVID-19 in the Hotel Quarantine Program was initially only offered to those who displayed symptoms of COVID-19 and even then only on a voluntary basis. This is so notwithstanding that substantial powers vesting within the Chief Health Officer and by delegation the Deputy Chief Health Officer under the *Public Health and Wellbeing Act* existed. Those powers were never used. Like many other aspects of the Hotel Quarantine Program, the testing policy did evolve over time. In early May, as part of the State-wide testing blitz, a new process of offering tests to all detainees on days 3 and 11 was initiated. All guests, even those without symptoms, were offered voluntary COVID-19 testing. It should be noted that Victoria was the first jurisdiction to offer testing even when people were not symptomatic.

It wasn't until 1 July, though, that a further public health direction --- that is, the Detention and Direction Order Number 6 --- was issued requiring quarantined detainees who had refused a COVID-19 test in hotel quarantine to undergo a further 10 days of quarantining. However, even under this direction, returned travellers who had been tested on day 11 and were awaiting results were still permitted to leave hotel quarantine so long as they could safely quarantine at home in Victoria.

The effect of the initial testing regime in the Hotel Quarantine Program was that many detainees were not tested before being released from the program. The Board heard evidence from witnesses who fit into this category. Those that were tested and who had returned positive results were still permitted to leave after day 14 on the undertaking that they were self-isolate. Professor Sutton himself acknowledged that this resulted in a situation where it was possible that people would have been released while carrying the virus and while themselves still infectious. He also agreed that in addition to the known case from the Stamford, where the driver who took that detainee away from the Stamford and contracted COVID from him, that there were potentially others released where it wasn't known if they were COVID-positive or not.

Importantly, persons who claimed to be symptom-free but who had not even tested, either because they were ineligible for testing or because they declined testing, were released into the community with no further quarantining requirement. In our submission, the initial approach to testing risked undermining at least to some degree the efficacy and intention of the Hotel Quarantine Program. In doing so, it risked transmission of COVID-19 from those detained in the program into the community.

I have already touched briefly on cleaning considerations insofar as they concern the Rydges. But just to expand on that theme briefly, as I referred to earlier, the guidance from the World Health Organization, dated 29 March, indicated that fomite

transmission was a recognised method by which infection may occur. That same guidance, the same document, emphasised:

> *The utmost importance of environmental cleaning and disinfection, among other infection prevention measures.*

The evidence makes it plain that fomite or environmental transmission was a recognised and known method of infection from very early on in the Hotel Quarantine Program. In March, we submit that there was knowledge within the Department of Health and Human Services of this way that the virus could be transmitted: specifically, the possibility of fomite transmission. It is against that backdrop that the evidence as to cleaning policies and processes needs to be assessed.

Whilst it is acknowledged that there were policies generated as to the cleaning of non-healthcare settings by the Department, from a period early on in the program, it is equally clear that there was no comprehensive specific cleaning advice tailored to the Hotel Quarantine Program environment until the updated advice called "The Hotel Quarantine Response: Advice for Cleaning Requirements for Hotels who are Accommodating Quarantined, Close Contact and Confirmed COVID-19 Guests --- Updated".

This policy document was provided to the DJPR by the DHHS on 17 June. At this point, it is important to recall the clear evidence about how the common areas in the Rydges hot hotel had been cleaned prior to the outbreak there by security and hotel staff, using inadequate methods and cleaning substances, thus resulting in what the outbreak team described as a high likelihood of fomite spread.

The Board has received evidence about cleaning services provided at the Rydges Hotel by IKON Services, and IKON is a commercial company that provides infectious cleaning services, among other services, to a range of clients. IKON, like many other services that were provided into the Hotel Quarantine Program, was contracted by the Department of Jobs, Precincts and Regions. According to its managing director, Michael Girgis, in other infectious cleans that were undertaken by IKON, the client would always --- "always" was his word --- engage a separate contractor to conduct swab tests to ensure the clean had been effective. He said, however, that didn't occur in the Hotel Quarantine Program. The evidence showed that IKON conducted cleaning in rooms that had been occupied at the Rydges Hotel on 15 and 18 May. IKON were not told that the Rydges was a hot hotel and they were not requested at that time to clean the common areas.

On 27 May, in the wake of the outbreak at the Rydges Hotel, IKON was again contacted by the DJPR and asked to clean the common areas of the hotel but they weren't told why. That clean was undertaken on 28 May, which was more than 48 hours after the initial outbreak case had been reported to the Department, resulting in what Dr McGuinness described as the site being uncontrolled for longer than it may have otherwise been.

IKON subsequently provided cleaning services at the Rydges Hotel on 3, 4 and 10 June and cleaned a number of rooms, including those rooms Mr Hugh de Kretser and his family were subsequently detained. Between 3 June and 27 June, the latter date being when Mr de Kretser arrived, the hotel had no guests and was subject to at least one inspection by the Department's infection prevention personnel. The Board will recall that Mr de Kretser provided evidence to it about his experiences whilst detained in quarantine with his wife and children. He described finding a plastic glove, children's toy, a face mask and another plastic glove, all under the furniture in the room. He described that there were food crumbs on the floors, stains on the doonas and walls, mould in the bathroom and dust everywhere and of course he provided photographs.

In his view, or in his words, Mr de Kretser said that the state of the room made him worried about his safety in the hotel. Mr Girgis was unable to explain the condition of the room or what had happened since IKON had undertaken cleaning earlier that month but he was emphatic that it was not the standard that his company had left the hotel in.

There does remain before you, Madam Chair, an unsatisfactory vacuum in the evidence as to how it was that the room was in the state that Mr de Kretser and his family found it. That is particularly the case given that the room was subject to infection prevention and control inspection, review and reporting, and was approved as suitable for reopening to guests. Self-evidently, the room was not sufficiently clean and the reviews were not conducted with appropriate care and rigour.

This evidence raises very serious questions about the efficacy of the infection prevention and control measures, which is especially concerning as in this instance it occurred in the immediate wake of a known outbreak and the subsequent closure of the Rydges Hotel for deep cleaning.

In our submission, there were additional factors that increased the risk of spread of transmission from workers at the Rydges Hotel to the community. In particular, the evidence was, as mentioned by Mr Garrow, there was a delay in undertaking a full clean of the Rydges Hotel which rendered it an uncontrolled site for longer than should have been the case, and people who had worked at Rydges during the relevant period were not initially instructed to self-isolate after their colleagues had tested positive for COVID-19. Indeed, the evidence shows there was a delay of at least seven days from the likely first infection event and some four days from the first awareness of the outbreak before any self-isolation or quarantining direction was given to the staff.

Although the use of hotels as a setting for mass quarantine may have been unprecedented, the factors that played a part at the Rydges and the Stamford Plaza were not unique to those sites. Those factors all contributed to an increased risk which we know eventuated at those sites. The risks were foreseeable and may have actually been foreseen had there been an appropriate level of health focus in the

program from top to bottom.

Turning to the second objective of the program, which was meeting the physical and mental health needs of those detained in quarantine, as identified by Ms Bamert. Through no fault of their own, people who are detained in a quarantine system like the Hotel Quarantine Program are simply unable to meet their own needs for food, for medical attention and for mental health care. All people in the program were vulnerable and at the mercy of the Government and its agencies to meet their basic health and human needs. Within the program, the evidence was that most returned travellers complied with directions, accepted the situation and managed, notwithstanding the substantial curtailment of their basic freedom. The Board received evidence from a number of witnesses who had direct experience of the Hotel Quarantine Program. Security guards, nurses, returned travellers, all gave evidence to this Inquiry.

The Board has heard much evidence which a number of those witnesses --- much of the evidence from those witnesses specifically concerned matters going to their health and wellbeing and the health and wellbeing arrangements in general in quarantine hotels. The Board will recall the evidence of Nurse Jen, who was engaged by Your Nursing Agency to work at three hotel quarantine hotels. She gave evidence that the Department of Health and Human Services staff at the ParkRoyal Hotel treated guests who were vulnerable or had health needs as problematic. She gave evidence about the specific concerns that she had relating to patient care, and they included concerns about the patient who had endometriosis and was unable to manage her symptoms using traditional Chinese medicine because she was unable to access hot water in her hotel room, nor was she allowed to receive a package containing her medicine in a different form. Nurse Jen also spoke of an incident where a person in quarantine had threatened suicide and a Department staff member telephoned the person to follow up and told the person word to the effect that they should stop threatening suicide when they want a cigarette. Of course, Nurse Jen told you of her discussions with other nurses working in the program by which she was informed that at least one of them, who was ascribed to work as a mental health nurse but didn't have particular training or experience in mental health.

Like Nurse Jen, Michael Tait was a nurse engaged by YNA to work at a quarantine hotel. His evidence was that people with pre-existing illnesses, such as cancer and arthritis, who didn't have access to those what he described as "little things" that they had learned to make their illness tolerable, like a bath or a microwave to heat a heat pack, really suffered, were his words, in hotel quarantine. The evidence from the detainees themselves included evidence about experiences which were of concern to them, experiences which suggested inadequacies as they found them in areas of communication, responsiveness, adequacy of information and a lack of assistance when they encountered difficulties and when they felt they really needed help. It would seem that sometimes they had what might be thought were very reasonable requests, which were not met.

In our submission, the program's undue focus on compliance and enforcement

affected the detainees' experience of being in quarantine. We submit that the program did not operate in a standard way across hotels. While it may be inferred that it did adequately cater for the needs of most, it did not always operate so as to meet the needs of those who were detained. Specifically, it may be concluded that for some of those who had particular needs or had specific vulnerabilities, their needs were not adequately met.

In that regard, the Board will recall the evidence of clinical psychologist Dr Rob Gordon. He gave evidence about the likely and expected psychosocial responses of those people detained in hotel quarantine and what might have been done to assist them better. Dr Gordon, who has significant experience in the field of emergency and disaster recovery, observed that:

> *On average, about 20 per cent of the community has various forms of needs, instabilities or personal issues which mean that they have an increased need for support, often including Government support, and will for that reason .... an increased level of contact with Government agencies or bodies.*

That includes, he explained, people who are living with diagnosed and those with undiagnosed mental health problems, disabilities, and other problems such as loss, illness and various forms of crises. Dr Gordon noted that it could be safely presumed that of the returned travellers entering hotel quarantine, we could expect them to reflect the general spectrum of people in the Victorian community. It was, he opined, therefore foreseeable that a proportion of detainees in hotel quarantine would have particular needs for support. Some of those needs to be acute needs.

Dr Gordon also gave evidence about the threat that all people in hotel quarantine were likely to perceive, irrespective of any predisposing vulnerability. The threats that he identified included the threat posed by the illness itself, the threat posed by the disruption of lifestyle and the threat posed by isolation.

Whilst there is evidence that there was engagement with the Chief Mental Health Nurse and some regard to health and welfare considerations, in our submission the measures adopted were, perhaps by reason of the rapidity with which the program was established, insufficient to prepare for and to meet the predictable needs of those who were to be detained within the program. Even if not prior to establishment, certainly very early on, better consideration ought to have been given to the likely psychosocial impact of detention and expert advice from an appropriate person such as Dr Gordon should have been sought about how to manage people's perception of the risks, which would have led to the establishment of the quarantine system and the ordinary desires which those risks will create, in particular to manage the social urges to communicate and to rejoin those that people need.

By way of related concept, I make some brief submissions about the Charter of Human Rights and Responsibilities. In our submission, questions arise as to whether proper consideration was given to the human rights of individual returned travellers when decisions were made and actions were taken in respect of them in the Hotel

Quarantine Program. As I have noted already, it is not the work of this Board to make findings or determinations as to whether the detention and/or review of the returned passengers was unlawful or what flows from that legally. That would be going beyond the purview of the Inquiry's Terms of Reference, and they are questions more appropriately dealt with by a court.

Nevertheless, the ostensible regard which was had to Charter rights, as borne out in the evidence, does raise significant questions as to whether the one-size-fits-all approach which was adopted was appropriate or desirable. In issuing Detention Notices and in the daily reviews, consideration of relevant human rights as mandated by the Charter seems to have been approached en masse. The necessary balancing exercise required by the Charter was largely conducted by reference to returned travellers as a cohort and not on an individualised basis.

On reflection, Operation Soteria Commander, Ms Williams, believed therefore that there should have been a "more nuanced assessment of the balance between transmission risk and guest health and wellbeing and human rights". She explained that in this respect what she meant by "more nuanced" was more thought about the guests' health and wellbeing and a more tailored assessment of each individual's circumstances rather than the en masse approach which was adopted.

In our submission, the program as it was established and the way in which it was run did not have regard to nor balance the individual consideration apposite to each of the returned travellers. Whilst we acknowledge that this may have initially been a function of the size of the program and the time in which it was required to be implemented, it appears that this approach, so to speak, stayed the course throughout the program. The en masse approach was not meaningfully revisited as the program matured and a more nuanced was called for but it never was, it would seem, implemented. Furthermore, the evidence on this matter lends support to the finding that we submit ought be made that there was insufficient focus on health and wellbeing in the program, that it was seen mainly as a logistics and enforcement and compliance exercise. We submit that the option of mandatory home quarantine or a hybrid model involving initial reception into a quarantine hotel for triage, taking into account all relevant factors for each returned traveller with increased compliance mechanisms would have proven to be less of an imposition, not only on the lives and basic freedoms of those returned travellers but also on the program itself. Such a model may also be at least as effective as achieving the objective of containing the virus.

There was an understandable tension between keeping healthcare workers separate from detainees, that is to guard against the possible transmission of COVID-19 on the one hand, and the challenge of meeting detainees' health and welfare needs on the other. Welfare calls were initially undertaken by nonclinical staff. Clinical and nonclinical staff were generally required to assess the health and wellbeing of patient remotely, that is over the phone, without the benefit of observing the person they were assessing and all the while without having access to a central repository of health information otherwise obtained during the program.

As the Board is aware, Safer Care Victoria investigated two serious incidents that occurred in hotel quarantine. The first incident occurred around 10/11 April and the report into that incident was released to the Secretary of the Department on 10 June. The second incident concerned events on 13 April and was given to the Secretary around 17 June. Neither report, despite expectation by the Minister for that it would be provided to her, that is the Minister for Health, in a timely way, was ever provided to her.

Safer Care Victoria made several findings and recommendations. In broad terms, they concerned the health and welfare structures and the governance of the program. Its findings identified issues about the frequency of welfare calls, issues with recordkeeping, information sharing, communication and control and responsibility for the hotel sites and the detainees.

The evidence also reveals that there were several other serious concerns, many of which fell outside the precise scope of Safer Care Victoria's investigation but that required escalation. Those concerns also related to the health and welfare of detainees and the governance of the program.

In our submission, notwithstanding that there were recognisable efforts, there were also shortcomings in the management of the welfare of those who were detained in quarantine. Particularly in the areas of communication, both between those working within and to those held in the program; responsiveness, recordkeeping and sensitivity and attentiveness to particular needs.

There were exemptions from the Hotel Quarantine Program. But the starting point of the whole program was that it applied universally, that is for all travellers who were returning to Australia coming in through Victoria. The Board will recall that the Secretary of the Department of Health and Human Services, in answer to a question from you, Madam Chair, stated that there were 440-odd exemptions that were provided, and I will refer to it, to be fair and accurate, 440-odd exemptions that were provided to people so that they could complete their quarantine program in an alternative setting. And often that was on the basis of input of the assessment of either the mental health nurses or the CART team that someone with complex needs --- that this setting wasn't appropriate for them. That evidence was given at page 2039 on the 23rd day of the hearings.

Subsequent evidence obtained by the Inquiry suggests that the figure of 440 exemptions was an inflated representation of the exemptions actually granted. In fact, a total of 426 individuals were given exemption. Of those exemptions, the vast majority, that is 269, were for travellers in transit, that is travellers continuing to a further international or interstate destination. Only 56 were granted on medical or compassionate grounds.

The Board has heard evidence that some returned travellers remained in quarantine even when it was not an appropriate or safe setting for them. Nurse Jen gave

uncontested evidence about a returned traveller who was, in her words, twice taken to the emergency department of the Royal Melbourne Hospital because of serious mental health concerns but that that passenger stayed there for two or three days each time, only to be sent back to hotel quarantine. Nurse Jen expressed the concern that, unlike a hospital setting, the nurses were unable to observe the patient at all times or indeed frequently, and she expressed concern that that person was held on an ongoing basis in the Hotel Quarantine Program.

Ms Bamert, one of the Operations Commanders for Operation Soteria, who is a former nurse herself, was of the opinion that the hotel environment was not an optimal location for quarantine. Ms Williams, in her twinned role as operation Commander, expressed the opinion that an approach that would have allowed flexibility and permitted appropriate persons to isolate at home would have greatly reduced the stress of many guests and would have reduced the operational pressure on the program as well as reducing the overall cost of the program. She made this observation having specific regard to the relatively few people in the program that ultimately proved to be carriers of the COVID-19 virus. She suggested that certain Victorian guests could have been released under home isolation orders.

In our submission, the exemption process could and likely should have been granted in more situations, especially in circumstances where it was inappropriate for a returned traveller to be confined in a hotel room because of their needs, whether they be mental health needs, physical needs or their family situation, and in situations where the returned traveller could demonstrate that they could safely and reliably quarantine in their own home.

In this regard, we note the apparent consistency in the practical result of the position we advance and the advice of the AHPPC that was given to National Cabinet prior to that fateful 27 March meeting. As explained by the Premier in his statement to the Board:

> *The AHPPC recommended enforcing the monitored placement of returned travellers in facilities such as hotels [and I emphasise] in high-risk cases where those persons would normally reside with others at home.*

Whether it be by way of a more generous exemption process or by a default position permitting people to quarantine at home unless they are high risk and otherwise unable to safely self-isolate, the burden on the individual and on the State would be significantly reduced without demonstrably increasing the risk of community transmission. In addition to exemption, the DHHS has advised the Inquiry there were more than 439 temporary leave permissions granted for travellers to take temporary leave from quarantine for compassionate reasons. These included attending funerals or visiting a family member in hospital but also included receiving medical treatment themselves.

Evidence before the Board does indicate that there were inconsistencies in decision-making in this regard and in the infection prevention and control

precautions taken around it. It was less than an ideal situation. Although not identified by the Operations Commander of Operation Soteria, in our submission a reasonable third objective in the Hotel Quarantine Program would have been ensuring the safety of workers working within the program. We pause to note that the evidence shows that people within the program worked extremely hard and made huge sacrifices to try their best to ensure that the program achieved its objectives.

Within the public service there were numerous individuals who worked long hours under great amounts of pressure, no doubt at significant cost to their own wellbeing. On the frontlines of the Hotel Quarantine Program, clinical and nonclinical staff worked hard to try and keep all that were there safe and healthy.

As identified by both Mr Neal and Ms Ellyard, and I join my voice to theirs, the evidence shows overwhelmingly that those working within the Hotel Quarantine Program did so with good faith and with good intentions. Nevertheless, it is our submission that there was insufficient regard to the health of people working in the Hotel Quarantine Program and that the safeguards put in place to protect them were not sufficient.

Workers were exposed to risk as a result. One such group is the security staff. Security staff at the frontline of the Hotel Quarantine Program worked in a high-risk environment. The training afforded to them was inadequate, as was the supervision in respect of their use of PPE and infection prevention and control. These issues were identified early on and thereafter were only dealt with on an ad hoc basis. This continued right up to the Stamford outbreak and until the control of the operation was taken over by the Department of Justice and Community Safety.

No evidence has been led that prior to that time there was any overarching infection prevention and control plan that subsisted, that is at least until the advent of the health hotel model, with the involvement of Alfred Health in mid-June. Nor was there any evidence of proper infection prevention and control oversight or accountability within the Hotel Quarantine Program.

Whilst the DHHS public health team was responsible for providing advice when requested, it took no role, it seems, in monitoring that advice's implementation nor the supervision nor the dissemination of that advice beyond DJPR. It was found that the practices adopted at Rydges were not in line with the recommended infection prevention and control policies. Instances of noncompliance, including persons working across multiple sites, inappropriate use of PPE, security guards not practising social distancing, and common areas being cleaned by security and hotel staff, are examples. As observed, Dr Crouch stated that many of these increased the risk of transmission from travellers to staff.

In the investigation of the Stamford Plaza Hotel outbreak it was found that hotel staff and staff of MSS Security were not adequately educated with regard to hand hygiene, PPE, zones for safe containment or social distancing. The Board heard evidence from an anonymous secured guard referred to as Security 16 who worked at three

quarantine hotels, including the Rydges Hotel. The Board will recall that Secured Guard 16's evidence was that after working two or three days at the Rydges, he was told that there was a shortage of masks and gloves and from that point on he would be given one pair of gloves and one mask for each shift. He was instructed to put his masks and gloves in his pocket when he went for a break and he was told to avoid the hotel security cameras when he did that. He wasn't cross-examined or this point, nor was he challenged on the evidence and there is no reason in our submission why the Board ought not accept it. Of course, we know that Security Guard 16 contracted COVID-19. When he became symptomatic, it was a freeway sign that prompted him to get tested.

In respect of the safety of clinical staff, the evidence indicates that at least initially there were issues with the supply of PPE. Nurse Michael Tait gave evidence of PPE shortages during his work at the quarantine hotel and he also gave evidence about the patient-to-nurse ratio, where he said it was about one nurse to every 100 patients, and it fluctuated up to one nurse to up to 150 patients from time to time. There was also evidence that nurses were denied N-95 masks for swabbing procedures in circumstances where that would have made them at least feel safer.

Again, whilst initial shortfalls in the supply of PPE may have been as a consequence of the result of the program and the rapidity with which it was stood up, as well as concerns about the supply of PPE that existed in general at the time, this issue further underscores that which arises from a substantial and important program having to be implemented from scratch. Even as at 27 March, it was appreciable that not getting this program right could have, as it subsequently proved to have, disastrous consequences. In an emergency, the need for a preplanned, albeit flexible, response is self-evident.

We also acknowledge and submit that the evidence demonstrates that the public servants working in the frontline of the program were also exposed to risks that may be seen to be unacceptable. The Board heard evidence from Luke Ashford, a senior employee at Parks Victoria. Mr Ashford worked on secondment to the DHHS as an authorised officer in the program. However, he quit the program because of concerns about his safety. In his own words:

> *I did not feel that this was a safe environment to work in and I was concerned for my health and the health of my family. I'm used to working in dangerous environment, having worked in firefighting and the military, but I could not rely on the system or people around me to keep the environment safe.*

The Board will also recall the evidence from Ms Kate Gavens, Chief Conservation Regulator at the Department of Environment, Land, Water and Planning, who provided a statement to the Inquiry. Her evidence was not the subject of any dispute or challenge and she was not required to be called.

Certain authorised officers were seconded from her Department to the DHHS to work as authorised officers within the program. The Board will recall that

Ms Gavens raised serious concerns about the safety and wellbeing of her authorised officers working within Operation Soteria. She set them out in detail in an email dated 24 June. Those concerns that she set out included concerns regarding a lack of process improvement following the Rydges outbreak, issues with fatigue management, lack of job-specific induction and ongoing training and briefing, lack of oversight, and issues with infection prevention and control.

On 10 July, as a result of those concerns and due to a lack of any response or any meaningful response from the Department of Health and Human Services, all DELWP staff were immediately withdrawn from the program. Mr Murray Smith, who was the Commander of enforcement and compliance at Operation Soteria, told the Board he didn't know why all the DELWP staff had been withdrawn from the program. He also told you that he wasn't aware, at least at the time or during any reasonable time thereafter, of Mark Ashford's resignation or the fact for it --- of the fact of the resignation or the reasons for it. That is so notwithstanding that he had, as he described it, responsibility for the entire enforcement and compliance command structure, including all of the AOs, AO team leaders and senior AOs.

In our submission, all those people working at hotels should have been given in-person training about infection prevention and control and the use of PPE. The Board will recall the evidence of Professor Grayson, where he said that remote and online training alone is not sufficient; there need to be physical supervision, people need to understand PPE, the reasons and circumstances of its use, as well as knowing how to correctly fit, remove and dispose of PPE correctly.

In our submission, the people working at quarantine hotels should have been required to demonstrate knowledge of how to use PPE, not merely required to take generic online training, which Professor Grayson explained was confusing and not appropriate for the environment in which they were working. Further, we submit that at all times there should have been supervision and monitoring on site to ensure IPC, that is infection prevention and control, and PPE requirements were met.

Dealing briefly with the health hotel model, the Inquiry heard evidence regarding the model of hotel quarantine described as a health hotel, that which was implemented by Alfred Health after the outbreaks at the Rydges and the Stamford Plaza Hotel. That model commenced at the Brady Hotel on 17 June and a substantially or at least relevantly similar model was rolled out to all hotels in the Hotel Quarantine Program from early July. The health hotel model has a range of relevant areas of difference from that which was initially set up in the Hotel Quarantine Program. Those relevant points of difference can be summarised as follows: infection prevention and control expertise present on site at all times; dedicated infection prevention teams taking responsibility for the training and oversight of all staff on site, no matter how they come to be there; personal protective equipment training for all staff on site, including to security staff, cleaning staff and later on to Victoria Police; contact tracing undertaken by Alfred Health for all staff working on site who test positive, which includes medical staff, cleaners, hotel staff, security and, when they took over the program, Department of Justice staff.

In the event of a positive case, the Alfred Health infection prevention unit steps in and provides a range of instructions and support, and at the end of the 14-day isolation period that unit makes contact to confirm negative swab results. The nursing staff are dedicated to a particular location and don't work across locations, and experienced and trusted hospital-grade cleaning services are utilised. There is, importantly, a robust auditing process completed by an outside agency to keep up the rigorous standards.

In her evidence before the Board, Simone Alexander, who is the Chief Operating Officer of Alfred Health, identified that it was necessary for this to be a team-based comprehensive approach, with clear communication, governance and leadership, to ensure that appropriate infection prevention and control measures are established and maintained. In essence, she says, it is not sufficient to write policies and merely ascribe contractual obligations to service providers, leaving them to their own devices. The process is one requiring interaction, reinforcement and the creation of a culture of safety.

Part of the process implemented by Alfred Health includes the auditing of the infection prevention and control measures on a regular basis to identify issues or gaps. Ms Alexander noted that that was standard practice in any clinical environment, and in our submission its benefits are self-evident. Importantly, Ms Alexander stated there was nothing, notwithstanding the impending consequences of the pandemic, earlier than late May that would have prevented Alfred Health from responding to requests from the DHHS for assistance in the same way that it did when it was requested in late May and into June. Her evidence in that respect can be found on page 1053 of the transcript.

We know that no approach to a health service, Alfred or otherwise, to establish a model such as the hot hotel was made earlier in the Hotel Quarantine Program. No such approach was made at the start of the program or at the time when the Rydges was stood up as the hot hotel.

The Board will recall the somewhat objective and lay view of the health hotel model proffered by Security 2. He was able to contrast his experiences within the hot hotel with his earlier experiences with hotels not run under the Alfred Health model. He provided a number of insightful observations, including that, in his words, the health hotel was run like a hospital ward. He also described the environment of collegiality and that everyone was on the same team, looking out for one another to ensure that IPC was adhered to.

Security 2's account of the infection control and prevention process as a culture of the health hotel aligned with the experiences given by Ms Alexander. The Board will note that there have been no outbreaks of COVID-19 in any hotel for which Alfred Health is responsible. In our submission, the model implemented by Alfred Health in the program provides the perfect point of contrast for the initial setup. The former is the apparent exemplar of a health- and wellbeing-focused hotel quarantine

arrangement. It has proven to be effective in achieving the primary objective of infection prevention and control, ensuring the health and wellbeing of people detained in quarantine and ensuring the health of people working in a safe environment within the program. Consideration should have been given to engaging the skills and experience of a large public health organisation earlier than it was. At latest, it should have been considered at the time of deciding to cohort COVID-positive cases in a hot hotel.

Madam Chair, I am moving to my last topic. I think I have maybe 10 minutes to go. I am in your hands as to whether to continue.

CHAIR: Keep going, Mr Ihle.

MR IHLE: If the Board pleases.

this is on the topic of responsibility and accountability, Madam Chair. In our submission, the evidence not only raises real questions about the accountability of those involved in the implementing, oversight and so-called operationalising of the Hotel Quarantine Program but their conduct raises further concerns for the Board as to their attitudes to transparency and accountability in general.

For example, we note the following: in its response to a complaint about fresh air raised with the ombudsman, the DHHS misquoted the extant policy. The policy in existence at the time of the that response provided, amongst other things, that:

> *Individuals in mandatory quarantine should be allowed one hour of suitable exercise or leisure time in open air daily, where it can be safely and practically implemented at the hotel, weather permitting, taking into account infection control and physical distancing precautions.*

For reasons that were not convincingly, we submit, or completely explained, this part of the policy was omitted from the response to the ombudsman. Secondly, concerns raised and advice provided by the Australian Medical Association in relation to the program were seemingly not acted on and not given any adequate response. Thirdly, the Department had a view, expressed in an email which was tendered before the Board, that the Government helpline established by the DJPR ought not proffer advice to detainees that they reach out to parliamentary representatives to raise concerns about their treatment.

Fourthly, the Board will recall Nurse Jen's evidence that at the ParkRoyal Hotel, Department staff made a rule that nursing staff were not allowed to give their name to a patient or to tell them who they worked for. She also gave evidence that she was told not to give the patient the names of the people working for the Department. Operation Soteria Commander Ms Williams said in evidence that she could not think of a good reason why Nurse Jen ought to have been given that instruction.

In the same regard, the Board will recall that when Mr Hugh de Kretser sought a

copy of the policy governing fresh air breaks, he was given the runaround, until eventually he was told a take make a freedom of information request. The evidence before this Inquiry demonstrates that not only was there a fresh air policy in existence when he asked for it but that it was the very same version that the Department misquoted in its response to the Ombudsman. No reason has been given as to why Mr de Kretser was not provided with the policy when he requested it.

The Board will also recall that when the DHHS provided its Initial Response to this Inquiry, by which it was asked to identify any shortcomings on its behalf, none were identified. That is so, notwithstanding that there had been serious issues of governance that had been raised by the senior members of the Public Health Team, identified escalation points brought to its attention by Safer Care Victoria that required immediate attention, two outbreak management reports, and the two reports prepared by Safer Care Victoria in recommendation to those clinical incidents. All of those things identified concerns with the program, including in particular those areas for which the Department had primary responsibility.

Finally, in respect of transparency and accountability, the Board will recall that Ms Peake acknowledged in her evidence that as Secretary of the Department of Health and Human Services, she is accountable to her Ministers, including the Health Minister. She was also accountable to the Premier in her role as Mission Lead Secretary for the COVID-19 response. In each role she was specifically accountable for keeping those Ministers informed of significant issues within their portfolio. Mr Phemister, the Secretary of the DJPR, was accountable in respect of his part in the Hotel Quarantine Program to Mr Pakula. Mr Phemister gave evidence that:

> *With regards to the briefing on the Hotel Quarantine Program, I briefed the Minister very rarely as it was an operation run through the State Control Centre.*

The evidence of Premier Andrews and Mr Eccles also demonstrates a failure by that Secretary to brief his responsible Minister as to the Commonwealth offer for ADF support. That was plainly an issue of significance falling within the Premier's portfolio of which he was not advised, and Ms Ellyard has already addressed you more expansively in respect of that.

In her evidence before the Board, Ms Peake acknowledged that there is a recognised tension between collaborative governance and the traditional Westminster accountability model. Irrespective of that tension, a separate question arises as to whether these three Secretaries, each of whom had important roles and accountabilities for the Hotel Quarantine Program, properly discharged their obligations in respect of ministerial briefings. It further follows that these issues raise serious questions as to whether their conduct had the effect of unsettling the ordinary processes of the traditional Westminster accountability model. Before the Board, those Secretaries gave a range of reasons for not briefing their Ministers. Those reasons included the following: "I didn't think it was part of the portfolio and I wasn't across the details of the contract." That was Mr Phemister's explanation in

respect of his infrequent briefing of Minister Pakula. "I don't recall what I did with that," which was Mr Eccles' explanation in regard to whether he passed on information about the offer of ADF assistance to the Premier. And, thirdly, "I considered that those matters had been resolved or were being resolved," which was Ms Peake's explanation in respect of the information that in our submission she should have brought to the attention of then Minister Mikakos.

There is a spectrum of seriousness as to these admissions. At one end there appears to be what is the deliberate and conscious decision to not inform the Minister of an issue which is of significance falling within the Minister's portfolio. At the other, not being across departmental information and bringing it to the Minister's attention and instead considering it as a matter only for relevance to the State Control Centre. And in our submission, falling somewhere in between there lays what appears to be an inexplicable oversight in relation to important information. Never, in our submission, none of those explanations were satisfactory. The evidence before the Board shows that these were indeed significant issues which should have been brought to the relevant Minister's attention. The Secretaries were obliged to ensure that they discharged those obligations.

Furthermore, a view, whether justified or not, that an issue of significant concern has been resolved does not obviate the need for briefing responsible Ministers about the fact that an issue arose. If that were to be so, ministerial and departmental accountability are affected, if not entirely lost, either knew the passage of time because a briefing has not been made in a complete or timely way, or at the whim of the Secretary. It might be trite to observe that bureaucrats, no matter how senior, are not directly accountable to the electorate. For responsible government to work, it is imperative that they remain accountable to their Ministers. That accountability starts first and foremost with discharging the fundamental obligation to keep their Ministers informed. In our submission, these matters tend to demonstrate attitude to transparency and accountability that likely manifested in practices that contributed to problems within the Hotel Quarantine Program. They also likely contributed to a loss in opportunities to identify and address issues which may have prompted better, fuller and more timely action.

Madam Chair, that conclusion the submissions that I wish to make, for your assistance. I understand that Mr Neal will make some conclusion remarks. If the Board pleases.

CHAIR: Thanks, Mr Ihle.

Are you in a position to continue, Mr Neal?

MR NEAL QC: Yes, I am, if the Board pleases.

CHAIR: I'm happy for you to proceed now, Mr Neal, given the hour of the day.

MR NEAL QC: Certainly, Madam Chair. Madam Chair, thus far, in submissions each of my learned juniors have taken you in detail to the issues which we say emerge if the evidence and in the course of doing so have identified to you with varying degrees of particularity what we say are the findings open to you.

The traversing of the evidence and the findings we urge are a reflection of what was said in the opening: that a multiplicity of factors compounded to lead to or perhaps even predetermine the failure of the Hotel Quarantine Program. In particular, through our submissions, what emerges is that at its threshold there was a failure to fully comprehend that this was not primarily an issue of physical accommodation and detention, nor was it an emergency capable of being managed like natural disasters with which we are familiar. The reason for and the superordinate goal of the program was infection control. We say that it is manifest in the evidence that this superordinate goal was not honoured in the implementation of the Hotel Quarantine Program. This failure of comprehension embedded in the emergency response, which the Hotel Quarantine Program was, the very genesis of its failure.

The findings that we have urged upon the Board today are obviously dependent on the fullness of our submissions. By way of closing now, I wish to collect and place on the record in terms those findings which we submit the Board should make. This is being done for convenience of all and in light of the fact that these submissions are being delivered orally, and responsive submissions are required within a week. Necessarily what follows is a collection of findings somewhat isolated from the fuller oral submissions which have given rise to them.

Because it is consciously so decontextualised, the approach I will follow is to briefly identify and caption each issue and then express the findings relevant to it.

Madam Chair, necessarily this exercise involves a degree of repetition and I will ask you to bear with me in doing that. For obvious reasons we wish the record on these proposed findings to be in clear and precise terms.

The first two findings you are invited to make are of a global nature: in setting up the Hotel Quarantine Program in response to the infection risk posed by returned travellers, the State created a program which carried within it its own infection risks. In doing so, the State assumed responsibility itself for identifying and managing those risks. In fact, the inadequacies of the program overall increased or at least failed to appropriately mitigate against the risk that the virus would be transmitted from returned travellers and into the community. That is a risk we now know eventuated with devastating consequences.

Turning of the issue of pre-planning for quarantining, we invite the Board to find as follows. Prior to 27 March, the Victorian Government and its Departments had no plan for large-scale quarantine. The lack of a plan meant that the Hotel Quarantine

Program had to be conceived of and implemented from scratch and within a very short space of time. This placed incredible strain on the resources of the State and more specifically on the Departments and people required to give effect to the decision of National Cabinet. What was established was, necessarily, untested and thus prudence would dictate that the program should have been accompanied by intensive ongoing monitoring and auditing. The Victorian Government failed to adequately ensure that this was done. These failures contributed to the difficulties with the implementation and operation of the Hotel Quarantine Program in this State and overall increased or at least failed to adequately mitigate the risk that the virus would be transmitted from returned travellers and into the community.

Failures to conceive of the Hotel Quarantine Program as, first and foremost, a public health program, contributed significantly to the nature and implementation of the program that followed. The program did not operate in standard ways across all hotels. As a separate issue, the submissions have dealt with the question of lead responsibility. The findings we urge are: firstly, the Hotel Quarantine Program was properly understood as part of the State's response to the public health emergency and properly allocated to the Department of Health and Human Services as control agency in accordance with the State Emergency Response Plan. The State Emergency Response Plan allocated human disease emergencies to DHHS because it is the Department with public health expertise. It was that expertise which DHHS should have brought to the Hotel Quarantine Program as well as to all aspects of the COVID-19 response.

The decision in February 2020 to appoint persons without public health expertise as the State Controllers for the public health emergency, contrary to the expectation in the State's existing health emergency planning, influenced the way in which DHHS subsequently understood and acted on its responsibilities in the Hotel Quarantine Program and limited the Hotel Quarantine Program's access to the public health expertise that the State Emergency Response Plan assumed that Department would bring to all response activities. Had the Chief Health Officer or another person with public health expertise been appointed State Controller in February 2020, they would have had direct oversight of the Hotel Quarantine Program and been able to directly influence the model of that program. That influence would have increased the Hotel Quarantine Program's focus on health issues, including infection prevention and control.

Contrary to the position put by some DHHS witnesses, the Hotel Quarantine Program was not under the absolute control of the Chief Health Officer or Public Health Commander as part of the public health emergency in Victoria.

A separate topic that we have dealt with in submissions is the issue of enforcement of quarantine. This of course was an issue which assumed very particular prominence as the Hotel Quarantine Program evolved and came to public attention because of the outbreaks and it being associated in the minds of some with supposed personal delinquency on the part of private security.

However, the findings we invite you to make are as follows. The conclusion that private security would be the first tier of enforcement in the Hotel Quarantine Program was not made before the State Control Centre meeting; no one person made that decision; it can be best understood, as my learned junior Ms Ellyard has said, as a creeping assumption or default consensus reached in the State Control Centre after the preference of Victoria Police was known; it was not Victoria Police's decision, but Victoria Police's clear position that security would be preferable was a substantial contributing factor to the consensus.

It follows that there was no proper consideration by anyone given to whether it was appropriate to rely so heavily on private security for what was a detention program, rather than a sporting event or a voluntary gathering. It was reasonable for DJPR to have understood that they had been tasked to appoint private security after the State Control Centre. However, the process followed to identify and contract with contractor companies was flawed and the terms of those contracts did not reflect the role security guards were originally intended to perform.

Security guards were present to enforce the detention of persons. Authorised officers were the delegate of the Deputy Chief Health Officer, who was detaining them. They should have been under the direct supervision of those authorised officers. It was a failure of the system that the authorised officers did not appear to understand that they were in charge.

As the Hotel Quarantine Program developed and the roles allocated to security companies evolved, no one turned their mind to whether they remained a suitable workforce for those roles because no one understood themselves to have been the original decision maker. Absent very clear oversight by persons properly trained in infection prevention and control and continued training for all on-site, it was not appropriate to use security guards for the roles that they ultimately performed in the Hotel Quarantine Program.

The Department of Jobs, Precincts and Regions should have used the State security contract to identify security companies and not made ad hoc enquiries via a section of DJPR without relevant expertise in the security industry. It is apparent that the three companies chosen had different levels of pre-existing capacity and preparedness for the work and that there was insufficient due diligence done by DJPR before the formal contracts were signed. Instead, personal on-the-ground observations were allowed to override ordinary procurement practices.

Once contracts were signed, there was insufficient supervision of those contracts to ensure compliance with the contractual terms, including as to subcontracting. Further, decisions about how work was allocated between security contractors did not involve any sufficient consideration of whether the companies could provide suitably trained and supported staff.

The next set of findings we invite the Board to make concern the critical question of infection prevention and control. The Hotel Quarantine Program was first and

foremost conceived and then continued as a scheme for providing a location for self-quarantine. There was not a sufficient focus on why that self-quarantine it was necessary; that is, to prevent the transmission of COVID-19. The contracts with hotels and security companies should not have placed responsibility for PPE and infection control education on those contractors. It is a matter of great concern that they did so and that the decision to allocate risk in that way was determined by mid-ranking DJPR officials rather than by way of considered decision-making at the Secretary or Ministerial level. The presence of those contractual arrangements did not remove the State's responsibility to ensure that the Hotel Quarantine Program operated as an effective infection prevention and control mechanism. Within DHHS, as the control agency, insufficient regard was given to health-related matters, including infection prevention and control. All people working at hotels should have been given in-person training about infection prevention and control and the use of personal protective equipment. People working at quarantine hotels should have been required to demonstrate knowledge of how to use PPE. There should have been supervision and monitoring to ensure adherence to IPC and PPE requirements.

The upper management of Operation Soteria, including senior personnel from within the Department of Health and Human Services, were disproportionately focused on compliance and enforcement. Senior and qualified people from within the Public Health Team were divested of the ideal "operational line of sight" over how their advice and guidance was to be implemented. The initial approach to testing risked undermining, at least to some degree, the efficacy and intention of the Hotel Quarantine Program and risked transmission of COVID-19 from those subject to the program into the community. Fomite or environmental transmission was a recognised and known method of infection from very early in the program. There was knowledge within the Department of Health and Human Services of the ways the virus could be transmitted, including the possibility of fomite transmission.

Although the use of hotels as a setting for mass quarantine may have been unprecedented, the factors that played a part in the outbreaks at Rydges and the Stamford Hotel were not unique to those hotels. These factors all contributed to an increase risk which eventuated. Those risks were foreseeable and may have actually been foreseen had there been an appropriate level of health focus in the program from the top to the bottom.

My learned friend Mr Ihle dealt with the question of the designation of a hot hotel. In respect of that, the findings we urge the Board to make are as follows: the idea of cohorting positive COVID-19 cases together in a single location or a hot hotel appears to have made sense as a sound public health measure. However, it behoved those involved in deciding to implement that concept to pay particular attention to the infection prevention and control measures deployed at that location and to have particular regard to the make-up of the workforce of those undertaking their duties there. The consequences of not doing so were foreseeable, even from the time the decision was made.

At the time the decision was made to cohort COVID-19-positive cases at Rydges,

insufficient regard was paid to the increased risk patent upon concentrating those cases in one location. This shortcoming increased or at least substantially failed to mitigate the obvious risks presented by the hot hotel model.

My learned friend Mr Ihle also dealt with the question of the findings that the Board should be making in respect of outbreaks. We invite the following findings: in respect of the Rydges Hotel, it is more likely than not that the outbreaks occurred as a result of environmental contamination rather than person-to-person contact. Poor training and education of frontline staff and the delays in cleaning the common areas of the Rydges Hotel and in quarantining all staff were further failures which contributed to the further proliferation of the virus into the community. The evidence does not permit the Board to find on balance that the transmission event at the Stamford was environmental over the equal possibility that it resulted from person-to-person contact.

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

As to the consequences of the outbreaks, we submit the following findings should be made: 90 per cent of positive cases in Victoria since those outbreaks are attributable to that initial outbreak at the Rydges Hotel in Carlton in late May. Just under 10 per cent of positive cases in Victoria since are attributable to the outbreak at the Stamford Hotel in mid-June. The movement of the virus through the barriers of quarantining is responsible for some 99 per cent of the recent COVID-19 infections in Victoria.

The Hotel Quarantine Program in Victoria failed to achieve its primary objective. The program that was intended to contain the disease was instead a seeding ground for the spread of COVID-19 into the broader community. Infection prevention and control measures were ad hoc and inadequate, not only at the Rydges Hotel in Carlton but across the entire Hotel Quarantine Program, until the establishment of the health hotel model with the standing up of the Brady Hotel in mid-June.

Several salient features of the structure of the Hotel Quarantine Program increased or at least did not sufficiently guard against the risk of transmission of COVID-19 from the Hotel Quarantine Program. These are features that applied generally but more specifically were evidenced at Rydges and Stamford in particular. The features are: mischaracterisation of the program as mainly a logistical and compliance operation; failure to engage and embed public health experts in the operational aspects of the program; inadequate testing of detainees; and deficiencies in cleaning processes and performance.

In terms of the impacts on those who were being detained, an aspect of the Hotel Quarantine Program which is sometimes overlooked, the question of infection

control was critical but not only --- but it was not the only metric by which the appropriateness of the Hotel Quarantine Program is to be assessed. The findings in this context we urge are: the program did not always operate so as to meet the needs of those who were detained, in particular those who had specific needs or vulnerabilities which were not adequately met.

Very early on, better consideration ought to have been given to the likely psychosocial impact of detention, and expert advice should have been sought about how to manage people's perception of risks which have led to the establishment of the quarantine system and the ordinary desires which those risks will create, in particular to manage the social urges to communicate and to rejoin those they need.

The program, as it was established and run, did not appropriately have regard to and balance the individual considerations apposite to each of the returned travellers. There were shortcomings in meeting the health and human needs of people in quarantine. The program's focus on compliance and enforcement affected detainees' experience of being in quarantine. The en masse approach was not sufficiently revisited as the program matured over the time that it went on. A more nuanced approach was called for but never, it would seem, implemented. Such a model may be at least as effective in achieving the objective of containing the virus.

Notwithstanding recognisable efforts, there were inadequacies in the management of welfare of those who were being detained in quarantine, particularly in the areas of communication, both between those working within and those held in the program, responsiveness and attentiveness to particular needs. The exemption process ought to have been more available, transparent and implemented. Exemptions could and likely should have been granted in more situations, especially in circumstances where it was inappropriate for a returned traveller to be confined in a hotel room because of their needs, including mental health need, physical health needs, family situation, et cetera, and the returned traveller could demonstrate that they could actually safely quarantine in their own home.

May I turn now to the findings we invite as to the alternatives to the Hotel Quarantine Program as implemented. The option of mandatory home quarantine or a hybrid model involving initial reception into a hotel for risk assessment and triage, taking into account all relevant factors for each returned traveller, with increased compliance mechanisms, would have proven to be less of an imposition on the lives and basic freedoms of those returned travellers who were caught by the program.

Lastly, the matter on which we seek formal findings, we urge formal findings to be made by the Board are the questions touched upon by my learned friend Mr Ihle of responsibility, accountability and transparency. The findings we invite are as follows: there were significant issues which should have been brought to the respective Ministers' attention; the departmental Secretaries were obliged to ensure that they discharged those obligations; for responsible Government to work, it is imperative that Secretaries remain accountable to their Ministers. That accountability starts with discharging fundamental obligations to keep their Ministers

informed.

The evidence demonstrates attitudes to transparency and accountability that likely manifested in practices contributing to the problems within the Hotel Quarantine Program. They likely contributed to a loss in opportunities to identify issues which may have prompted better, fuller and more timely action.

Madam Chair, that concludes the capture of the formal findings that we were urging the Board to make and that concludes the formal submissions that I wish to make on behalf of those assisting you today. Before closing, Madam Chair, may I say something by way of informal remarks.

As to the nature of the effort and undertaking of this Inquiry. It is clear that the Inquiry has involved a colossal effort by each person engaged by the Board toward assisting the Board to deliver on its task. It has often been remarked that the Inquiry has mimicked the compressed timeframe of the setting up of the program into which the Board is Inquiring. May I on behalf of those assisting you take this opportunity to acknowledge the Inquiry's staff as well as those working tirelessly behind the scenes to facilitate this Inquiry. May I express my thanks on behalf of those assisting the Board and those instructing us. Similarly may I take the opportunity to thank each witness and each party with leave to appear as well as their lawyers and counsel for their important contributions to this Inquiry. If the Board please, those are the remarks we wish to make.

CHAIR: Thanks, Mr Neal. With respect to the reference you made this morning to the chronology that has been compiled by the legal team for the benefit of all parties with leave to appear, has that document now been circulated or is going to be circulated?

MR NEAL QC: Madam Chair, I can only say that it is in an approved form but I'm not sure that it has necessarily been circulated.

CHAIR: But will be circulated shortly to, as you said this morning, circumvent for the need for any party with leave to appear who wishes to make a written submission in reply to rehearse all of those accepted timelines and aspects of the chronology that are non-controversial?

MR NEAL QC: Indeed, Madam Chair. I believe there is no impediment to it being circulated quickly, as in this afternoon.

CHAIR: Thank you. I want to take a moment to explain the process for those watching and those unfamiliar generally with the process of Inquiries and forums such as this. So that the process that has taken place today is, as I think anyone who has been following the day will understand, what is called closing submissions. So that --- I want to say something about it to avoid any misunderstanding, and do my best of course to maintain fairness to all of the parties, and in particular to those parties with leave to appear who have been the subject of the Counsel Assisting

team's closing submissions. To make clear that what you have heard throughout the day are not the findings of the Board. What you have been listening to are what the Counsel Assisting team are submitting to me are findings or conclusions that I could or should make on the basis of the evidence before me.

So there is now a very important next step. Each of the parties with leave to appear before the Inquiry has seven days to make submissions in reply in writing, saying what they wish to say about the conclusions I should come to on the evidence before me and, as Mr Neal has indicated, responsive of course to the closing submissions of the Counsel Assisting team.

This process of closing submissions and submissions in reply is an established practice whereby those parties who wish to do so can address the submissions made by Counsel Assisting today and say why the Board should not reach such conclusions or make such findings on the evidence before it. Upon receipt of the written submissions in reply, they will be published on the Board's website, unless otherwise directed by me.

As a result of the number of parties with leave to appear or leave to make submissions to the Board on recommendations, the only sensible course to adopt has been to direct that those submissions and responses be made in writing. Those written responses and submissions are to be provided, as you've heard already from Counsel Assisting, to the Solicitors Assisting the Board no later than 4.00 pm next Monday, 5 October.

Now, I want to be absolutely clear to everybody, there will be no extensions of that deadline. Submissions or responses received after the deadline will not be considered.

As has been done for good reasons in other Inquiries and Commissions and in particular in circumstances where time constraints are upon all of us, I'm setting a page limit on the written submissions in reply and I have fixed that page limit at no more than 70 pages. I anticipate there will be a considerable number of parties who have been granted leave to appear during this Inquiry who will be able to make appropriate, concise submissions in far fewer pages than the upper limit and for obvious reasons I strongly encourage them to do so.

I also anticipate that there will be a number of parties with leave to appear who do not choose to make written submissions and that is acceptable to me. There is no requirement to make written submissions.

I should add, for the purposes of clarity, that page limit of 70 pages is 70 pages and no addendums or appendices or other attachments, so it is 70 pages neat, if I can use that expression. Given the thousands of pages that the Board has already received, any reference to documents can be made within that 70-page limit.

Of course, I will carefully, as I must, consider the contents of any submissions in

reply before coming to my conclusions on the evidence, which, as I think it is understood, will be published in the report which is due to the Governor on 6 November.

I join with Mr Neal in expressing my thanks to all of those identified by Mr Neal. I add my thanks also to the counsel team and indeed the legal team and all of the staff who have assisted the Inquiry to run its virtual hearings live and publicly over these last couple of months. And I also thank those --- those thanks go to all members of counsel and your legal teams for your efforts in adapting to this somewhat strange and new and challenging virtual environment in which we have all had to work.

Thank you. And that brings to a close this part of the Inquiry's work.

MR NEAL QC: If the Board pleases.

CHAIR: Thanks, Mr Neal.

HEARING CONCLUDED AT 4.37 PM

Index of Witness Events

CLOSING SUBMISSIONS BY MR NEAL QC	P-2190
CLOSING SUBMISSIONS BY MS ELLYARD	P-2197
CLOSING SUBMISSIONS BY MR IHLE	P-2228
FINAL CLOSING SUBMISSIONS BY MR NEAL QC	P-2263

Index of Exhibits and MFIs