BOARD OF INQUIRY INTO THE COVID-19 HOTEL QUARANTINE PROGRAM

WITNESS STATEMENT OF DR FINN ROMANES

Name: Dr Finn Romanes

Address: 50 Lonsdale Street, Melbourne, Vic, 3000

Occupation: Deputy Public Health Commander

Date: 9 September 2020

1. I make this statement to the Board of Inquiry in response to **NTP- 138,** the Notice to produce a statement in writing (**Notice**) dated 1 September 2020. This statement has been prepared with the assistance of lawyers.

ROLES AND RESPONSIBILITIES

Question 1. Please describe your relevant professional experience and qualifications.

2. I hold the following qualifications:

   (a) Fellowship of the Australasian Faculty of Public Health Medicine, Royal Australasian College of Physicians;

   (b) Fellowship of the Faculty of Public Health, Royal College of Physicians of the United Kingdom;

   (c) Master of Public Health & Tropical Medicine, James Cook University, Queensland; and

   (d) Bachelor of Medicine and Surgery, University of Melbourne.

3. I have had the following professional experiences:

   (a) Deputy Public Health Commander – COVID-19, and Executive Director – Strategy and Policy – Public Health – COVID-19, Department of Health and Human Services (Department) (current);

   (b) Public Health Physician (Communicable Disease), Department, 2017 to current;

   (c) Acting Deputy Chief Health Officer (Environment), Department, 2017;

   (d) Deputy Chief Health Officer, Department, 2016 to 2017;

(e) Senior Medical Adviser, Department of Health and Human Services, 2012 to 2016;

(f) Consultant in Public Health Medicine, NHS Tayside, Scotland, 2009 to 2012;

(g) Specialist Registrar in Public Health Medicine, NHS Scotland, 2005 to 2009;

(h) Medical intern and resident medical officer, various Australian hospitals, 2000 to 2004.

Question 2. What is your role within the Department of Health and Human Services (the Department) and for what are you ordinarily responsible?

4. I am a senior medical advisor normally employed within the Health Protection Branch of the Department.

5. Since 2017 I have worked as a public health physician with responsibilities for communicable disease control, including outbreak management, policy development and professional leadership of a range of health protection matters.

6. I was involved in advising the Deputy Chief Health Officer (**DCHO**) and Chief Health Officer (**CHO**) on the response to COVID-19 from January 2020, including when the first Victorian CHO Alert was issued to advise clinicians of the risk of COVID-19 on 10 January 2020.

7. I was involved in assisting the DCHO and CHO by chairing, at times, the State Health Incident Management Team (**SH-IMT**) for the Novel Coronavirus Public Health Emergency from 2 February 2020.

8. I am aware that in early April 2020, a Public Health Incident Management team (**PH-IMT**) was formed to respond to COVID-19. Its structure was then again revised on or about 8 April 2020, to better respond to the COVID-19 pandemic. I was one of the four Deputy Public Health Commanders (**DPHC**) in the PH-IMT that reported to the Public Health Commander (**PHC**), these teams are:

   (a) Pathology and Infection Prevention and Control;

   (b) Case, Contact and Outbreak Management;

   (c) Strategy and Policy; and

   (d) Intelligence.

9. The PH-IMT had functions fulfilled by 'Executive Leads' who report through to the Public Health Commander. The Executive Leads are responsible for Strategic Communication, and Public Health Operation Coordination.

10. Since the stand-up of the Public Health Incident Management Team (**PH-IMT**), I have filled the role of Deputy Public Health Commander (**DPHC**) for Strategy and Policy, also referred to as the Deputy Public Health Commander - Planning. The PHC is a role documented in the State Health Emergency Response Plan Edition 4 (**SHERP**), responsible for the line of control at the state tier of that plan. The plan indicates the Public Health Commander is appointed State Controller for identifiable public health emergencies. The PHC leads the public health command function within and across the public health emergency.

11. I have also performed the role of PHC. Initially, upon stand up of the SH-IMT in February 2020, I was the PHC. In March 2020, the role transitioned to the DCHO and I performed a deputy PHC role. From time to time, I performed the role of PHC when the DCHO was on leave or on a rostered day off. On 20 July 2020, I again assumed responsibility for the role of PHC until 13 August 2020 when responsibility for the role transitioned to the CHO.

12. The responsibilities of the DPHC - Planning included responsibility for the Physical Distancing Cell, which included an enforcement and compliance lead and a strategy and planning lead. The functions and role of the cell were to advise the PHC and to provide evidence and an informed policy rationale for decisions. The cell also prepared and consulted on policy and procedures.

13. More recently, the DPHC – Planning role became the lead of the Strategy and Policy – Public Health Branch, COVID-19. That Branch focused on public health policy relating to restrictions and Directions, public health advice and engagement with other Departments and stakeholders. The Branch also makes recommendations to the PHC and CHO for endorsement of policies and procedures prepared by the PHC.

14. I am an authorised officer under section 199 of the *Public Health and Wellbeing Act 2008* (**PHWA**) since 16 March 2020. Since mid-July 2020, I have usually been the authorised officer that has issued directions under the PHWA in the context of the state of emergency for the COVID-19 public health emergency. That role did involve advising on the scope and design of detention order templates but did not include the individual issuing of detention orders to individual persons being detained, such as under the hotel quarantine program.

15. I have not been an authorised officer in the hotel quarantine program.

16. I am a human biosecurity officer for the purposes of the *Biosecurity Act* 2015 (Cth) and exercise powers in relation to Listed Human Diseases, of which human coronavirus with pandemic potential (novel coronavirus 2019 (nCoV-2019)) is one such disease. The management of people who may have a Listed Human Disease at an international border falls under the jurisdiction of the Commonwealth Department of Agriculture, Water and Environment, and under that arrangement, human biosecurity officers authorise screening

and transfer of persons who may have a Listed Human Diseases to state public health arrangements.

Question 3. What role did you play in the Hotel Quarantine Program and what were your responsibilities in that role?

17. My roles and responsibilities have changed over the course of the hotel quarantine program.

18. From around 24 March 2020 and at the start of the hotel quarantine program until about 16 April 2020, I was the DPHC - Planning. This role started with a focus on broad public health control measures, especially advising on physical distancing policy, isolation of suspected and confirmed cases, and quarantine of people at higher risk of infection, such as close contacts or returned travellers from overseas. At the same time, I was providing advice on a range of a public health control measures and hotel quarantine was one manifestation of such a measure. Within this portfolio, one of my core responsibilities was to work with the PHC, in particular with respect to advice regarding exemptions from detention in hotel quarantine.

19. Together with the Department's Infection Control Consultant, in March 2020, I approved the Department's cleaning and disinfection guidelines, Cleaning and disinfecting to reduce COVID-19 transmission: Tips for non-healthcare settings.[1] Those guidelines are publicly available on the Department's website since about 20 March 2020 (**Cleaning Guidelines**).

20. The purpose of the Cleaning Guidelines was to provide advice on cleaning and disinfecting to reduce the risk of COVID-19 transmission in all non-healthcare settings in Victoria. The document was intentionally drafted to be applicable to all non-healthcare settings to minimise the risk of confusion about what standard should be applied to particular settings. The principles in the document apply to domestic settings, office buildings, small retail businesses, social venues and all other non-healthcare settings. Hotels are identified on the second page, in the context of cleaning where a suspected or confirmed case remains in a facility that houses people overnight (the examples given include a boarding house or hotel).

21. The Cleaning Guidelines includes a title, "How to clean and disinfect", which explains the process of wearing gloves at the time, thoroughly cleaning surfaces using detergent and water and then applying disinfectant to the area and ensuring surfaces remain wet for the period of time required to kill the virus. It addresses the appropriate PPE to be used when cleaning, including that gloves should be worn when cleaning and disinfecting. While eye protection, masks and gowns are not required for routine cleaning, a surgical mask and eye protection may provide a barrier when undertaking cleaning and disinfection for suspected and confirmed cases, along with a full length gown if there is visible contamination with

[1] Cleaning and disinfecting to reduce COVID-19 transmission: Tips for non-healthcare settings, DHS.0001.0015.0323.

respiratory secretions. The Guidelines advises that advice on correctly wearing PPE should be obtained by the reader's health and safety consultant. Finally, the Cleaning Guidelines also explains the appropriate disinfectants to use, including to prepare an appropriately concentrated 0.1% bleach solution (1000ppm) for disinfection.

22. I was also involved in instigating the development of other specific policies relating to healthcare and wellbeing for detained individuals, and assisted with some compliance policies. I discuss my involvement in instigating policy and procedure documents in my answer to question 4.

23. In late March and early April, I oversaw the preparation of the draft *COVID-19 – DHHS Physical Distancing and Public Health Compliance and Enforcement Plan dated 4 April 2020* (the **Physical Distancing Policy**).[2] The Physical Distancing Policy explains the effect of the various control measures (including restrictions) which aimed to reduce the spread of COVID-19 and is explained further in paragraph 46 below.

24. I commenced preparing the Physical Distancing Policy before National Cabinet's announcement that returning travellers were to be quarantined. At the time, the document was focussed on other aspects of public health control measures for COVID-19, except for case and contact management, because that was addressed by the COVID-19 Case and Contact Management Guidelines for Health Services and General Practitioners (**CCOM Guidelines**). I was also responsible for overseeing the preparation of many of the early editions of the CCOM Guidelines. This process began in January 2020 when we first became aware that we may have a COVID-19 case in Victoria. The CHO issued an alert on 10 January 2020 and we prepared the CCOM guidelines as a document that would describe how to minimise the risk of COVID-19 in healthcare settings. In preparing this document, we sought advice and input from relevant stakeholders including all major health services (Austin Health, Alfred Health, Monash Health, Melbourne Health as examples) and experts, including Professor Allen Cheng and others. The guidelines are routinely updated, and when changes are made we share those changes with general practitioners and health services including highlighting changes.

25. After the announcement of mandatory quarantine (I was unaware of it until it was announced), I updated my then draft of the Physical Distancing Policy to address the mandatory detention of returned travellers to address their healthcare and welfare as well as the protocols applicable to Authorised Officers. I did this with the objective of having a single policy and procedure document addressing the mandatory detention of returned travellers.

[2] Earlier drafts of this plan bear different names and subsequent to 16 April 2020, I understand it was titled the Draft Mandatory Health and Welfare Plan.

26. Under the Physical Distancing Policy, until on or around 16 April 2020, my role as the DPHC Planning was to:

    (a) report to the PHC in relation to enforcement of and compliance with physical distancing interventions relating to directions;

    (b) in respect of hospital or other Directions exemption requests:

        (i) sit on an informal panel with Compliance Lead and Legal Services which considers priority 2 (complex, lower/medium urgency) hospital visitor or other Directions exemption requests; and

        (ii) assess submissions for exemptions considered reasonable by the Compliance Lead and recommend outcomes required by the PHC. This is explained further below.

27. Between 28 March 2020 until around 16 April 2020, in broad terms, as DPHC Planning, I also provided advice to the then DCHO/PHC[3] on decisions about whether a grant of leave from detention should be made and executives within the detention program would, from time to time, seek public health advice on some welfare matters, and public health policy matters.

28. Although I was not the State Health Coordinator or the lead for detainee welfare (roles with health and welfare responsibilities), I did provide advice, when asked, about issues arising relating to the health and wellbeing of people in detention. From the commencement of the hotel quarantine program, at the end of March 2020, to about 15 April 2020, I was involved in providing advice and public health guidance in relation to physical distancing and enforcement and compliance actions in response to requests that came to me from within the Department. Typically, these requests were escalated to me from the Director of the Health and Human Services Regulation and Reform in the Department who became the Enforcement and Compliance Commander. If I was not able to resolve an issue, or if it was outside the scope of my normal remit, I escalated the matter to the PHC usually with a recommendation as to how I considered it ought to be resolved.

29. Typically, these matters and other issues that came to me would be raised with me by telephone or email and I was asked to provide guidance about how to respond to particular circumstances. I would provide guidance, usually by drafting a guidance document or sending guidance in an email.

30. As DPHC Planning, I took an active role in advocating on behalf of the PHC/DCHO and CHO for a central location for all plans that drive actions and an involvement by Public Health Command in the operational structure for the hotel quarantine program, including recommending clear governance, clear lead roles, and comprehensive operational plans to

[3] The role of PHC is now filled by the CHO.

assist officers and detainees. In mid-April it was decided between the PHC/DCHO and the State Controller that the PH-IMT would be responsible for providing policy and procedures and the Emergency Operations Centre would be responsible for implementing those procedures.

31. I was not involved in settling content of the Operation Soteria Plans but from conversations with my colleagues, I think that some of the material I worked on in the Physical Distancing Policy made its way into the Operation Soteria Plans as healthcare standards.

32. In providing public health advice on the issues I identify in this answer, I would prepare my advice having regard to the PHWA and the existing Victorian policy and regulatory framework and based on national guidance including by the Communicable Diseases Network Australia in the Series of National Guidelines for COVID-19 (**CDNA SoNG**), the national guidelines for COVID-19 communicable disease control. I also had regard to Australian Health Protection Principal Committee (**AHPPC**) advice and public statements, and international literature and guidance published by public health entities including the World Health Organisation and the Centers for Disease Control and Prevention. From time to time, as may have been required, I also typically would consult my colleagues or other experts in the relevant area before preparing a document.

33. An example of this relates to the preparation of a smoking policy for people in hotel rooms. Around 1 April 2020, I prepared a policy within the existing legislative and regulatory framework and provided it to the PHC for approval. It was approved and I then communicated the policy to the Director of the Health and Human Services Regulation and Reform in the Department who had made the request.[4]

34. Another example, which also arose on 1 April 2020, concerned a policy for unaccompanied minors who were Victorians arriving back from overseas. I drafted a policy for inclusion in the draft Physical Distancing Policy for implementation.[5]

35. Policies addressing these matters and other matters were then recorded in the draft Physical Distancing Policy (dated 4 April 2020).[6]

36. Another issue I was engaged to advise on, early in the program, was the exercise of the discretion not to detain a person (referred to in the questions I have been asked as 'exemptions' from detention) and permissions to temporarily leave detention. In the former category of case, a person was not exempted from detention but was not given a notice of detention to be detained in hotel quarantine. This relates to question 12.

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[4] Email to Meena Naidu, 1 April 2020, DHS.5000.0096.3347.

[5] Email from me, 1 April 2020, DHS.5000.0075.1034.

[6] COVID-19 – DHHS Physical Distancing and Public Health Compliance and Enforcement Plan, 4 April 2020, DHS.5000.0123.3241.

37. Typically, I was asked to provide advice and guidance on complex requests but the ultimate decision maker on these matters was either the PHC or CHO. I would consider the circumstances of a request, and make a recommendation to the PHC. I was not always involved in those ultimate decisions, but until about 15 April 2020, I generally was consulted.

38. In early April, my team (the PH-IMT Planning Cell) prepared the *COVID-19 – Interim Healthcare and Welfare Mandatory Quarantine plan*.[7] This document was a single policy and procedure addressing the healthcare and welfare of people in mandatory quarantine. It was prepared as a document to be used by those operating the hotel quarantine program. I also discuss this document below at paragraph 48.

39. I am aware that the DCHO was also keen to improve governance and plans and was engaged in discussions with the State Control Centre. On 15 April 2020, Dr van Diemen communicated to me the outcome of her discussions with the State Controller and advised me that it was agreed that the PH-IMT would be responsible for the creation of policy and associated procedures for health and welfare of passengers while the "Emergency Operations Centre was responsible for the operationalising of all policy and procedures including logistics and rostering at hotels etc".[8]

40. Working within the agreed framework, members of the Physical Distancing cell advanced the preparation of the *Healthcare and Welfare Mandatory Quarantine plan*. On 17 April 2020, I circulated by email a further Draft Mandatory Quarantine Health and Welfare Plan to the DCHO, CHO and State Controller with my observations that the document was continuing to be finalised but as a holding policy contained what I thought to be the current position on healthcare and welfare including exit arrangements.[9] On 18 April 2020, I submitted the Mandatory Quarantine Health and Welfare Plan to the State Controller, for endorsement.[10] I ceased to have a detailed involvement in these matters after this date. Members of the Physical Distancing Cell reporting direct to the PHC took on responsibility for those matters.

41. In addition to overseeing the preparation of policies and procedures, my team and I reviewed and drafted documents that were given to detainees to explain the process of discharging them from hotel quarantine. I recall that in the lead up to the first group of detainees being released, I advocated and was responsible for the distribution of an initial version of such a document. Later, on 18 April 2020, I reviewed a new version of the factsheet to be provided for new arrivals into hotel quarantine.[11] This is also relevant to question 12.

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[7] Interim Healthcare and Welfare Plan for mandatory quarantine dated 11 April 2020, DHS.5000.0126.1658.
[8] Email from Dr van Diemen, 15 April 2020, DHS.5000.0126.1654.

[9] Email sent by me, 15 April 2020, DHS.5000.0111.4902 attaching 'Protocol for AO -Direction and Detention notice' DHS.5000.0111.4903 and Draft Mandatory Quarantine Health and Welfare Plan DHS.5000.0111.4966.

[10] Email from me, 18 April 2020, DHS.5000.0110.7942.

[11] Email to me, 18 April 2020, DHS.5000.0124.5308 attaching DHS.5000.0124.5310, DHS.5000.0124.5314 and DHS.5000.0124.5316.

HEALTH AND WELLBEING OF PEOPLE IN QUARANTINE

Question 4. What measures were in place to manage the healthcare and wellbeing of people in quarantine? If your answer differs for different time periods, or for different locations, please specify.

42. I have partly answered this question in my answer to question 3.

43. The healthcare and wellbeing of people in quarantine has always been a deep area of consideration for me and was a focus of my involvement in the hotel quarantine program. This is partly because the Public Health Command function and role, exercised through me at that time in relation to hotel quarantine, is accountable for the detention of persons, the rules around detention, and the rationale for detention in order to manage a public health risk.

44. However, I was not involved in overseeing the implementation of the policies or procedures I discuss in my statement. Specifically, I was not aware of how health and welfare was being promoted in hotel quarantine by Operation Soteria staff pursuant to the documents I identify here, or pursuant to other documents.

45. While I believe that some of the measures I was involved in advising on in early April were continued (in that they were later found in the healthcare standards in the Operation Soteria Plan), I am unable to speak beyond the period from about mid-April 2020 because I was not involved after that date in the preparation of the policies and procedures to address healthcare and wellbeing of people in quarantine. Until mid-April, I did provide guidance upon request about matters relating to healthcare and wellbeing for those in hotel quarantine, as I explain in this statement. After mid-April 2020, my focus turned to state-wide physical distancing policies, outside hotel quarantine, and the public health effort to control COVID-19 in Victoria more generally.

46. As I have stated above, in my role as DPHC Planning, I was responsible for the preparation of the **Physical Distancing Policy**.[12] This document described a strategy and recorded the protocols for the physical distancing response to COVID-19 and also described many aspects of the compliance and enforcement policy for directions issued by the DCHO including the mandatory detention policy. The document included policy and procedures to address the health and wellbeing of people in mandatory quarantine by identifying risks that may arise. Colleagues responsible for welfare contributed content on welfare checks.[13] I was not responsible for welfare checks and do not know how welfare checks were conducted.

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[12] COVID-19 – DHHS Physical Distancing and Public Health Compliance and Enforcement Plan, 4 April 2020, DHS.5000.0123.3241.

[13] Ibid, page 27-34.

47. The document also indicated the process for assessing and managing exemption requests, having regard to the public health objectives of minimising the spread of COVID-19 and thus the consideration of whether to grant an exemption while minimising the risk of exposure of people who could be infected with COVID-19 to others. Given those fundamentals to the public health control of COVID-19, a policy to link the controls and means to agree how compliance was managed seemed important. Shortly afterwards, with the introduction of a hotel quarantine program which extended the previous policy of self-quarantine for returned travellers, that draft policy was expanded to include hotel quarantine matters and draft protocols, including health and welfare, and compliance. This was especially as the need for extremely careful management of all persons in hotel quarantine was clear.

48. On 3 April 2020, I provided the then *COVID-19 – Interim Healthcare and Welfare Mandatory Quarantine plan* (the **Interim Plan**)[14] to the DCHO and CHO[15] for endorsement and circulated that plan to those with responsibility within the Department for operational aspects of the hotel quarantine program. This was selected content from the Physical Distancing Policy that related to healthcare and welfare and compliance. Around 9 and 10 April 2020, I forwarded the draft to Operation Soteria via the State Control Centre stating that the plan was with the DCHO and CHO for approval, but that it was useable as the working approach.[16] I expected that the plan would be implemented prior to its final approval.

49. The measures in the Interim Plan to manage the healthcare of people in quarantine until around mid-April included matters relating to the provision of healthcare, including medical care, pathology and pharmacy services, nursing and mental health care, access to transport to hospital if required and emergency care.

50. The measures relating to the welfare and wellbeing of people in quarantine until around mid-April included an initial assessment of welfare, provision of information to guide some choices about accommodation, welfare check requirements, smoking and fresh air breaks and exercise protocols, and protocols relating to alcohol and drugs, nutrition and food safety, care packages and safety and family violence risks. Further measures included notes on the desirability of provision of a COVID-19 positive floor or area, a requirement for PPE equipment, actions for confirmed cases of COVID-19, and protocols for exit from quarantine.

51. It is my understanding that many of these measures as documented in the Interim Plan were used in hotel quarantine program because I frequently discussed them with my colleagues, particularly exemptions and permissions to leave. However, I do not know with certainty whether all of the measures were adopted by Operation Soteria.

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[14] Interim Healthcare and Welfare Plan for mandatory quarantine dated 11 April 2020, DHS.5000.0126.1658. This document captured the authorising environment, and relevant content relating to mandatory detention.

[15] Email from me to the DCHO and CHO, 4 April 2020, DHS.5000.0123.3240 attaching DHS.5000.0123.3241.

[16] Email from me, 4 April 2020, DHS.5000.0095.9277.

Question 5. In your view, were those measures adequate and appropriate? Why or why not?

52. I believe the proposals in the draft documents I oversaw were adequate and appropriate because they were based on the best practice advice from experts and people with responsibility for those areas within the Department at the time they were prepared. I was not accountable for the implementation of the policies and did not have data or intelligence to confirm whether or to what extent they were implemented by Operation Soteria.

Question 6. How were decisions made, and what factors were taken into account, when determining which detainees (or groups of detainees) could be placed in locations with, or separated from others?

53. These decisions were not within my role and I am not aware of how these decisions were made.

54. In relation to whether travelling groups or families stayed together within a hotel room or were provided separate rooms, I did advise when requested by Operation Soteria that detainees should be offered – if possible – the option of separating at the outset. This was because the quarantine period might be extended if a person was not separated and if one person was subsequently confirmed to be infected with COVID-19. I understand this extension did occur on some occasions, although detainees did report in some cases that they would still have remained with their partner even if given an option.

55. I did advise as part of a proposed unaccompanied minors policy that an unaccompanied minor who is normally resident in Victoria should only be detained in hotel quarantine if their parent / guardian joined them in detention, as a safety measure to avoid detention of unaccompanied minors alone.[17]

[17] Email from me, 1 April 2020, DHS.5000.0075.1034.

RYDGES CARLTON AS A "HOT HOTEL"

Question 7. Who decided that there would be a "hot hotel" and who decided that it would be the Rydges Hotel on Swanston St in Carlton (Rydges Carlton)?

56. I do not know who made the final decision that there would be a "hot hotel" or that the hot hotel should be the Rydges Carlton. I was involved in and aware of discussions relating to the issue, as I set out below.

57. The idea of having a "hot hotel" is a manifestation of the concept of "cohorting", which is the practice of isolating individuals with an infectious disease together, and separate from others who do not have that disease. This is a sound public health approach when managing risk from an infectious disease, also known as a communicable disease. This general approach aims to concentrate the risk of transmission of infection by reducing the exposure of susceptible people, and so can facilitate control over the spread of the infection. For this reason, it is a technique used in communicable disease control.

58. I indicated support for the idea of COVID-19 positive individuals within the hotel quarantine program being moved to a dedicated hotel on 30 March 2020.[18] The following day, on 31 March 2020, in the context of an arriving passenger with COVID-19, I passed on the PHC's recommendations in relation to how to appropriately manage that individual, including recommendations in relation to personal protective equipment (PPE) and that "the Chief Health Officer has advised cohorting of positive COVID-19 cases in hotels should ideally be in one hotel only, or if necessary, on one floor of a hotel".[19]

59. In an email of 3 April 2020, I mentioned that the cohorting of COVID-positive individuals, either on a single floor of a hotel, or in a particular hotel might be undertaken in the future. I understand that by 6 April 2020, COVID-positive individuals started to be cohorted into a single floor of a hotel. I do not know who made the final decision to enact a policy to establish a 'red zone' or cohorting of positive cases on one floor of a given hotel.

60. I do not know of any further steps that were taken in relation to having a "hot hotel" until 7 April 2020, when my views were sought by the DHHS Commander on standing up an entire hotel for all COVID-positive individuals subject to hotel quarantine. I indicated that I thought it was a good strategy and endorsed the idea.[20]

61. As acting PHC, I recall attending an Accommodation Response – Governance Taskforce teleconference on 8 April 2020. At that meeting, I learned that formal steps were being taken

[18] Email from me, 30 March 2020, DHS.5000.0054.6660.

[19] Email to me, 31 March 2020, DHS.5000.0054.9039.

[20] Email to me, 7 April 2020, DHS.5000.0131.0503 attaching DHS.5000.0131.0507.

to use the Rydges Carlton as the "positive hotel". I did not object to the idea during that teleconference. As I explained, I do not know who made the final decision to establish a "hot hotel", or who made the decision that it should be the Rydges Carlton.

Question 8. What was the rationale for creating a "hot hotel"?

62. I do not know the specific rationale underlying the decision to make the Rydges Carlton a "hot hotel". However, I have explained a more general rationale for why cohorting was likely adopted in the form of a "hot hotel" in my answer to question 7, above.

Question 9. What (if any) additional control measures were implemented when it was decided to use the Rydges Carlton as a "hot hotel"? Please provide details, including relevant documents.

63. I was not involved in overseeing infection prevention and control (**IPC**) in the Hotel Quarantine Program, so I am not aware of what specific control measures were put in place in the Rydges Carlton when it was decided to be used as a "hot hotel".

Question 10. In your opinion, were the infection control measures at the Rydges Carlton when it was a designated a 'hot hotel':
(a) appropriate?
(b) adequate?
Why? Why not?

64. As I answered to question 9, I am not aware about the specific infection control measures at the Rydges Carlton that were in place when or after it was a designated as a "hot hotel". I therefore cannot comment on whether they were either appropriate or adequate.

Question 11. Why was there a subsequent decision to involve Alfred Health in the management of 'hot hotels' in the Hotel Quarantine Program?

65. I do not know why Alfred Health was selected for this task.

66. Having worked with staff at The Alfred in relation to communicable disease control issues over many years, I am aware that Alfred Health have experienced leaders in infectious diseases and infection prevention and control. There are likely to be benefits gained by

involving experienced people from a public health service in overseeing IPC, as the oversight of infection prevention and control is an important function within a public hospital.

END OF DETENTION

Question 12. What was the policy for when people were permitted to exit quarantine? If a different policy applied at different times, or in different locations, please specify. Please provide any relevant documents.

67. In this answer, I refer to the policy for exiting people who had been detained in hotel quarantine due to their status as returning travellers.

68. Separately, there were occasionally people who had returned from overseas but were not detained, for example because they were transiting to another state due to being an unaccompanied minor as part of an agreement with that state that they would quarantine in that other state.

69. Outside hotel quarantine, Victorians identified as close contacts of a confirmed case of COVID-19 also face a requirement to self-quarantine under Diagnosed Persons and Close Contacts Directions[21] as in force at the time, normally at a premises at which they normally reside. Those people normally exit that form of quarantine at the time specified in a notice provided by the Department, which is typically 14 days after the last time of close contact, provided they have not become infected with COVID-19.

70. In the period of hotel quarantine in which I was most involved, up to about 15 April 2020, I was aware of three categories of circumstances where a person may be permitted to exit quarantine: first, where they were given a grant of leave from the place of detention on a temporary basis before being required to return; second, where they were given grant of leave to serve the period of quarantine detention at an alternative location; and third, where they had been in quarantine detention for 14 days.

71. If a person was in mandatory quarantine and wanted to be exempted from the requirement to quarantine, they needed to apply for a grant of leave. I believe that the circumstances in which such applications were granted were limited to those in the Physical Distancing Policy on page 22, namely where:

    (a) a person required medical treatment in a hospital (typically providing for leave for a temporary period);

    (b) a person has recovered from confirmed COVID-19 infection and is released from isolation (providing for a person to leave mandatory quarantine without needing to return);

[21] Isolation (Diagnosis) Direction (No 2), 13 April 2020, DHS.5000.0003.3169; Diagnosed Persons and Close Contacts Directions, 11 May 2020, DHS.5000.0006.9729.

(c) an unaccompanied minor in certain circumstances (which was rare but might involve a temporary period or the full quarantine period); and

(d) instances where a person had a reasonably necessary requirement to leave the room for physical or mental health needs or on compassionate grounds. This category required that exceptional circumstances be demonstrated, and could be for a temporary period or for the full quarantine period.

72. The decision-making process for each type of consideration of grant of leave from detention involved a request, consideration of the circumstances including human rights considerations, an assessment of public health risk and a decision. There was a stated requirement for these requests to be processed in a timely way by an authorised officer working directly to the Lead Executive - Compliance and Enforcement. My role was to advise on the decision-making and in some cases to arbitrate as to the degree of public health risk likely and measures to mitigate that risk, and in some cases to endorse advice to the DCHO/PHC to permit a grant of leave.

73. In relation to people who had served their 14 days of hotel quarantine, I was involved in preparing documentation for the first group of people who had entered hotel quarantine with regards to their leaving quarantine.

74. Returned travellers who had arrived in Victoria on Sunday 29 March 2020 had received detention orders that expired at midnight on Sunday 12 April 2020. In the leadup to that day, I was quite involved with the Lead Executive – Enforcement and Compliance in a number of assessments in relation to grants of leave and the documentation and processes that were necessary for that cohort of returned travellers, and for those who had arrived subsequently. These assessments did involve, in some cases, determining how to continue a person's management under the directions that applied in the community at the time under the PHWA, including having regard to whether or not they had COVID-19.

75. My involvement in the exit process was to advise on the timing of exit, the safe process for exit, whether a health check should be required, and what should occur if a person was unwell prior to exit or had been tested and the result was not yet shown to be negative. I understand that the preparation of documentation and notices under the PHWA in advance of the imminent departure was undertaken by the Lead Executive – Enforcement and Compliance and I was not involved in that preparation.

76. We needed to address the situation of people leaving quarantine detention that were and were not COVID-19 positive, and who had or had not recently been tested due to symptoms, and also had to manage the process such that no one remained in hotel quarantine after 14 days and the detention notice had expired. For this latter reason, I was an advocate for people being able to leave a few hours ahead of the time of expiry of the detention notice and

that the exit process should be started early on the relevant day. That led to some people exiting a few hours before 14 calendar days were up. It seemed to be a better approach than to risk people staying in quarantine longer than the notice provided for.

77. A further situation requiring judgment was what to do if someone whose detention period was ending was a confirmed case of COVID-19. Our assessment was that it was appropriate for someone to leave mandatory detention if they were a confirmed case of COVID-19 so long as we transitioned the person to a safe place to self-isolate for the remainder of their infectious period, as was required under the Diagnosed Persons and Close Contact Directions in force at the time, in keeping with other diagnosed persons already self-isolating in the community. This was because the key public health imperative was knowing whether or not someone was infected with COVID-19, and being clear with the person what actions were needed to prevent transmission. That way, we could agree and implement clear isolation arrangements, with a recognition between the person and the department that the person was potentially infectious and must carefully isolate.

78. We also permitted a person to leave quarantine at the time even if they had recently been tested, because we wanted to encourage people to take up testing towards the end of their quarantine period (which was not and is still not legally mandatory). It seemed that some people may have been motivated to decline testing and to decline to disclose symptoms, because they wanted to leave quarantine and might believe this would not occur if they got tested. If they were to hide any symptoms, they might exit quarantine whilst infectious and may not appropriately isolate. Put another way, given that people wanted to leave hotel quarantine, the concern was that some people would hide their symptoms or refuse to get tested, and then exit hotel quarantine in an uncontrolled and potentially unsafe manner.

79. To this end, we prepared different notices to be issued to people leaving detention, depending on whether they were confirmed to be infected with COVID-19 or not. These were formal directions under the Act and required the same approach as in the community – self-isolate if positive. I advised on the appropriate transportation that would be needed for such an exit, to ensure the safety of persons including the following of infection control principles and for cleaning and disinfection to occur. This included advising that it occur by non-emergency patient transport (**NEPT**) while wearing PPE or via Ambulance Victoria transport if needed, as opposed to using commercial passenger vehicles such as a taxi.

80. On behalf of the DCHO/PHC I endorsed a policy to introduce day 11 testing of people in mandatory quarantine detention. This was an evolution of the thinking around the exit of people from quarantine and eventually involved a 10-day extension of hotel quarantine being

introduced for people who refused the day 11 testing. I was not involved in that latter approach.[22]

RESERVATIONS AND REFLECTIONS

Question 13. Did you, at any time, have any reservations about any aspect of the Hotel Quarantine Program? If so, what were those reservations and to whom did you convey them? What was their response?

81. As with the management of any complex program, as the situation changed, so did our response. In that context, I would from time to time identify potential ways we could improve the hotel quarantine program and would provide advice to the relevant people. As far as I am aware, this advice was heard and where possible, implemented. I outline below some of the observations and advice as to potential areas for improvement, and the responses I received.

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

83. In order that public health risks were carefully and consistently managed, in early April, I formed the view that it was important for experienced public health staff to have an opportunity to design and influence the hotel quarantine program and to participate in its governance at the highest level. This was not least because the detention of people was arising through an assessment by public health of the need for the program and that it arose through the authorisation of the DCHO (and the CHO's advice that a declaration of a state of emergency should occur, enabling the exercise of the relevant powers under the PHWA). For these reasons, I provided advice, alongside the DCHO and the CHO, on 9 April 2020 to the State Controller, that there should be a review of the program's governance, establishment of a line of accountability to the DCHO/PHC for policy, and clearly identified leads reporting to that line of accountability across healthcare and welfare, compliance, and logistics.

84. Further to that advice, I observed that there could have been merit in conceiving or managing the hotel quarantine program as a health program or public health program, implemented with a public health approach, with embedded aspects of healthcare and welfare, compliance, and accommodation or logistics. From what I could see, the program was characterised and managed predominantly as an accommodation or logistics program. I drew

[22] Email from me, 9 May 2020, DHS.5000.0119.6251 attaching DRAFT - Enhanced testing programme for COVID-19 in mandatory quarantine, DHS.5000.0119.6252.

this view from observations of the appointment of senior leadership figures that did not have significant public health experience, and that the Operation Soteria governance meetings I attended did not involve the PHC initially, and did seem to me to focus heavily on logistics considerations. While the program had significant logistical challenges attached to its implementation at that time, these were part of the challenge only and I felt that public health considerations needed to be concurrently addressed.

85. At a number of points up to and including 10 April 2020, I advised the PHC/DCHO and CHO about the advisability of a unified plan for the healthcare and wellbeing of people in hotel quarantine program and the need for public health command oversight in the operation of the program given the people detained were being detained under the direction of the DCHO and CHO. This advice was acknowledged and I was encouraged to oversee the compilation of a plan covering policy around healthcare, welfare and compliance protocols in particular, which I did by adapting the Physical Distancing Policy commenced around 26 March 2020 which at the time had a broader focus.

86. After discussion with the DCHO and CHO, I wrote to the State Controller to provide advice to request a unified plan, which I advised could benefit from being clear and comprehensive, to promote consistent approaches.[23] I also attended the State Control meeting on 10 April 2020 and provided this advice at that forum. I provided a draft plan with many of these elements to the State Controller on 10 April 2020 for consideration of adoption. Subsequently I spoke to the Deputy State Controller – Health on that day about those needs, and was advised to raise them directly with the State Controller which I did. I also discussed the importance of clear governance, accountability and a healthcare and welfare plan with the State Health Coordinator that evening, who I recall was agreeable with the advice and indicated there would be actions taken to progress the matters.

87. In response to advice to the State Controller, the State Control Centre provided a draft operating plan, which I reviewed and provided feedback about with the advice that the more detailed plan we had drafted could be used.[24] The subsequent draft *COVID-19 – Interim Healthcare and Welfare Mandatory Quarantine plan*[25] referred to in paragraph 38 above, was prepared to provide a comprehensive single source document to address these issues.

88. An example of one of these issues was the searching of people's bags or care packages being delivered to people in hotel quarantine. I considered this to be inconsistent with the rights of people in hotel quarantine and not required to address public health risk. The practice motivated me to advise Operation Soteria that there was a need for clear plans

[23] Request - Governance and Planning for Mandatory Quarantine Programme (aka Operation Soteria), DHS.5000.0053.6677.

[24] Email from me, 10 April 2020, DHS.5000.0077.8484 attaching DRAFT COVID-19 Mandatory Quarantine Healthcare Welfare and Compliance Plan 9 April 2020, DHS.5000.0077.8485.

[25] Interim Healthcare and Welfare Plan for mandatory quarantine dated 11 April 2020, DHS.5000.0126.1658.

detailing what Authorised Officers and other staff involved in Hotel Quarantine could and could not do. This advice was drafted in the Physical Distancing Policy.

Question 14. Did you have any views as to the role(s) that should be played by:

(a) Victoria Police; and
(b) Australian Defence force personnel,
in relation to the Hotel Quarantine Program? If so, what were those views, and to whom were they expressed?

89. No, I did not have any views about those matters.

Question 15. What, if anything, do you consider that:
(a) the Department;
(b) other government departments or private organisations;
(c) you,
should have done differently, in relation to the Hotel Quarantine Program?

90. Many staff from the department, other government departments, agencies and other entities worked very hard in challenging circumstances to establish the hotel quarantine program at short notice and in a complex and challenging environment.

91. I have advised above on the key matters that, in retrospect and with the passage of time and experience, could have had more focus or where the governance of the response may have benefitted from a different structure or focus.

92. With what is now known about the degree of infectiousness of COVID-19, and the ease with which even asymptomatic and minimally symptomatic persons can transmit infection person to person or indirectly through contamination of the environment, I reflect that I would have devoted more focus on ensuring that Operation Soteria had detailed, peer reviewed and audited infection prevention and control arrangements.

FURTHER INFORMATION

Question 16. If you wish to include any additional information in your witness statement, please set it out below.

93. I would like to acknowledge the hard work and dedication of my colleagues in public health, who worked tirelessly to protect the health of Victorians in this unprecedented public health emergency. Circumstances changed rapidly, and were incredibly complex and challenging, requiring decisive action in the face of uncertainty, based our expertise and knowledge.

94. Public servants from many departments and agencies, across the disciplines of public health nursing, environmental health, public sector management, regulation and public health medicine, worked long hours, made difficult decisions and deployed their expertise and knowledge to protect the health and wellbeing of all Victorians.

Signed at Melbourne

in the State of Victoria

on 9 September 2020

Dr Finn Romanes