Hon Jill Hennessy MP

Minister for Health
Minister for Ambulance Services

GPO Box 4057
Melbourne Victoria 3001
Telephone: +61 3 9096 8561
www.dhhs.vic.gov.au
DX: 210081
E4623487

Professor Euan Wallace
Chief Executive Officer
Safer Care Victoria
50 Lonsdale Street
MELBOURNE VIC 3000

Dear Professor Wallace Euan

I am pleased to provide you with this Statement of Expectations (SoE) for Safer Care Victoria. This SoE will be reviewed every two years in accordance with recommended practice or unless otherwise amended.

This SoE sets out my expectations of Safer Care Victoria in relation to the Victorian Government's commitments to ensuring that all Victorians, irrespective of their economic circumstances, receive world-class health care.

Objectives

Safer Care Victoria has been created in response to *Targeting Zero: Supporting the Victorian hospital system to eliminate avoidable harm and strengthen quality of care*, the final report of the Review of Hospital Safety and Quality Assurance in Victoria.

In line with the recommendations in *Targeting Zero*, Safer Care Victoria has been established to work in partnership with consumers, clinicians, health services, and the Department of Health and Human Services (the department) to drive quality improvement and the oversight of patient safety across healthcare services in Victoria.

Statement of Functions

The functions of Safer Care Victoria are to:

1. Support all public and private health services to prioritise and improve safety and quality for patients.
2. Strengthen clinical governance, lead clinician engagement and drive quality improvement programs and processes implemented in health services.
3. Provide independent advice and support to public and private health services to respond and address serious quality and safety concerns.
4. Review public and private health services and health service performance, in conjunction with the department, in order to investigate and improve safety and quality for patients.
5. Lead Victoria's contribution to the development of national accreditation and other clinical care standards by the Australian Commission on Safety and Quality in Health Care.

6. Undertake research and coordinate the provision of evidence-based research and guidelines throughout the sector.
7. Coordinate the efforts of clinical networks to:
    a. Reduce clinical variation and issue best-practice guidelines
    b. Report annually on improvement strategies
    c. Ensure improvement activities are coordinated.
8. Reduce avoidable harm by:
    a. Sharing trends and learnings from significant harm incident reports
    b. Respond to and anticipate health system issues relating to patient safety
    c. Coordinate system responses to specific safety events
9. Provide advice to the Minister and Secretary on any issues arising out of its functions.

Further, I expect that Safer Care Victoria will share data and information with the department and with the Victorian Agency for Health Information to enable each of these organisations to carry out its functions with respect to the funding, management, planning, monitoring, improvement and evaluation of health services. This includes data and information that may be received from third parties.

I expect Safer Care Victoria to put in place appropriate arrangements so that all data and information is protected by the security and privacy provisions outlined in legislation and in government policies. I also expect Safer Care Victoria to put in place appropriate controls to manage the risk of unauthorised disclosure of information.

Independence and Accountability

Safer Care Victoria has been established under section 11 of the *Public Administration Act 2004* (the Act) as an administrative office in relation to the department by Orders in Council dated 18 October 2016 and published in the Victoria Government Gazette on 20 October 2016.

Safer Care Victoria will operate as part of the Victorian Government and, under section 14(1) of the Act, the Chief Executive Officer is responsible to the Secretary to the department for the general conduct and effective management of the functions and activities of the Administrative Office and must advise the Secretary in all matters relating to the Administrative Office.

Consistent with the recommendations in *Targeting Zero*, Safer Care Victoria will perform its functions independently of the department and with a view to best practice. However, like other government agencies, I also expect Safer Care Victoria to take account of government policies and legislation in performing its role.

Further, I expect that Safer Care Victoria will promptly inform the department, and my office, in relation to any significant, sensitive or imminent issues, including media issues, and any known risks to the effective operation of Safer Care Victoria.

Annual corporate plan

I expect Safer Care Victoria to prepare a three year strategic plan for coordinating interdisciplinary improvement work and an annual corporate plan, which it will submit to the department within thirty (30) days of the start of each financial year. The corporate plan

should be developed in consultation with the department to ensure alignment between the strategic and annual work plans of the department and its entities.

I expect you to respond to this Statement with your first corporate plan by 1 November 2017, outlining how you intend to deliver your functions in the first year including details of key activities, timelines and targets.

Performance reporting

In addition to performance reporting required by the department, I expect Safer Care Victoria to provide to me as the Minister for Health an annual report within thirty (30) days of the end of each financial year. The report should detail the Administrative Office's key achievements and any challenges faced in delivering on your functions in the preceding year.

Finally, I expect this SoE, together with your corporate plan, to be published on the Safer Care Victoria website.

I look forward to seeing Safer Care Victoria's progress and its contribution to the strengthening of Victoria's health system.

Yours sincerely

Hon Jill Hennessy MP
Minister for Health
Minister for Ambulance Services

2 /10/ 2017

Safer Care Victoria

Safer Care Victoria report on clinical incidents occurring in hotel quarantine in Victoria

At the request of the Secretary of the Department of Health and Human Services, Safer Care Victoria undertook reviews into two serious clinical incidents involving detainees in hotel quarantine in Victoria. The first incident involved the apparent suicide death REDACTED (Hotel Quarantine Incident 1), and the second incident involved the care of [redacted] year old REDACTED who developed COVID-19 symptoms and deteriorated rapidly, requiring intensive care unit admission at the Alfred Hospital (Hotel Quarantine Incident 2).

Two teams of reviewers with relevant incident review and subject matter expertise were convened to undertake the reviews. The purpose of the reviews was to identify contributing factors relevant to the specific incidents, as well as provide insights into issues affecting the operation of hotel quarantine in Victoria, with the view to facilitating timely system improvements. To this end, the final output will be two separate reports, each detailing the contributing factors relevant to the incident, along with a summary of key high-level themes identified in both reviews which are relevant to the overall operation of hotel quarantine. These will be shared with the Secretary as well as the Operation Soteria Working Group, which includes representatives from Public Health, Emergency Operation Centre, Accommodation Commander, Welfare Cell, Office of Chief Psychiatrist and Safer Care Victoria. The Operation Soteria Working Group will be responsible for monitoring the implementation of the recommendations.

Herewith please find a draft report detailing the contributing factors for Hotel Quarantine Incident 1, along with a summary of key themes relevant to the overall operation of hotel quarantine in Victoria that have so far been identified across both reviews (see Appendix 2). The draft report for Hotel Quarantine Incident 2 will follow shortly.

The findings and recommendations provided are based on evidence and information available to the review teams at the time of writing and relate to issues and circumstances at the times and places the incidents took place (i.e. 3 to 13 April 2020). It is also noted that certain information sought by the review teams was not able to be provided or obtained, or was conflicting, and some individuals with potentially relevant information declined to be interviewed. It is further acknowledged that a number of recommendations and key themes may have since been addressed.

Yours sincerely,

REDACTED

REDACTED
Director, Patient Safety and Experience
Safer Care Victoria

Date: 10 June 2020

VICTORIA State Government

Incident review report: Hotel Quarantine Incident One

ENDORSEMENT

Review lead

Signature: REDACTED **Date:** 03/06/2020

Executive sponsor

Signature:  **Date:** 10/06/2020

REVIEW TEAM

Executive sponsor	Director, Centre for Patient Safety and Experience, Safer Care Victoria
Review project manager	Senior Project Officer, Centre for Patient Safety and Experience, Safer Care Victoria
Review lead	Academy Member, Safer Care Victoria
Human factors / methodology lead	Manager, Patient Safety Review, Centre for Patient Safety and Experience, Safer Care Victoria
Review coordinator	Senior Project Officer, Centre for Patient Safety and Experience, Safer Care Victoria
Team member	Academy Member, Safer Care Victoria
Team member	Chair, Mental Health Clinical Network, Safer Care Victoria
Review team support	Senior Project Officer, Safer Care Victoria
Administrative support	Project Officer, Centre for Patient Safety and Experience, Safer Care Victoria

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Safer Care Victoria

CONFIDENTIAL

ABOUT THE REVIEW

Background

On 11 April 2020, REDACTED was found deceased in his room at the Pan Pacific Hotel, Docklands, while in mandatory detention as part of the initiative that would later become known as Operation Soteria. As part of the response to REDACT death, the Secretary of the Department of Health and Human Services requested that Safer Care Victoria undertake an independent review into the incident. This report pertains to that review. We acknowledge that REDACT death will be examined by the Coroner, who is the authority on his official cause of death. However, for the purposes of this review, the review team considered his death as though it were a suicide.

Unless otherwise specified or indicated by grammatical tense, the information in this review describes and relates to the period of the incident, being 3 April 2020 to 11 April 2020. The team acknowledges, based on evidence provided during the review, that some systems and processes have changed since that time. This may mean that certain recommendations have since been addressed, or some findings do not reflect the current state. However, the methodology requires that the review address the events and circumstances as they were at the time.

Method

The ongoing detention of people in hotel quarantine, and need to identify and address any ongoing risks to these individuals in real time, necessitated a rapid review methodology. This methodology has certain limitations regarding data collection and scope. These limitations were weighed against the need for a rapid review process in making final determinations about the methodological approach and scope of the review. The review used a version of the AcciMap method, customised to use the London Protocol – both widely-recognised and validated approaches to rigorous incident review.

The review team acknowledges that REDACT death was unexpected for all involved. We note that in cases of suspected suicide, the purpose of a review is not to determine the 'cause' of the person's death, as this requires speculation about the state-of-mind and complex circumstances of the person who has died. Therefore, the review team cannot determine for certain whether changes to the events and factors surrounding REDACT death would have ultimately contributed to a different outcome. For this reason, the review focuses on addressing whether the management of REDACT quarantine corresponded to an adequate standard of care, based on the information available about him to those involved at the time. Therefore, in producing this report, the team do not purport to make any conclusions about fault or blame, nor whether any changes to the circumstances outlined would have prevented REDACT death.

Evidence

The team has collected and considered a variety of evidence, including (but not limited to):

- Interviews with staff from the following categories: DHHS/Operation Soteria management, welfare check team members, hotel team leaders, nursing staff, Authorised Officers and REDACT family.
- Templates, forms and questionnaires pertaining to detainee health and wellbeing including the 'Welfare Check – Initial long form survey', 'Confidential Hotel Questionnaire', 'DHHS Hotel Isolation Medical Screening Form' and 'COVID-19 Assessment Form'.
- Copies of the above containing REDACT information. Except for the 'Confidential Hotel Questionnaire', for which only a blank template was provided, despite the completed version being requested.

- Other ad hoc records including an incident report, Victoria Police witness statement, handwritten on-site nurse notes, Post-it notes, Pan Pacific Room Request records (provided for 5-7 April 2020).
- Plans, policies and procedures including 'Operation Soteria – Operations Plan', 'COVID-19 – Interim Healthcare and Welfare Mandatory Quarantine Plan (Draft)', 'Team Leader Pack – Hotels' and 'Referral Pathways for people issued COVID-19 quarantine orders'.
- Information for detainees including 'Mental Health and coronavirus (COVID-19) – Information for those in isolation' and 'Mental Health and Wellbeing'.

We acknowledge the cooperation and openness of the Operation Soteria staff who shared their experiences with us, and their willingness to do so despite the significant emotional impact the event had on some of them. We are especially grateful to REDACTED for providing information about REDAC who he was to those who loved him, his life, and the events surrounding his death, during their time of grief.

The information in this report is based on evidence and information available to the team at the time of review. It is noted that certain information sought by the team was not able to be provided or obtained, and some individuals with potentially relevant information declined to be interviewed. Therefore, the review team acknowledges that there may be unintended gaps or inaccuracies in the report that the team's reasonable efforts to seek required information were unable to rectify. The information presented was accurate - to the best of the team's knowledge – at the time of writing, given the information available to us, and with an eye to the potential limitations identified above.

Safer Care Victoria

INCIDENT REVIEW

Description of the Incident

On 03/04/2020 REDACTED was issued a detention notice after arriving from REDACTED where he normally resided. The detention notice required him to remain in hotel quarantine for 14 days.

REDACTED was detained as part of the Victorian government's response to the COVID-19 pandemic (later known as Operation Soteria), in line with a national agreement to require mandatory quarantine of any international arrivals after midnight 28/03/2020. REDACTED was detained alone in REDACTED at the Pan Pacific Hotel in Docklands, Melbourne.

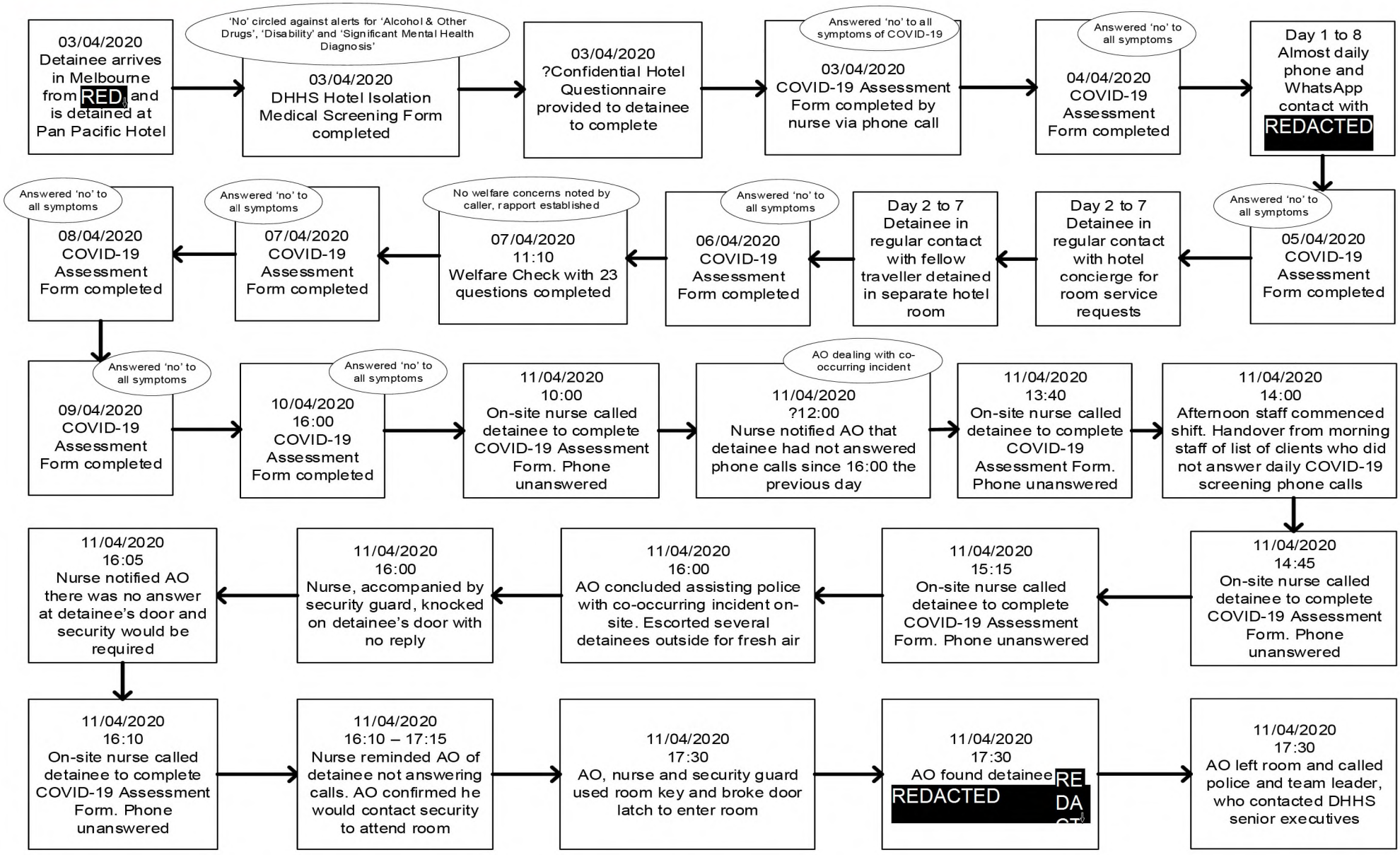
REDACTED

REDACTED on-site nurses phoned him daily to complete the COVID-19 Assessment form (to screen for COVID-19 symptoms). He completed this assessment daily, and did not report COVID-19 symptoms during his detainment. The 'Welfare Check – Initial long form survey' was completed on day five of REDACTED REDACTED No concerns were identified. The welfare check caller spent approximately REDACTED REDACTED

On 10/04/2020, there was a serious incident involving another detainee barricading themselves in their room. The incident resulted in significant police attendance and activity at the hotel. That incident continued into 11/04/2020 – the day REDACTED was found deceased REDACTED

Throughout day nine of his detainment (11/04/20), REDACTED did not answer repeated calls to his room from nursing staff attempting to complete the COVID-19 Assessment form. Nursing staff escalated the issue of R REDACTED unanswered calls to the Authorised Officer. The Authorised Officer attended to some other matters, including the barricading incident and other detainees with identified significant mental health concerns, before turning his attention to the concerns raised REDACTED On the basis of the repeated unanswered calls, at approximately 17:30 on 11/04/2020, the Authorised Officer, a security guard and on-site nurse attended RE REDACTED room, and obtained entry. They found REDACTED deceased. It appeared he had died by suicide, REDACTED REDACTED

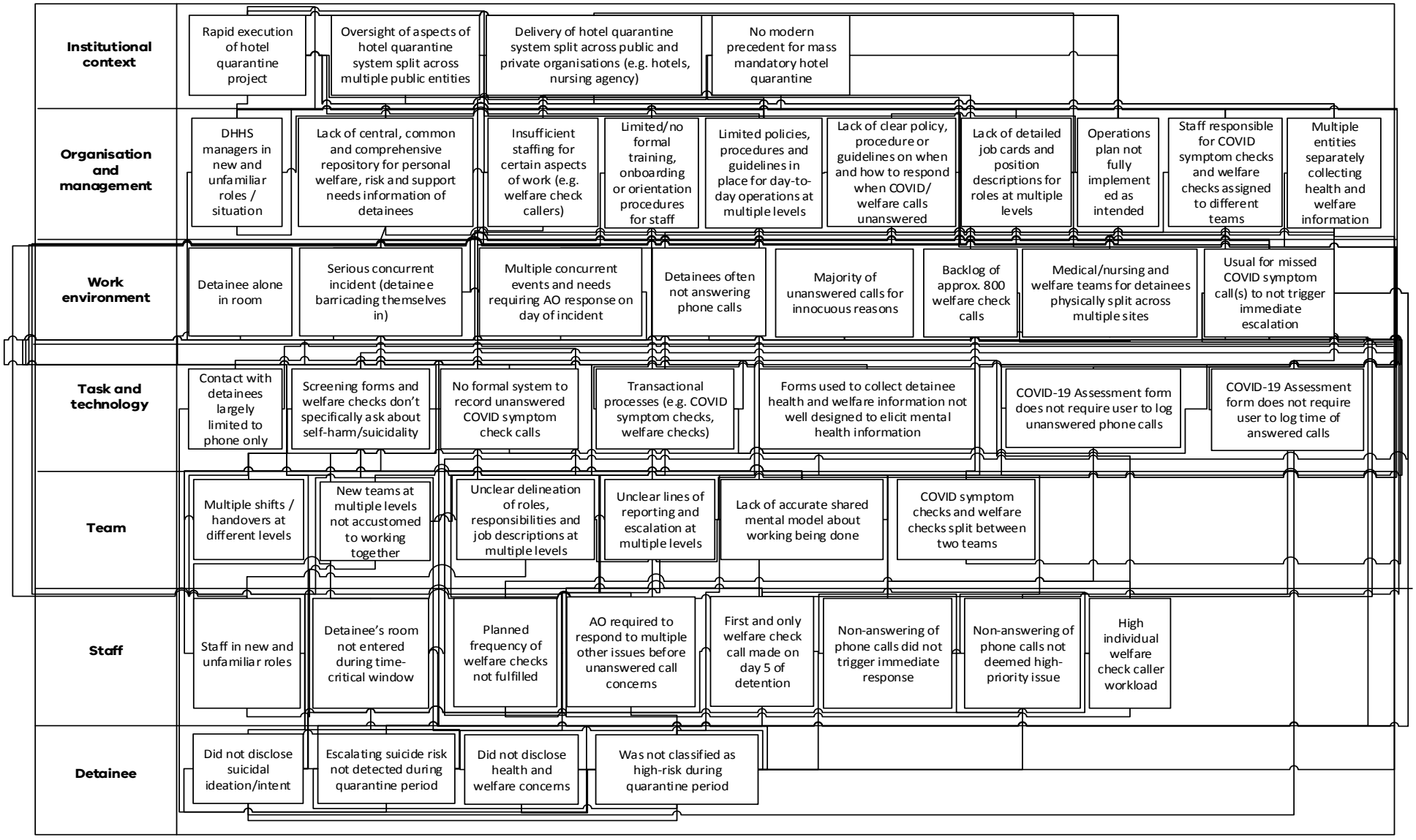
TIMELINE OF EVENTS



ACTOR MAP

Institutional context	Victorian Government	Department of Health and Human Services	Department of Jobs, Precincts and Regions			
Organisation and management	DHHS management					
Work environment	Hotel public areas	Hotel room	Hotel work areas	DHHS offices		
Team	DHHS Authorised Officer Team Leader					
Task and technology	DHHS Hotel Isolation Medical Screening Form	Welfare check - initial long form survey	COVID-19 Assessment Form	Confidential Hotel Questionnaire		
Staff	Welfare check caller	DHHS Authorised Officer	Nurse 1	Nurse 2	Nurse 3	Team Leader
Detainee	Detainee	REDACTED	REDACTED	Fellow detainee involved in major incident		

ACCIMAP



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ANALYSIS OUTCOMES

The review team has identified system and process improvement opportunities. Some are directly related to the event. These are described in 'Findings'. Others were identified in the course of reviewing the event, but the review team did not establish that they played a direct role in the events surrounding REDACTED death. These are described in 'Learnings'.

FINDINGS

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

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

Reasoning

While not completed prior to the incident, the Operation Soteria 'Operations Plan' is indicative of the intentions for running the hotel quarantine system at the time. It notes that DHHS would be responsible for the "provision of regular welfare calls to all quarantined passengers". The meaning of "regular" is not further specified. Interviewees advised the review team that the original intention was that welfare check calls would be made daily. Staff from outside the welfare check team indicated they believed or assumed that welfare check calls were and had always been made daily to all detainees.

Staff reported that at the time of the first and only welfare check call to REDACTED the welfare check team had a backlog of approximately 800 calls to work through. In interview, staff also noted that the script/form provided to welfare check staff for making initial calls to detainees included a paragraph – to be read to the detainee – telling the detainee to expect welfare calls "regularly". This script has been sighted by the review team. They told the review team that staff were instructed not to convey this information, as it was no longer accurate. In interview, staff indicated that due to the backlog, the revised aim was for two welfare calls to be made to detainees throughout their detainment.

Due to the backlog, the first welfare check call (to administer the 'Welfare Check – Initial long form survey') was not made to REDACTED until day five of his detainment. It was the only welfare check call made during the nine days of detainment before his death. Evidence obtained in interview indicated that it was not unusual for detainees who were not already identified as high risk to receive their first welfare check call around detainment day 5-7.

Detainee safety implications

The delayed and infrequent welfare check calls resulted in missed opportunities to monitor detainee welfare and meet duty-of-care obligations in a timely and consistent manner. It also resulted in missed opportunities for detainees to request support or disclose health and welfare concerns.

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

Reasoning

Welfare check team members reported that they had access to minimal information about detainees prior to calling them for the first time (by then, often day 5-7 of the detainee's detention). Information available to staff making these calls was typically only the detainee's name, date of birth, and expected detention period. Therefore, any information already collected about the detainee's health, welfare and support needs through other channels (including information in the 'welfare questionnaire' referenced in the 'Team Leader Pack – Hotels and Confidential Hotel Questionnaire'), was not accessible to welfare check callers.

The review team has sighted a template of the 'Confidential Hotel Questionnaire' provided to detainees. The template advises detainees that "the information [they] provide will be used to help support [them] during [their] quarantine period". However, the information gathered was not systematically shared with key teams responsible for detainee health and welfare, including welfare check callers and medical staff. The review team requested a copy of the completed 'Confidential Hotel Questionnaire' for REDACTED However, it was not provided. Therefore, it is unclear if REDACTED received and/or completed this questionnaire, or what answers and information he provided on it.

Similarly, staff reported generating and having access to health and welfare information about detainees that was not systematically made readily available to other teams and individual staff members. For example, information about detainee responses to daily COVID-19 Assessment Form calls was available to nurses, but not the welfare check team. In addition, some detainee health and welfare information was written on a whiteboard (visible only to some on-site staff), in staff member's personal notebooks (not visible to others), and on 'Post-it' notes.

Detainee safety implications

The lack of central, comprehensive and accessible repository for detainee health and welfare information resulted in inadequate communication about detainee health and welfare concerns and needs within and between teams. It also resulted in staff being unable to have holistic and global oversight to adequately identify, assess and manage health and welfare risks for individual detainees.

3. **Detainee health and welfare information was collected in a fragmented manner, involving multiple entities and teams and multiple formats.**

Reasoning

The review team has sighted multiple templates/forms/questionnaires/surveys, some of which have been completed about, for or by REDACTED Examples include the 'COVID-19 Assessment Form', 'Hotel Isolation Medical Screening Form', 'Welfare Check – Initial long form survey' and 'Confidential Hotel Questionnaire'. The content of these forms is not complementary – with evidence of both duplication and, in the view of the review team, notable omissions (see Finding 7).

For example, both the 'DHHS Hotel Isolation Medical Screening Form' and 'Welfare Check - Initial long form survey' ask detainees to answer questions about allergies and "immediate" health/medical conditions. And both the 'Welfare Check - Initial long form survey' and the 'Confidential Hotel Questionnaire' ask the detainee how

children/others travelling with them are “coping”. And the ‘COVID-19 Assessment Form’ and ‘Welfare Check - Initial long form survey’ both ask detainees about symptoms of COVID-19. By contrast, none of the forms sighted by the review team directly and clearly ask the detainee if they have mental health concerns aside from those attached to a formal medical diagnosis, if they are a smoker (there is a question about requiring nicotine patches, but the two are not synonymous), or if they would like to speak with someone about any issues of concern regarding their health and welfare.

The review team requested a copy of REDACTED ‘Confidential Hotel Questionnaire’, but this was not provided. It is therefore unclear if REDACTED received and/or completed this questionnaire, or what answers and information he provided on it.

The review team noted that day-to-day operations were marked by a lack of communication and coordination regarding detainee information collected through these fragmented channels. The review team also noted that the content of each form is focused on issues which match the specific functions of each of the entities and teams administering them. In interview, staff indicated that detainee health and welfare information was collected on separate forms because individual entities and teams were separately collecting only information required to fulfil their designated function. For example, the nursing team received the ‘Hotel Isolation Medical Screening Form’, the hotel received the ‘Confidential Hotel Questionnaire’, and the welfare check team conducted their own 23-question survey in the first call (therefore not receiving substantive information about individual detainees beforehand).

The review team’s view is that, most detainees were most likely unaware of the nuances of the complex structure of the hotel quarantine system and its many teams and entities. Therefore, it would have been unclear that information they provided in the varying forms was not shared among all those who had responsibility for their health and welfare. It would also have been unclear which form or team was most appropriate for raising concerns that were not explicitly addressed by the pre-formulated questions.

Detainee safety implications

The lack of a coordinated and consistent method for collecting detainee health and welfare information, and collating and sharing it, compromised staff members’ ability to adequately identify and manage health and welfare risks for individual detainees. It also compromised detainee’s ability to direct their health and welfare questions, support needs and concerns to the individuals and teams best suited to address them.

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

Reasoning

In interview, on-site staff tasked with completing daily COVID-19 Assessment symptom screening calls articulated a shared mental model that unanswered calls to detainees were almost never a cause for health and welfare concerns. They noted that most unanswered calls were the result of detainees being engaged in innocuous activities such as sleeping (they specifically sighted the effects of jet lag), bathing, talking on the phone or online, or using headphones. Staff reported that the daily transactional nature of the COVID-19 Assessment symptom screening calls became predictable to detainees, contributing to some who were asymptomatic not answering the calls, or taking the in-room landline phone off the hook.

The review team heard that on average, by the end of a typical day, between 5-15 detainees had not answered repeated COVID-19 Assessment symptom screening calls, and a nurse was required to knock on their door to elicit a response. Between them, staff reported that in their personal experiences of such follow-up 'door knocks', only one had uncovered a serious reason for the unanswered calls. Nursing staff and AOs reported that as a result, they did not routinely prioritise or escalate unanswered calls (beyond follow-up calls) until the end of the day, or even later.

In REDACTED case, there were at least five unanswered calls throughout 11/04/2020. Due to a lack of formal system for documenting these unanswered calls (see Finding 5), the review team could not be certain if there were more unanswered calls. There was a delay of more than 24 hours from the time REDACTED last answered a COVID-19 Assessment symptom screening call (approximately 16:00 on 10/04/2020 - as per police witness statement) to when the AO, nurse and security guard forced entry to his room at approximately 17:30 on 11/04/2020.

It is the view of the review team that the frequency of unanswered calls, and the pattern of these unanswered calls not indicating serious issues, resulted in less priority being placed on following up unanswered calls compared with other tasks. In REDACTED case, the AO noted the issue of REDACTED unanswered calls was escalated to him, but he was required to deal with multiple competing issues that he deemed to be of higher priority, before attending REDACTED room for follow-up. The other matters deemed to be of higher priority included the concurrent serious barricading incident, and providing assistance to several detainees with anxiety who has previously been identified as high risk.

Detainee safety implications

The shared mental model that unanswered COVID-19 Assessment symptom screening calls mostly did not indicate significant concerns increased the risk that a definitive response may be delayed. This posed a risk to safety in instances where the main indicator of a detainee's need for urgent assistance was unanswered calls.

5. **There was a lack of specific formal policy about the threshold for escalating concerns about repeated unanswered COVID-19 Assessment calls, and a lack of formal procedure for tracking these.**

Reasoning

In interview, staff stated there was no formal policy about when to escalate instances of repeated unanswered COVID-19 Assessment symptom screening calls for more definitive action (e.g. knocking on or opening the detainee's door), and no formal procedure for tracking unanswered calls. This lack of formal policy was corroborated by an email (sighted by the review team) from then Director, Emergency Management and Health Protection, South Division, to DHHS senior executive on 12/04/2020 (the day after REDACTED was found deceased). In that email, the Director cited the lack of such a policy, and the need for one to be developed.

The lack of clarity about the threshold for escalating unanswered calls was evident when the review team asked staff to describe the escalation process for unanswered calls. They gave variable answers as to when escalation should occur (e.g. after two calls, after four hours), but were clear that the AO was the appropriate line of escalation. They noted that when to act was a matter of judgement (in the absence of a formal policy), and their decisions took into account perceptions that AOs sometimes had high workloads and competing priorities.

In the absence of a formal policy or procedure, nursing staff described having developed a work-around to track and follow-up unanswered calls. If a call was not answered the first time, nursing staff would place the detainee's COVID-19 Assessment Form in a designated box. Nurses would later revisit that box "if [they] had time" and make the follow-up calls. The forms of detainees who answered follow-up calls were removed from the box. The forms of those who did not answer were returned to the box, and were revisited again when a nurse had time available. Post-it notes/whiteboard notes were also used to record the names of detainees with repeated unanswered calls. This cycle continued until the end of the day, when staff would attend the rooms of any detainees whose forms remained in the box, to knock on their doors.

The lack of policy and process for tracking unanswered calls was also evident in the COVID-19 Assessment Form, which does not require (or provide specific space for) the caller to log unanswered calls. It also does not provide space for callers to log the times of answered calls (only the dates). This issue was evident in RE REDA case, where the date of his last answered COVID-19 Assessment was recorded on his form, but not the time. Therefore, the extended time since his last answered call was not readily evident to all relevant staff.

Detainee safety implications

A lack of formal policies and processes around tracking and responding to unanswered COVID-19 Assessment calls increased the risk that a definitive response may be delayed. This posed a risk to safety in instances where the main indicator of a detainee's need for urgent assistance was unanswered calls.

6. **Due to workload and delegation challenges, Authorised Officers (AOs) were sometimes required to prioritise multiple competing demands, resulting in delays in attending to potential detainee health and welfare concerns.**

Reasoning

Due to the strict legal requirements around detention procedures, and the AOs specific legal role, they had limited ability to delegate tasks required of them under the Health and Wellbeing Act 2008. In addition, the ability to accurately predict any AO's workload from day-to-day was limited. This was due to multiple factors including a reported lack of prior information about the needs of the detainee cohort (and individual detainees) before arrival, and uncertainty about how these needs may arise and change over time. In interview, on-site staff reported that AOs were frequently very busy, juggling multiple competing demands for their time and attention.

This was seen in REDACTED as evident in interviews, as well as the AO's statement to police. On the day nurses escalated their concerns about REDACT unanswered calls to the AO, he was required to deal with a serious concurrent multi-day incident involving a detainee who had barricaded himself in his room, requiring significant police presence. Concurrently, the AO was required to attend at the rooms of multiple people identified as high risk due to anxiety-related issues. He attended to these issues before attending REDACTE room to follow-up the unanswered calls.

Detainee safety implications

Because AOs sometimes face complex competing demands and priorities with limited opportunities to delegate to non-AO staff, this may limit their ability to respond to detainee health and welfare needs or incidents in a timely manner.

7. **The forms for collecting detainee information were not well designed to readily elicit specific and detailed information regarding past or current mental health concerns, self-harm or suicidal ideation.**

Reasoning

The review team has sighted multiple templates, forms and questionnaires used to gather information from and about individual detainees. None of those sighted by the review team directly and specifically asked about past or current self-harm or suicidal ideation. Welfare check staff also reported they did not routinely ask such questions of detainees.

Overall, the forms sighted contained limited questions that addressed mental health. In the view of the review team, questions that did allude to mental health generally were not direct, in plain language, or written in a manner that was relatable and understandable to the general public. Where mental health was mentioned, this was typically done using a 'medical model' approach, focused on identifying diagnoses, but not more general issues about mental distress, risk factors or concerns that may not specifically correlate to a 'diagnosis'. For example, the questions may not have captured the concerns and risks associated with people worried about managing grief in quarantine. For example, the one direct mental health question in the 'DHHS Hotel Isolation Medical Screening Form' read "Significant mental health diagnosis Y/N". This question only clearly applied to those with a formal diagnosis, used the subjective word 'significant', and only provided for a binary yes/no answer (without encouraging further elaboration or disclosure). In another example, the 'Confidential Hotel Questionnaire's' possible allusions to mental health are vague and indirect (e.g. "are you feeling well at the moment?" and "do you or anyone in your group have any immediate health or safety concerns?"). It also contained questions about how children/people accompanying the detainee were "coping", but did not ask the same about the detainee themselves.

In the forms sighted, questions about their support needs place a significant onus on detainees to anticipate their psychological response to, and needs in an unfamiliar, uncertain and potentially stressful situation. And did so prior to detainees having spent any significant time in that situation. Of note is that the forms do not include a list of common support needs to select from (alongside free text space for other needs), which may otherwise assist detainees in identifying their likely support needs.

Detainee safety implications

Not routinely asking a specific question(s) about past or current mental health concerns, self-harm or suicidal ideation represented a missed opportunity for detainees to disclose this information, and thus the opportunity for their welfare and safety to be adequately supported. Forms designed in a way that did not readily elicit information about mental health information and associated risk factors compromised staff members' ability to adequately identify and manage health and welfare risks for individual detainees. It also resulted in missed opportunities for detainees to request support or disclose health and welfare concerns.

Safer Care Victoria

LEARNINGS

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

	Learnings
1	Separate welfare check calls and COVID-19 Assessment symptom screening calls were made to the same detainees by separate teams located at different sites (welfare check team and nursing team respectively). These teams had ostensibly different remits (general welfare checks vs COVID symptom screening), although the distinction was blurred in practice. This duplication of effort decreased the opportunity for holistic oversight of detainee health and wellbeing. It may also have increased the probability a detainee would mention concerns or issues during a call from one team, where those issues were within the remit of the other team, and the information would not be definitively acted upon.
2	Staff sometimes had to use (or felt they had to use) indirect means to request escalation and assistance regarding issues and concerns (such as use of general email addresses or helpline-like phone numbers). This lead to a delayed response or definitive action, or none at all. This was exacerbated by escalated issues being 'lost' in generic email inboxes which received copious numbers of emails, or because staff answering calls to generic helpline numbers were unable to provide definitive answers or actions.
3	Welfare check callers had been working remotely (the team understands this began after the incident), reducing the ability for their work interacting with detainees to be supervised and monitored for quality control and training purposes.
4	Staff putting themselves forward to take up temporary new roles in the hotel quarantine system did not have an adequate opportunity to nominate at the outset the types of roles for which they would or would not be suitable. In selecting and assigning the above staff to new roles, there were limited checks regarding their relevant skills, experience, education or professional background to assess their suitability. Therefore, some staff were placed in roles for which they were not suitably knowledgeable, skilled or experienced, or for which they were otherwise ill-suited.
5	For many new roles created for the hotel quarantine system, there was a lack of clear and detailed job descriptions and/or job cards at the outset, resulting in a lack of clarity about roles and responsibilities.
6	There was limited to no standardised formal training, orientation or shadowing for staff starting new roles in the hotel quarantine system.

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RECOMMENDATIONS

Recommendations describe actions that could be taken to address the findings and/or learnings identified in the review, and achieve system improvement.

The strength of recommendations (weak, moderate or strong) describes the overall likelihood that their implementation is likely to succeed in establishing sustained changes in risk and/or behaviour, and achieve the desired outcomes. This likelihood is determined based on general evidence about human factors, systems improvement and change management.

	Recommendation	Associated findings / learnings	Strength
A	Develop and implement a detainee arrival pack that consolidates the current suite of 'onboarding' forms into a single onboarding form (for data entry into the central repository in Recommendation H), alongside printed information for detainees.	Findings 2, 3 and 7	Moderate
B	Design the new onboarding form to: include a specific question(s) about past or current self-harm and suicidal ideation; be clear, direct and use plain language; not use relative, subjective words such as 'significant' to delineate what information is important; encourage disclosure beyond binary answers; address mental wellbeing from both medicalised and non-medicalised perspectives; and provide specific examples of common support needs.	Findings 3 and 7	Moderate
C	Establish a formal process to ensure each (newly consolidated) detainee onboarding form is reviewed by a single staff member within 48 hours, adopting a holistic approach, to identify and act upon any immediate or ongoing support needs or health and welfare risks factors, identify detainees requiring further risk and assign an initial risk level (see Recommendation D).	Findings 2, 3 and 7 Learnings 1 and 5	Weak
D	Establish a formal process for nursing staff (with additional clinical advice if required) to assign and monitor a health and welfare risk level (low, medium or high) for each detainee, based on all information available (e.g. onboarding form, 'initial screening call', staff observations).This level should be dynamic and changeable at any time in the face of new information or circumstances, with a schedule for regular review of each detainee's risk level.	Findings 3 and 7 Learning 1	Weak
E	Replace current daily COVID-19 Assessment symptom screening calls with daily 'health and welfare screening calls', delivered by nursing staff for detainees of **all risk levels**. Include in these calls the COVID-19 Assessment symptoms screening questions, and other basic health and welfare questions to screen for unmet support needs or elevated safety and welfare risks.	Findings 1, 3, 4 and 7 Learnings 1, 2 and 5	Moderate
F	For detainees classified as **medium or high risk** only, extend the purpose of the new daily 'health and welfare screening calls' (see Recommendation E) to specifically discuss, monitor and provide support around their specific health and welfare issues.	Findings 1, 3, 4 and 7 Learnings 1, 2 and 5	Moderate
G	For detainees classified as **low risk**, make the provision of regular 'check-in calls' from the welfare team an optional, opt in addition to receiving the mandatory 'health and welfare screenings calls' (to provide social contact and practical needs-check) (see Recommendation E). Implement processes for welfare team members with concerns to escalate these for potential re-classification of a detainee as higher risk.	Findings 1 and 4 Learning 1	Weak
H	Implement a comprehensive central repository for detainee's personal information (including health and welfare information) accessible to all staff with a role in providing services, care, support and oversight for detainees. Include functionality to provide an 'alerts list' for each shift to identify detainees with a medium or high risk level, and the reasons for those ratings.	Findings 2 and 3 Learning 1	Strong
I	In the central repository of detainee personal information, design the section for logging health and welfare calls (from the nursing and welfare teams) to include a specific field(s) for users to record the dates *and times* of both answered and	Findings 2, 3 4 and 5	Moderate

	unanswered calls to detainees (with the list of unanswered calls automatically visible to users).		
J	Offer detainees the option (at onboarding and throughout their detainment, for example via text message or email) to nominate a time slot each day in which they prefer to take calls from welfare and/or nursing staff, and call detainees during the nominated time slot.	Findings 1 and 4 Learning 1	Weak
K	Implement a formal policy about when to escalate situations in which detainees are not answering calls from nursing or welfare teams – using a decision-tree approach that accounts for factors such as number and frequency of unanswered calls, detainee's existing health and welfare risk factors, and previous behaviour in answering/not answering calls.	Findings 4 and 5 Learning 5	Weak
L	Increase and/or more strategically roster the number of AOs on duty at one time to ensure adequate baseline capacity, and rapid response surge capacity that AOs can directly and immediately request if they are task- or demand-overloaded.	Finding 6 Learning 2	Moderate
M	Establish a formal selection process for staff taking up new roles that accounts for their skills, preferences and attributes. Require that welfare team members have relevant background or experience (e.g. mental health, counselling, social work, peer support etc). Complement this with targeted initial and ongoing training and supervision (including for remote working staff) for all new and current staff.	Learnings 3, 4, 5 and 6	Moderate

APPENDIX 1: RECOMMENDATION ACTION PLAN TEMPLATE

Please outline the plan for how recommendations will be enacted.

If a recommendation has been wholly enacted when the report is received, indicate 'wholly' in column two of Table 1. Write N/A in subsequent columns of Table 1. Then complete Table 2 for that recommendation.

If a recommendation has been partly enacted when the report is received, indicate 'partly' in column two of Table 1. Complete the remaining columns in Table 1 for aspects of the recommendation that have not yet been enacted. Then provide details in Table 2 for aspects of the recommendation that have been enacted.

If no part of a recommendation has yet been enacted when the report is received, indicate 'no' in column two of Table 1. Complete the remaining columns in Table 1. Do not use Table 2 for that recommendation.

Table 1.

Recommendation	Already enacted (Write: 'wholly', 'partly' or 'no')	Actions still required to enact recommendation	Outcome measure(s)	Executive position sponsor	Position responsible/ accountable	Due date for completion
A						
B						
C						
D						
E						
F						

G						
H						
I						
J						
K						
L						
M						

RECOMMENDATIONS ALREADY IMPLEMENTED

If any recommendations have been wholly or partly implemented when the report is received, use Table 2 to provide details of what has been done, how implementation has been monitored (e.g. monitoring on-the-ground uptake and impacts – intended and unintended), and outcomes (using appropriate outcome measures).

Table 2.

Recommendation	Actions already completed	Monitoring undertaken	Outcomes

APPENDIX 2: KEY THEMES FROM HOTEL QUARANTINE INCIDENTS 1 AND 2

Operation Soteria Hotel Quarantine – Common themes arising from two incident reviews as of 15 May 2020.

Below is a summary of key quality and safety issues, and associated contributing factors, identified by Safer Care Victoria during their review of two incidents involving returned travellers in hotel quarantine in Victoria.

Based on evidence and information available to Safer Care Victoria at the time of writing, these issues were evident at the time of the two incidents REDACTED. It is noted that certain information sought by the team was unable to be provided or obtained during the data collection period. In addition, some individuals invited for interview in relation to these incidents declined to be interviewed during the data collection period.

Due to the ongoing detention of returned travellers in hotel quarantine as a result of the COVID-19 pandemic, a rapid review methodology was employed. This methodology has some limitations regarding data collection and scope. These limitations were considered against the need for a rapid review process to inform system improvement in real time. With that approach and goal in mind, the review teams share a summary of issues identified below.

Issue	Comments
Selection of staff	Victorian public sector staff putting themselves forward to take up temporary new roles in the hotel quarantine system did not have an adequate opportunity to pre-emptively nominate the types of roles for which they would or would not be suitable. In selecting and assigning staff to new roles, there were limited checks regarding their relevant skills, experience, education or professional background, in order to assess their suitability for particular roles. As a result of the above (and possibly other factors) some staff were assigned to roles for which they did not have the appropriate knowledge base, skill set or relevant experience.
Onboarding and training of staff	For many of the new roles created for the hotel quarantine system, there was a lack of clear and detailed job descriptions and/or job cards available to staff when they commenced in their roles. This resulted in a lack of clarity about individual roles and responsibilities. There was limited to no formal and standardised training, orientation or opportunities for mentoring available to staff commencing new roles within the hotel quarantine system. Some individuals reported taking the initiative to develop and provide training for their teams. However, these efforts were individually driven by frontline staff and were therefore not consistently adopted across the system. On the day of their first shift in their new role, some staff did not experience adequate handover from their counterpart who had worked the previous shift.
Continuity of staffing	Continuity of staff rostered at hotel locations was limited. This resulted in staff reporting challenges relating to their roles. These included issues relating to hotel familiarity, teamwork, clarity regarding roles and responsibilities, and continuity of support provided to returned travellers. Some staff reported requesting to be rostered at the same location and/or team. However these efforts were individually-driven by frontline staff, and therefore were not consistently adopted across the system.
Collection, storage and access to personal information about returned travellers	There were reports of inadequate and inconsistent systems and resources (paper or electronic) available for the recording information about returned travellers. As a result, such information (e.g. health and welfare notes, returned traveller requests and concerns) was commonly recorded in ad hoc ways (e.g. staff member's personal note books, post-it notes, whiteboards etc). During a returned traveller's period of detention, they were required to complete (either on paper or via phone) a variety of forms, questionnaires and assessments. These were administered by multiple entities and teams (i.e. nursing staff, welfare check team, hotel staff and the Department of Jobs, Precincts and Regions). The information gathered through the multitude of channels was not centrally coordinated and stored, and thus was not available to all staff who required it. As a result, staff often did not have the information needed to perform their roles optimally and provide adequate support and care to returned travellers. For example, welfare check callers did not have access to nursing notes or the hotel questionnaire when making calls to returned travellers.
Policies and procedures	A number of policies and procedures considered necessary to ensure safe operation of the hotel quarantine system were reported to be either under development or not readily accessible by frontline staff at the time these incidents occurred. For example, policies regarding appropriate use of personal protective equipment,

	escalation of concerns about returned travellers not answering calls, how to conduct handovers, record-keeping and issues tracking, or managing ambulance attendance. Some policies or procedures reflected plans and intentions that were not operationalised or achieved in practice (e.g. differences between planned frequency of welfare checks and actual frequency of these).
Escalation and leadership responsibilities	There was a reported lack of clarity among frontline staff about escalation processes and pathways, and the circumstances under which they should be utilised. Where formal policies or processes had been formulated, frontline staff reported being either unaware of these, or these were not operationalised fully. There was a reported lack of understanding amongst frontline staff in relation to decision-making hierachies in complex and unprecedented situations. For example, deciding on the appropriate level of clinical care, or when to escalate concerns about a returned traveller not responding to phone calls and door knocks. There was no dedicated role on-site with specific responsibility for decision-making regarding returned traveller health and wellbeing. This role was often either shared between nurses, or an informal 'lead' nurse was appointed for the shift by the nursing team, with access to consultation with a doctor (most often off-site) if required. Some team leaders, authorised officers and nurses reported not receiving adequate information about to whom they should escalate concerns (e.g. specific names, roles and direct phone numbers). Staff sometimes had to use indirect means to request escalation and assistance about issues and concerns (such as use of general email or 'helpline' phone numbers), leading to reported delayed or no response or definitive action.

APPENDIX 3: REPORT VERSION TRACKING

Date	Action
21/05/2020	Draft report shared with Merrin Bamert, Director, Emergency Management and Health Protection, South Division requesting fact check. Response received 22/5/20.
25/05/2020	Final report shared with Merrin Bamert, Director, Emergency Management and Health Protection, South Division and Operation Soteria Working Group.
03/06/2020	Role description under finding five updated in response to feedback from Andrea Spiteri, Director Emergency Management, Emergency Management Branch

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Safer Care Victoria report on clinical incidents occurring in hotel quarantine in Victoria

At the request of the Secretary of the Department of Health and Human Services, Safer Care Victoria undertook reviews into two serious clinical incidents involving returned travellers in hotel quarantine in Victoria. The first incident involved the apparent suicide death of REDACTED (Hotel Quarantine Incident 1), and the second incident involved the care of R[redacted]-year-old REDACTED, who developed COVID-19 symptoms and deteriorated rapidly, requiring intensive care unit admission at the Alfred Hospital (Hotel Quarantine Incident 2).

Two teams of reviewers with relevant incident review and subject matter expertise were convened to undertake the reviews. The purpose of the reviews was to identify contributing factors relevant to the specific incidents, as well as provide insights into issues affecting the operation of hotel quarantine in Victoria, with the view to facilitating timely system improvements. To this end, the final output has been two separate reports, each detailing the contributing factors relevant to one incident, along with a summary of key high-level themes identified in both reviews which are relevant to the overall operation of hotel quarantine. These will be shared with the Secretary as well as the Operation Soteria Working Group, which includes representatives from Public Health, Emergency Operation Centre, Accommodation Commander, Welfare Cell, Office of Chief Psychiatrist and Safer Care Victoria. The Operation Soteria Working Group will be responsible for monitoring the implementation of the recommendations.

Please find a draft report detailing the contributing factors for Hotel Quarantine Incident 2. The findings and recommendations provided are based on evidence and information available to the review team at the time of writing and relate to issues and circumstances at the times and places the incident took place (7 to 13 April 2020). It is also noted that certain information sought by the review team was not able to be provided or obtained, or was conflicting, and some individuals with potentially relevant information declined to be interviewed. It is further acknowledged that a number of recommendations and key themes may have since been addressed.

Yours sincerely,

REDACTED

Director, Patient Safety and Experience

Safer Care Victoria

Date: 17 June 2020

VICTORIA State Government

Safer Care Victoria

Incident review report: Hotel Quarantine Incident Two

ENDORSEMENT

Review lead

Signature: REDACTED **Date:** 12 June 2020

Executive sponsor

Signature: REDACTED **Date:** 17 June 2020

REVIEW TEAM

Executive sponsor	Director, Centre for Patient Safety and Experience, Safer Care Victoria
Review lead	Senior Project Officer, Patient Safety Review Team, Centre for Patient Safety and Experience, Safer Care Victoria
Human factors / review method advisor	Manager, Patient Safety Review Team, Centre for Patient Safety and Experience, Safer Care Victoria
Review coordinator	Project Officer, Centre for Patient Safety and Experience, Safer Care Victoria
Team member	Safer Care Victoria Academy Member
Team member	Safer Care Victoria Academy Member
Team member	Senior Project Officer, Centre for Patient Safety and Experience, Safer Care Victoria
Administrative support	Project Officer, Centre for Patient Safety and Experience, Safer Care Victoria

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While this report is accurate to the best of the authors' knowledge and belief, Safer Care Victoria cannot guarantee completeness or accuracy of any data, descriptions or conclusions based on information provided or withheld by others. Conclusions and recommendations relate to the point in time the review was conducted. Neither Safer Care Victoria nor the State of Victoria will be liable for any loss, damage or injury caused to any person, including any health professional or health service, arising from the use of or reliance on the information contained in this report.

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ABOUT THE REVIEW

Background

On 13 April 2020, R[redacted]-year-old REDACTED, was transferred by ambulance to the REDA[redacted] Hospital from the Four Points Hotel, Southbank, Melbourne, where R[redacted] had been in mandatory quarantine since returning from overseas. At the time of his transfer, REDACTED had returned a positive COVID-19 swab result on day seven, and had experienced rapid deterioration in his condition, having shown symptoms for several days. As part of the response to REDACTED transfer to hospital, the Secretary of the Department of Health and Human Services (DHHS) requested that Safer Care Victoria undertake an independent review into the incident.

Unless otherwise specified or indicated, the information in this review refers to the period of the incident 7 April 2020 to 13 April 2020. The team acknowledges, based on evidence provided during the review, that some systems and processes detailed have changed since that time. This may mean that certain recommendations have since been addressed, or certain findings may not reflect the current state.

Method

The ongoing detention of people in hotel quarantine and need to identify and address any ongoing risks to these individuals in real time, necessitated a systems review method that could be undertaken rapidly. The time limited nature of rapid reviews means that their data collection and scope are also limited. These limitations were weighed against the need for a systems review process in determining the review method and scope. The review used the AcciMap method, customised with elements of the London Protocol – both widely-recognised and validated approaches to rigorous incident review.

In cases of clinical deterioration, the review team cannot determine for certain whether changes to the contributing factors would have ultimately contributed to a different outcome. Therefore, the review team has focused on addressing whether the care REDACTED received, and management of RE[redacted] quarantine, corresponded to an adequate standard of care. The team has done so without making conclusions about whether any changes to the contributing factors would or would not have prevented his present situation. At the time of writing this report, REDACTED remains intubated and ventilated in the Intensive Care Unit at the Alfred Hospital, Melbourne.

Evidence

The review team has collected and considered evidence from a variety of sources, including (but not limited to):

- Interviews with seventeen people, drawn from the following groups: DHHS/Operation Soteria leadership, hotel team leaders, nursing staff, medical staff, authorised officers and REDACTED family and general practitioner.
- A letter to DHHS written by REDACTED (REDACTED) outlining RE[redacted] concerns in relation to the incident.
- Clinical notes and documentation relating to REDACTED.
- Audio recordings of telephone calls with Ambulance Victoria related to the incident.
- Plans, policies and procedures including 'Operation Soteria – Operations Plan', 'COVID-19 – Interim Healthcare and Welfare Mandatory Quarantine Plan (Draft)', 'Team Leader Pack – Hotels' and 'Referral Pathways for people issued COVID-19 quarantine orders.

The review team would like to acknowledge the cooperation and openness of the Operation Soteria staff who shared their experiences with us, and their willingness to do so. We are especially grateful to REDACTED family for providing information relating REDACTED and the events surrounding this incident during this difficult and challenging time.

The information in this report is based on evidence and information available to the team at the time of writing. Certain information sought by the team was not provided or obtained within the review timeframe, and some individuals declined an invitation to be interviewed. Therefore, the review team acknowledges there may be unintended gaps or inaccuracies in the report that the team's reasonable efforts to seek required information were unable to rectify. The information presented was accurate – to the best of the team's knowledge – at the time of writing, given the information available, and with consideration of the potential limitations identified above.

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DESCRIPTION OF THE INCIDENT

On 7 April 2020, REDACTED, REDAC and REDA were placed into mandatory hotel quarantine in adjoining rooms RED and RED at the Four Points Hotel, Southbank, Melbourne. This followed their arrival in Melbourne on a flight from REDACTED after disembarking from the REDACTED cruise ship, where they had been quarantined at sea for four weeks. REDACTED and RE relatives were detained in accordance with section 200(1)(a) of the Public Health and Wellbeing Act (2008) (Vic) as part of the Victorian government's response to the COVID-19 pandemic (Operation Soteria). This was in line with a National Cabinet agreement for international arrivals, after midnight 28 March 2020, to complete mandatory hotel quarantine for 14 days.

On days two and four of his quarantine, REDACTED reported physical symptoms to nursing staff (shaking and coughing). Nursing staff provided him with paracetamol. On day five, having been in contact with R and RE REDACT, REDACTED REDACTED general practitioner (GP) contacted nursing staff (via telephone) expressing concerns about REDACTED clinical presentation and symptoms. The GP relayed concerns that RE REDACT had a history of not appearing as unwell as RE was and queried whether RE may have urosepsis (sepsis causes by an infection of the urinary tract). In response, nursing staff attended to REDACTED in RE room, obtaining a self-administered swab for COVID-19 testing, and noting RE had a high blood pressure reading, a rapid heart rate and fever. After consulting with a doctor, nursing staff gave paracetamol. Later that day, a follow-up visit by nurses was conducted and it was noted by them that RE symptoms had improved.

Overnight from day five into day six, there were several contacts between RE and RE REDACT and nursing staff, with handover provided to the on-call doctor by nursing staff. During routine COVID-19 symptom screening on day six, REDACTED reported R did not feel feverish or shaky. In the subsequent hours, RE REDACT told RE REDACTE -based REDAC (by telephone) that REDACTED condition had worsened, but RE had been unable to contact on-site nursing staff for several hours, citing issues with the intercom system (in-room telephone). RED also told RE daughter RE had repeatedly requested help from a security guard to secure nursing assistance, without success. R and REDACTED daughter advised RE parents to call an ambulance.

REDACTED called 000 and was transferred to a secondary triage clinician (AV clinician). REDACTED relayed REDACTED history and symptoms, and RE concerns, particularly about accessing help if RE condition was to deteriorate overnight. The AV clinician contacted hotel nursing staff directly to discuss how to proceed. After discussions between the on-site doctor and nursing staff, the AV clinician and nursing staff then later agreed for nursing staff to visit REDACTED room and call the AV clinician back with their assessment.

In a subsequent call, nursing staff and the AV clinician discussed the importance of providing reassurance to REDACTED, noting the benefits of not dispatching an ambulance in the 'community interest'. After a series of failed attempts to contact REDACTED on the telephone, the AV clinician finally contacted RE REDACT via hotel reception while nursing staff were attending their room. The AV clinician repeated that it was not in REDACTED best interest to go to hospital, to which REDACTED responded with RE disagreement and concern. The AV clinician then spoke directly with REDACTED, at which point the nurse present in the room, subsequently took over the call. After relaying the features of REDACTED clinical presentation to the AV clinician, the AV clinician and nurse present in the room agreed that an ambulance was not needed and would not be dispatched. This was done despite protests from REDACTED, and without their explicit agreement.

On returning downstairs to the staff area of the hotel, the nurse advised the on-site doctor of the ambulance cancellation. After expressing concern the on-site doctor had a phone consultation with REDACTED, in which RE reported having fever, chills and fatigue. In two subsequent phone calls, REDACTED REDACT and staff discussed the ambulance cancellation and the most appropriate course of action for RE care.

On day seven, REDACTED condition deteriorated rapidly, marked by shortness of breath, dizziness, lethargy, chest pain, high blood pressure, a rapid heart rate, fever and low oxygen saturations. By then REDACTED positive COVID-19 swab result had been notified. Hotel nursing staff called an ambulance, which transferred RE REDACT to the REDA Hospital shortly after. RE was intubated and ventilated two days later (16 April 2020).

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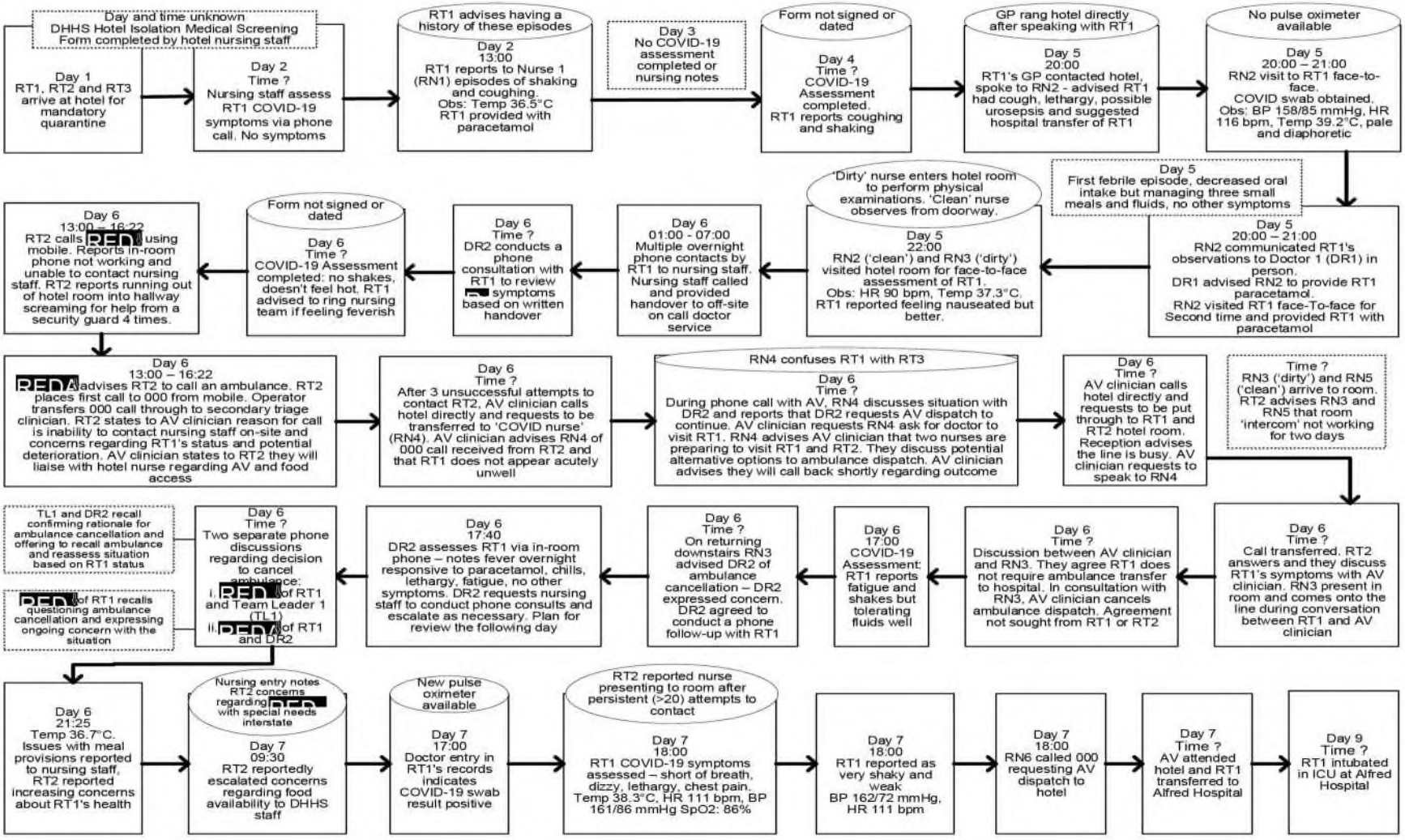
TIMELINE OF EVENTS

- On 7 April 2020 (Day 1), returned traveller (RT1), wife (RT2) and RT1's brother (RT3) detained at hotel after 4 weeks quarantined on a cruise ship.
- Accommodated in adjoining rooms.
- RT1: [REDACTED] history of cardiac disease and ulcerative colitis.



Glossary of terms

DHHS	Department of Health and Human Services
AV	Ambulance Victoria
RT1	Returned traveller 1
RT2	Returned traveller 2
RT3	Returned traveller 3
DR	Doctor
RN	Nurse
TL	Team Leader
HR	Heart rate
bpm	Beats per minute
BP	Blood pressure
mmHg	Millimetres of mercury
SpO2	Oxygen saturation
Temp	Temperature

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ACTORMAP

		Parties with no direct involvement
Institutional context	Victorian Government; Department of Health and Human Services (DHHS); Department of Jobs, Precincts and Regions; Chief Health Officer (Public Health Victoria); Public Health and Wellbeing Act 2008; Australian Border Force	
Organisation and management	State Emergency Management Centre (SEMC); Ambulance Victoria (AV); External nursing agency; External medical agency; Hotel groups	
Work environment	Hotels; Hotel rooms (adjoining); Staff office (Green room); DHHS offices; Remote working; Call centres (AV)	
Team	Nursing team; Medical team; Team Leaders; DHHS hotline (Emergency Operation Centre); DHHS Logistics team	Authorised Officers
Task and technology	Clinical consultation (Telehealth); Personal Protective Equipment; In-room communication system; Documentation system; Handover within and between frontline teams; Transfer procedures (hospital); Clinical equipment and sanitisation	
Staff	Team Leader 1; Nurse 1; Nurse 2; Nurse 3; Nurse 4; Nurse 5; Nurse 6; Doctor 1; Doctor 2; Security guard; AV clinician	
Returned traveller	Returned traveller 1 (Patient); Returned traveller 2 RED; Returned traveller 3 RED of traveller 1); RED of returned travellers 1 and 2; General Practitioner	

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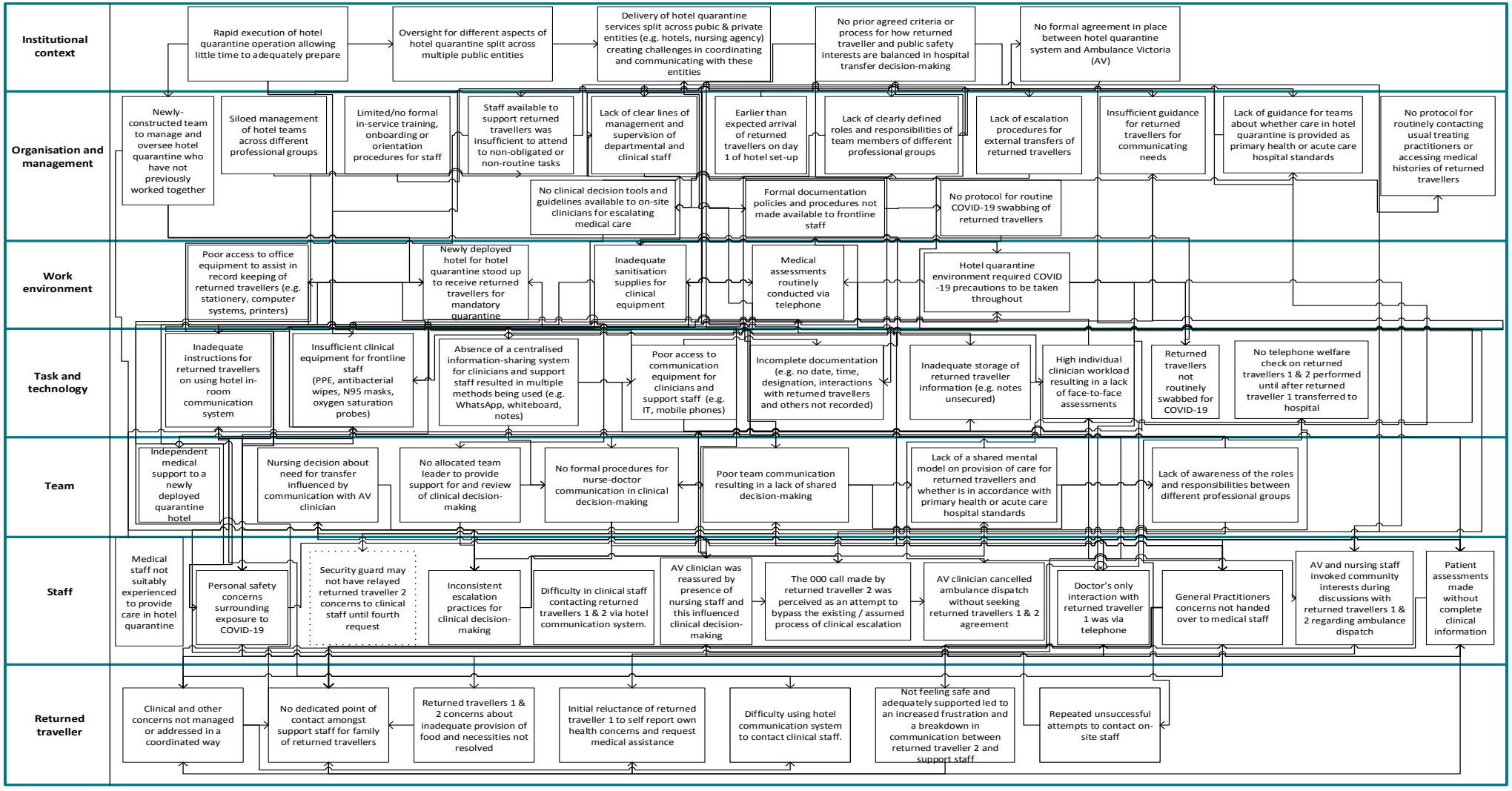
ACCIMAP

This AcciMap analysis reflects the system at the time this incident occurred. It does not consider any subsequent changes to conditions, processes or systems made after the incident.



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SYSTEMS ANALYSIS OUTCOMES

The review team has identified system and process improvement opportunities. Some are directly related to the event. These are described in 'Findings'. Others were identified in the course of reviewing the event, but the review team did not establish that they played a direct role in the events surrounding REDACTED deterioration and transfer to hospital. These are described in 'Learnings'.

FINDINGS

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

1. **On-site clinicians were constrained in their ability to conduct face-to-face clinical assessments when indicated due in part to an insufficient supply of readily accessible and reliable personal protective equipment (PPE). Medical consultation with returned travellers was routinely undertaken by telephone only, limiting the ability of medical staff to perform a complete and independent assessment.**

Reasoning

Staff took the risk of exposure to COVID-19, and transmitting it to others, very seriously. In interviews staff expressed concerns about these risks, and the resources available in the hotels to assist in mitigating them. In particular, they described a lack of sufficient, readily accessible, reliable and fit-for-purpose PPE for use while undertaking their roles. They also reported a need to prioritise and reserve use of available PPE supplies to allow certain staff groups to undertake their routine duties.

Consistent with safe work practices, staff would not enter the rooms of returned travellers for the purposes of providing clinical care without donning what they described as 'full' PPE, consisting of a gown, disposable gloves, mask and goggles. In interview, staff noted that they routinely lacked some components of full PPE, a situation which was confirmed in interviews with those in management roles. As a result, staff purposefully endeavored to provide clinical care, including clinical assessments, in a 'contactless' manner (specifically, by telephone), avoiding visiting or entering the rooms of returned travellers wherever possible.

The routine use of telephone-only consultation by both medical and nursing staff with returned travellers resulted in clinicians not being able to use visual cues or conduct a comprehensive physical examination during their clinical assessments and monitoring of returned travellers. These limitations in clinical assessment capability were compounded by a lack of clinical equipment and sanitation capacity (see Finding 2). Together, these limitations resulted in clinicians having to make clinical assessments and decisions based on incomplete clinical information.

Staff reported that on the occasions when returned travellers were physically examined, this was most often (although not always) done by nursing staff. Therefore, doctors (onsite and on-call) most often provided assessments and clinical decisions about returned travellers based on verbal information only, either from direct conversation with the returned traveller or their family member, or via information relayed by nursing staff.

These factors were observed in REDACTED case whereby staff expressed an initial (and ongoing) hesitancy to attend to RE face-to-face. In RE case, despite having experienced many days of symptoms, RE was not directly sighted or physically attended to by a doctor until day seven, when the second ambulance was called by nursing staff. Therefore, assessments about the seriousness of and

deterioration in RE condition, and related decision-making, were based on incomplete, and likely inadequate, information.

Returned traveller safety implications

The delays in and reduced intervals of face-to-face clinical assessments resulted in missed opportunities to monitor and trend clinical parameters in a timely and consistent manner. It also resulted in a missed opportunity for comprehensive physical assessment and for returned travellers to directly express any health and welfare concerns to medical staff.

2. **Unavailable or unreliable access to clinical equipment for physical examination and clinical monitoring of returned travellers, resulted in clinical decision-making being based on incomplete clinical information and assessment.**

Reasoning

Staff reported that they did not have access to the clinical equipment they required to fully examine, assess and monitor the clinical status of returned travellers. Clinical equipment not always readily available included pulse oximeters (to measure blood oxygen saturation levels) and COVID-19 swabs. They also noted that a lack of adequate sanitisation supplies and equipment (e.g. sanitising agents and wipes) limited their ability to use the items they did have (e.g. stethoscopes and blood pressure cuffs), especially as re-use for multiple returned travelers is necessary. In the absence of access to adequate clinical equipment and ability to sanitise equipment, staff were unable to perform complete clinical assessments of returned travellers. This limitation of being unable to conduct thorough clinical assessments was compounded by the practice of routinely providing care to returned travellers without physically seeing or attending to them (see Finding 1).

These factors were observed in the case of REDACTED in that several assessments of RE physical condition were conducted by telephone only, and during interviews staff suggested that inadequate pulse oximeter access may have contributed to a delay in clinical staff being aware REDACTED had low oxygen (O_2) saturation levels. An earlier awareness of this clinical sign, had low O_2 saturation been present, may have influenced the decision to cancel the ambulance called on day six.

Returned travellers safety implications

Clinical staff not having access to the equipment necessary required to perform complete assessments resulted in clinical decision making based on incomplete information, specifically in the absence of key markers of COVID- 19 prognosis and deterioration. This may have contributed to missed opportunities for clinical staff to adequately assess REDACTED .

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3. **Staff involved in clinical assessments and decision-making often did not have timely, direct access to returned traveller clinical and welfare information to perform their roles effectively.**

Reasoning

In requesting information and evidence to undertake the review, the challenges experienced by staff were evident. These mainly related to difficulty readily locating and accessing information from records about specific returned travellers. This was partially due to the fragmented nature of how this information was collected, stored and accessed. There was also a need to navigate the multiple entities, sources and necessary permissions associated with accessing the information.

Similarly, staff reported being unable to readily access required health and welfare information about returned travellers due to the absence of an accessible, comprehensive, central repository for this information. Staff reported that this made it difficult to identify returned travellers with high and/or escalating health and welfare risks, especially monitoring this across different shifts, over time, and between different teams (e.g. nursing and medical staff). This impaired their ability to have good visibility of the full clinical picture of unwell returned travelers in a timely manner. It also affected attempts by staff to provide a holistic and coordinated response to distress or frustration among returned travellers who felt that their support needs were not being met. These limitations in accessing information meant that staff did not have the complete information required to make fully informed clinical and non-clinical decisions about the care and support of returned travellers.

In REDACTED ' case, these limitations meant that staff did not have ready access to all available information regarding RE medical history; risk factors for COVID-19 complications; the length and deteriorating nature of RE condition; and the context, events and issues that contributed to RE and REDACTED ' concerns about accessing help when needed.

Returned travellers safety implications

The absence of a coordinated and consistent system for the management of returned traveller health and welfare information, including its collection, recording and sharing, compromised the ability of staff members to adequately identify and manage health and welfare risks for individuals. It also reduced returned travellers' ability to direct their health and welfare questions, support needs and concerns to those best placed to efficiently and effectively address them.

4. **The number and skill set of staff rostered on shifts in the hotel quarantine system did not always match workload demands and the health care needs of returned travellers. This resulted in delays or tasks not being completed when needed to address returned traveller health and welfare.**

Reasoning

Staff reported consistently having high workloads and managing multiple competing demands – to the extent that they were often unable to attend adequately to the needs of returned travellers, or systematically address concerns raised by returned travellers in a timely manner. Routine tasks that nursing staff were required to undertake included completing initial medical screening forms; conducting COVID-19 assessment symptom checks; obtaining medication lists from returned travellers to arrange prescription and dispensing of necessary medications; and undertaking COVID-19 testing (swabs) in symptomatic returned travellers. In addition to these tasks, nursing staff were responsible for assessing returned travellers in their rooms, if deemed necessary and the needs of returned travellers could not be adequately addressed over the telephone. This required one nurse to

stay outside (referred to as the 'clean' nurse), while the other nurse would don PPE and enter the room (referred to as the 'dirty' nurse). In the context of many other competing tasks, this meant that direct nursing assessment of returned travellers was time and resource intensive.

Staff reported problems with both baseline levels of staffing, as well as the adequacy of staffing in response to surges in workload demand. At any given time, there were generally three nurses rostered onto a shift, attending to the health needs of all the returned travellers, (approximately 200 to 350). On the day REDACTED arrived at the hotel, there were only three nurses on-site to receive the new cohort of approximately 200 returned travellers, who had arrived earlier than had been expected (see Finding 10). Staff described the experience as 'chaotic' and highlighted the challenges of attending to a cohort of mostly older returned travellers with multiple health needs.

On day six of REDACTED stay, medical staffing was provided by one on-site doctor during the day, and an on-call doctor overnight (who was responsible for the provision of services to several hotel quarantine sites concurrently). In addition to addressing the routine and ad hoc health needs of returned travellers, nursing and medical staff were also involved in sourcing the equipment they needed to perform their duties (e.g. pulse oximeters, blood pressure cuffs, cleaning equipment, stationery). They were also called upon by returned travellers to assist in procuring items such as books, toys, and games. The diverse nature of the tasks that frontline staff were required to address added to the cognitive and physical demands of their work.

The skillset and level of experience of the nursing staff was variable and included those with backgrounds in general medical, oncology, surgical and emergency nursing. The pool of medical staff working in the hotel quarantine system was equally variable and included hospital medical officers with less than two years of experience, working as independent medical practitioners. Most of the frontline staff had not previously worked in a similar detention setting and had not been provided with any formal guidance on the tasks they were undertaking (see Findings 8 & 9).

The high workload and limited number of staff generated a backlog of work that resulted in routine tasks not always being completed. This was reflected in documentation relating to REDACTED case. RE daily COVID-19 symptom screening checks were not always recorded as having been conducted, and RE did not receive a welfare check telephone call for the entire duration of RE time in hotel quarantine. REDACTED received RE initial welfare check call on day nine.

Returned travellers safety implications

Staff facing high workloads and multiple competing demands led to routine tasks including health and welfare checks not being completed in a timely manner. This limited the ability for staff to identify and promptly act on returned traveller needs and concerns.

5. Outside of routine targeted COVID-19 symptom screening checks, some returned travellers did not receive timely welfare screening checks, which reduced the opportunity to identify and address their needs and concerns in a suitable and systematic way.

Reasoning

Clinical staff were required to conduct daily COVID-19 symptom screening using the 'COVID-19 Assessment' form. The purpose of the form was to identify if the returned traveller was potentially symptomatic with COVID-19. Returned travelers were asked if they had any of five symptoms of COVID-19, (fever, cough, shortness of breath, sore throat and/or fatigue) each day via telephone. The form did not specifically prompt staff to inquire about any broader health and welfare issues.

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Screening for such broader health and welfare matters was the responsibility of the DHHS welfare team, who were remotely located and were tasked with conducting welfare checks with returned travellers by telephone.

During interviews, staff reported that the welfare team experienced a significant backlog in overdue calls to be made. This meant some returned travellers did not receive their first welfare check call (to complete the 'Welfare check – initial long form survey') in a timely manner. This resulted in missed opportunities to identify and address returned travellers' concerns early, establish rapport and clear channels of communication, and provide returned travellers with information about how to access support, if needed.

Neither R nor REDACTED received a welfare telephone call to complete the 'Welfare check – initial long form survey' before REDACTED transfer to hospital on day seven. A copy of RE REDACTE form (completed on day nine, after REDACTED hospital transfer) was sighted by the review team. This form included responses to questions which, had they been flagged and appropriately referred earlier, may have assisted staff to appropriately identify and act upon RE REDACTE escalating concerns. Responses indicated REDACTED expressing RE was very unhappy with the responsiveness of nursing and medical staff in the hotel. Having an awareness of this may have allowed staff to ameliorate REDACTED frustration that RE needs were not being adequately met. In turn, this may have assisted the returned travellers to feel safer and more supported. It may have improved the relationship and collaboration between the returned travellers and staff. A welfare check may have provided an opportunity to provide REDACTED with information about how to successfully contact staff to ask for help, and how to escalate any additional unaddressed concerns.

Returned travellers safety implications

The delay in conducting initial welfare check calls resulted in missed opportunities to monitor returned traveller welfare in a timely and consistent manner. It also resulted in significant health and welfare concerns not being disclosed, identified and missed opportunities to attempt to resolve these by direct escalation to the most appropriate person/agency.

6. Frontline staff working in the hotel quarantine system did not have access to adequate resources, training support and polices relating to documentation and record keeping of health and welfare information for returned travellers. This resulted in the information often being incomplete, inconsistently recorded, not fit-for-purpose, and not readily accessible by relevant staff.

Reasoning

Staff reported an overall lack of resources for record-keeping, such as stationery, forms/templates, access to printers, (including permission to use printers being granted at the discretion of individual members of hotel management), IT equipment and systems. Staff reported that they had to develop ad hoc workarounds, including sourcing their own supplies of stationery from office supply retailers, and using personal notebooks to keep clinical records, which did not always remain onsite or securely stored. They also reported that there was a lack of formal policies, systems and training to guide them in documenting returned traveller information and events that occurred during each shift.

This was reflected in the clinical notes and records sighted by the review team. Records were often created in ad hoc formats, using resources that were not specifically fit-for-purpose (e.g. handwritten records in notebooks, on loose and nondescript pieces of paper). In addition, information about returned travellers (including their health and welfare), was often not systematically filed or was inter-

dispersed with information about other returned travellers. Documentation was frequently missing key information such as dates, times and staff identifiers (names, signatures and designations).

Limitations in the quality of record-keeping impaired staff members' ability to proactively identify returned travellers with high and/or escalating health and welfare risks, especially across different shifts, over time, and between different teams (e.g. nursing and medical). It also impaired their ability to see the full clinical picture, and better understand the reasons for returned travellers' reactions and behaviour.

The lack of a centralised, coordinated system for logging and monitoring issues raised by returned travellers resulted in concerns and needs raised by REDACTED either being incompletely addressed, addressed after considerable delay, or not addressed at all. These returned travellers had a range of health and welfare needs that, during interview, were described by staff as unanticipated. As also described in Finding 10, the limited set-up time, and staff onboarding and training meant that the manner in which health and welfare concerns were identified and addressed was often inadequate and inconsistent.

The experience of not having RE concerns appropriately tracked and actioned meant that RE REDACT sought support through alternative means, namely by seeking help from a security guard in the hotel, telephoning RE REDACT, REDACTED usual GP and ultimately 000 to request an ambulance.

Unavailable, incomplete and conflicting records contributed to staff members making clinical decisions with incomplete and/or inconsistent information. Some staff may not have been sufficiently aware of events and issues that contributed to REDACTED feeling unsafe and unsupported.

Returned travellers safety implications

Unavailable or inconsistently documented records relating to returned travellers resulted in increased frustration experienced and/or expressed by some, who often needed to raise their concerns repeatedly with multiple staff members for appropriate action to be initiated. Staff receiving this information, either through routine or ad hoc contact with returned travellers, may not have been privy to earlier concerns raised and may have borne the brunt of cumulative frustrations they expressed.

7. Many clinical staff were unclear on the processes for escalating health concerns raised by returned travellers, which resulted in independent ad hoc decision-making by staff.

Reasoning

Staff reported not being suitably aware or understanding policies and processes about escalating concerns, including about returned traveller health and welfare issues. This included who to escalate to, how to escalate, and circumstances that necessitate escalation. Clinical staff reported feeling unsure, and lacking formal guidance, about who had authority to make certain decisions (e.g. ambulance cancellation), and who was 'ultimately responsible' for making final decisions in certain clinical situations.

Staff reported that, on some occasions, certain issues could only be escalated through indirect channels. These channels included generic email addresses that were overwhelmed with incoming emails or general 'hotline' phone numbers, where call-takers were unable to offer definitive assistance. Staff reported that these indirect methods often resulted in slowed or no responses to their questions or concerns. In such instances, staff reported that they sometimes took steps to seek advice from others (e.g. by telephoning or emailing their counterparts at other hotels or identifying

contact details for relevant individuals). At times, this resulted in inconsistent advice that led to more confusion.

Staff noted that there was no clear, designated clinical care lead on-site, each shift (i.e. a line manager for the clinicians). This meant that it was unclear to whom they should escalate clinical concerns or complex cases requiring leadership input or guidance on how to proceed. Some staff reported developing informal workarounds for this issue, such as appointing a 'head' nurse for the shift through consensus agreement, based on who had worked at the specific hotel for more than one shift only. However, these workarounds remained informal and person dependent.

Returned travellers safety implications

Limited understanding of the processes to escalate clinical concerns were evident, e.g. the challenges in resolving different views among doctors and nurses regarding ambulance dispatch/cancellation and the best course of clinical care.

8. **Team-based care and care continuity for returned travellers was compromised by inadequate handover, issues tracking and communication processes within and between teams, and with external health practitioners.**

Reasoning

As described in Findings 3 ,6 and 8, information and communication systems and processes in the hotel quarantine system were fragmented and ad hoc. Staff noted a lack of formal handover policies and processes between shifts, as well as for inter-team communication during shifts. Some described developing ad hoc workarounds to address these limitations, but these efforts were individually driven, and thus not always consistently applied.

No central repository for returned traveller health and welfare information combined with ad hoc record-keeping, meant that returned traveller concerns, health needs and welfare issues were not well tracked. This included a lack of formal systems for collecting and acting upon concerns raised by returned travellers' usual treating clinicians in the community. Therefore, there was no systematic way to track that issues were acknowledged, responded to, actioned, and then finalised, and to assign accountability for these steps. Staff noted that responses to these issues or concerns were often delayed, incomplete or unaddressed.

These limitations in communication, issues-tracking and handover contributed to staff needing to make both clinical and non-clinical decisions without a proper overview of all the relevant information. It also contributed to inconsistent advice and information being provided to returned travellers.

Returned travellers safety implications

The information and concerns raised by REDACTED usual general practitioner (in the community) were not adequately conveyed or available to those making clinical decisions at that point in time or later. Similarly, there were minimal records kept of the multiple contacts between REDACTED and staff; of REDACTED difficulties with making contacting with staff by telephone and of the lack of a welfare check call, as well as of the concerns RED had raised. This resulted in staff having an incomplete view of RE experiences. This may have contributed to staff not appreciating the extent to which REDACTED felt unsafe and unsupported whilst in quarantine.

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9. Some staff were unclear on the scope of their role, as well as the delineation of roles and responsibilities within and between teams, which affected team care delivery and completion of tasks to address returned traveller health and welfare needs.

Reasoning

During interviews, staff reported that they had not felt suitably briefed on the purpose and scope of their role, and the broader context in which they were operating within the hotel quarantine system. This included being uncertain about the boundaries and delineations between different teams within the hotel quarantine system, including in supporting the health and welfare of returned travellers. They described not receiving job descriptions or job cards pertaining to their roles, and limited or no formal training, orientation or supervision. Some reported that the extent of their 'onboarding' was an informal and brief 'handover' on their first day, from the person who worked their role in the previous shift, who was themselves often new.

The lack of a formally designated clinical lead role on-site (see Finding 7) contributed to uncertainty about lines of escalation and hierarchies of responsibility. In addition, some medical staff were in roles that exceeded the level of independent decision-making responsibility and accountability, and involved lower levels of supervision, than they had in their usual substantive roles, (this relates to both clinical and non-clinical roles).

Together, the lack of clarity about roles and responsibilities led to some tasks not being completed, and others being completed inconsistently, or in a delayed manner. It also put clinicians in situations where they had to make clinical decisions without being certain about their authority to do so, or the correct escalation processes to follow.

Returned travellers safety implications

In REDACTED case, interviews and recordings relating to interactions between staff working in the hotel and Ambulance Victoria show that there was mutual uncertainty about processes around ambulance dispatch or cancellation, and who should perform what role in decision-making regarding this. During interviews, staff also described a lack of agreement between nursing staff and medical staff about who (if anybody) had the authority to agree to the cancellation of an ambulance called by returned travellers.

10. The earlier than expected arrival of returned travellers during the hotel's designated set-up period for mandatory quarantine use, limited the ability of frontline staff to orient returned travellers and effectively implement processes to address their health and welfare needs.

Reasoning

Staff reported that the first cohort of travellers (which included REDACTED) arrived unexpectedly during the period designated to set the hotel up as a mandatory quarantine site. They described how this led to a disrupted and truncated time to set up the hotel, become familiar with and implement systems, policies and procedures, before receiving returned travellers. This affected the 'onboarding' of staff and may have contributed to staff not being fully aware of policies and procedures that existed at the time. The earlier than expected arrival therefore affected the 'onboarding' of staff (see Finding 6) as well as the orientation of returned travellers to their quarantine environment. A potential repercussion of this may have been that inexperienced staff onboarded subsequent staff. Staff mentioned that the earlier than expected arrival of the returned travellers may also have contributed to lack of access to adequate resources of various types (e.g. stationery, IT resources, record-keeping resources, clinical equipment, sanitisation supplies and PPE). These

played a role in the clinical care provided to REDACTED (see Findings 1 and 2). In turn, this reduced staff capacity to identify returned travellers who had health, welfare and/ or other concerns and required extra support. This was evident in REDACTED not receiving a welfare check call prior to RE transfer to hospital.

The quality of orientation of returned travellers to their new environment was also negatively impacted. For example, returned travellers received little or no instructions on how to access help and support. This meant that REDACTED was not adequately supported in learning how to use the hotel's in-room communication system and was not provided with alternative options for seeking help.

Returned travellers safety implications

Insufficient staff preparation time has immediate and latent negative effects on the systems and processes needed to address the health and welfare needs of returned travellers.

11. There was no clear agreement between the hotel quarantine system and Ambulance Victoria (AV) about managing the hospital transfer needs of returned travellers. This contributed to improvised clinical decision-making by frontline staff.

Reasoning

If a returned traveller became unwell and required transfer to hospital under quarantine conditions, there was no evidence of any formal policies or guidelines to support clinical staff in their decision-making. The review team confirmed that there was no formal agreement between the hotel quarantine system and Ambulance Victoria to address the hospital transfer needs of returned travellers.

After the initial 000 call was placed by REDACTED requesting an ambulance, there were several calls between AV and the hotel to identify the appropriate people to communicate with and determine the best course of action. There was discussion regarding whether to contact the returned travellers directly, or whether hotel staff or nurses should act as conduits. The ambulance requested by RED REDACT was not dispatched, instead the AV clinician sought further information from others at the hotel.

The decision to not dispatch an ambulance was reached during a conversation between the AV clinician and a nurse attending to REDACTED in RE room. REDACTED was considered at high risk of being COVID-19 positive. Considering RE age and comorbidities, the shared decision not to dispatch an ambulance appeared to be based in part on the nurse's observations that R was 'standing', 'not dehydrated' and on incomplete clinical assessment outlined in Findings 1 and 2. It was also influenced by consideration of the risk of community and occupational risk of COVID-19 transmission. The AV clinician and nurse purported the importance of 'community interests' as a factor in deciding whether to dispatch an ambulance – a formal agreement would perhaps have provided guidance on whether factors outside of clinical need should be considered in making dispatch decisions.

The initial conversation between the AV clinician and REDACTED was interrupted by the nurse who had entered their room which meant their concerns may not have been fully heard, they disagreed with cancelling the ambulance and protested the decision.

Returned travellers safety implications

In the absence of a formal agreement, balancing the acute health needs of deteriorating returned travellers with broader community safety risks relies solely upon the individuals working at the time to determine the most appropriate response. The concerns of returned travellers, which reflects their understanding of their own health, is an important consideration in any hospital transfer decision.

LEARNINGS

Learnings describe system issues for which there was insufficient evidence that they contributed to the incident, but nonetheless provide important opportunities to improve.

	Learnings
1	There was limited to no standard process for routine early screening for COVID-19 of returned travellers in hotel quarantine. For returned travellers both with and without demonstrated or reported COVID-19 symptoms, testing was performed on an ad hoc basis, at the discretion of clinical staff. As a result, it was common for asymptomatic returned travellers to not undergo testing for the duration of their hotel quarantine period.
2	Staff working in the hotel quarantine setting were not aware of the process for managing instances in which a COVID-19 positive result was obtained for a traveller accommodated in the same hotel room as another returned traveller(s). Staff were unclear on the process of separating returned travellers in these instances, and relocation to a different room for the remainder of their quarantine period was at the discretion of the returned travellers involved.
3	The in-room communication system (i.e. hotel room telephone) was not able to be used by some returned travellers in order to make calls external to the hotel. As a result, it was necessary for some returned travellers to use their own personal mobile telephones to communicate. However, some returned travellers did not have suitable access to a functioning mobile telephone (e.g. if they had been overseas for an extended period or did not have adequate reception or access to suitable telephone charger or credit to make calls).
4	There was inconsistent language used to describe returned travellers in hotel quarantine (e.g. passengers, guests, detainees). Some of the terms have connotations that could bring unconscious bias to the way they are cared for by the staff working in the hotel quarantine environment.
5	Inconsistent rostering practices exacerbated the perception by staff working in the hotel quarantine environment that their work was temporary in nature. Some staff were rostered to work a single shift across different hotels, which prevented them from gaining familiarity with the operations of the specific hotel, the other staff members, or the returned travellers in their care, and may have contributed to a lack of shared understanding, team development and accountability.
6	A lack of systems and capacity existed in the hotel quarantine system to ensure concerns and needs raised by returned travellers were managed and resolved in a timely, systematic, responsive and reliable manner. This led to returned travellers expressing their frustration with various aspects of their hotel detention. In some instances, deteriorating health concerns expressed by returned travellers may have been misinterpreted as expressions of frustration with the lack of systems and resources to resolve a broad range of hotel detention issues in a timely way.

RECOMMENDATIONS

Recommendations describe actions that should be taken to address the findings and/or learnings identified in the review and achieve system improvement.

The strength of recommendations (weak, moderate or strong) describes the overall likelihood that their implementation is likely to succeed in establishing sustained system changes to achieve the desired risk mitigation and safety outcomes. This likelihood is determined based on general evidence about human factors, systems improvement and change management.

	Recommendation	Associated findings / learnings	Strength
A	As a matter of priority, implement measures to ensure an adequate and reliable on-site supply of Personal Protective Equipment (PPE) that is readily accessible to all staff working in the hotel quarantine system.	Finding 1	Strong
B	Develop and implement robust, fit-for-purpose, readily accessible policies and procedures relating to the appropriate use of PPE for staff working in hotel quarantine.	Finding 1	Weak
C	Develop and implement processes to enable clinical staff working in the hotel quarantine system to conduct visual telehealth (i.e. video calls) consultations for returned travellers who are willing and able to use these methods, particularly those identified as higher risk. This would enhance initial 'contactless' clinical assessments for returned travellers. These processes should be co-designed. The visual telehealth platform should be capable of including external family members, community caregivers in telehealth consultations, at the discretion of the returned traveller, particularly in circumstances requiring a case management approach. The visual telehealth platform should also enable participation of language interpreters, consider the specific needs of returned travellers with visual or hearing impairment and other physical and/or mental disabilities, as needed.	Finding 1 Learning 2	Strong
D	As a matter of priority and in consultation with clinical leads, implement measures to ensure an adequate and readily accessible on-site clinical equipment and the resources required to effectively sanitise this equipment. This would ensure timely assessment, monitoring and first line treatment of returned travellers.	Findings 1 & 2 Learning 1	Strong
E	Develop and implement a policy with clear guidance and specific criteria for when medical staff are required to assess returned travellers via visual telehealth or face-to-face whilst in mandatory hotel quarantine.	Findings 3 & 7 Learning 1	Weak
F	Implement an off-the-shelf, fit-for-purpose (or easily customised), single, centralised and real-time information sharing and tracking system containing all individual returned traveller information (including their health and welfare), accessible by all staff with a role in providing services, care, support and oversight for returned travellers. This should include functionality to provide 'alerts' to identify to staff working on each shift, returned travellers with significant health and/or welfare risks requiring monitoring or follow-up.	Finding 3 Learning 2	Strong
G	Undertake ongoing needs analyses to strategically match the number and designation of staff rostered on shifts to ensure there are adequate staff available to be able to provide a rapid response surge capacity to meet the dynamic needs of specific cohorts of returned travellers. This should include a mechanism by which if necessary additional resources can be mobilised to respond to evolving situations.	Findings 4 & 5 Learnings 1 & 5	Moderate
H	Expand the daily COVID-19 assessment symptom screening calls to include other basic health and welfare questions to screen for unmet support needs or issues. For returned travellers with medium to high risk health conditions, this presents an opportunity to discuss their specific issues. Ensure adequate, dedicated and appropriately qualified staff are available to conduct these calls daily for the duration of returned travellers' period of mandatory quarantine.	Findings 5 Learnings 2 & 6	Moderate
I	Implement formal, standardised processes for the recording and tracking of issues raised by returned travellers with hotel quarantine staff (via all means – including screening calls). This should include assignment of these issues for follow up, tracking progress to completion, and alerting relevant staff when issues have not	Findings 5 Learnings 2 & 6	Weak

	Recommendation	Associated findings / learnings	Strength
	been actioned and closed.		
J	Co-design with frontline staff and implement the use of specific fit-for-purpose materials, methods and systems suitable for recording returned traveller health and welfare information in a consistent, comprehensive and systematic way. This includes record keeping templates and information systems. Ensure the availability of resources so these systems are readily accessible to all relevant staff, and feedback mechanisms ensure continuous evaluation and improvement relating to the suitability of related current policies and processes.	Finding 6 Learnings 5 & 6	Weak
K	Develop and implement formal policies and procedures for recording information provided by external health providers about returned travellers in quarantine, and ensure that relevant information be reviewed, actioned as needed and evaluated by an appropriate clinician on-site.	Findings 3, 6 & 8 Learning 6	Weak
L	Implement formal processes for conducting handover and communication within and between teams working in the hotels in the quarantine system.	Finding 8 Learning 4	Weak
M	Co-develop with staff detailed descriptions for all roles in the hotel quarantine system, and a visual and simple written guide to how these roles work together. Provide this to all existing and future staff and include this information in staff orientation and in-service training.	Findings 6, 8 & 9 Learning 5 & 6	Weak
N	Based on experience to date and staff input, revise methods for determining the staffing level and mix needed around the time of large returned traveller influxes and implement revised models of staffing and rostering based on these. Ensure readily available increased staffing capacity for surges in workload associated with arriving cohorts of returned travellers.	Findings 4 Learning 4, 5 & 6	Moderate
O	Co-develop agreed formal processes with relevant entities (e.g. Australian Border Force, the Department of Foreign Affairs and Trade) to improve the accuracy, detail and optimise timeliness of information received about incoming returned traveller cohorts to facilitate planning and preparedness.	Findings 3, 8, 10 Learning 4 & 6	Weak
P	Co-develop and implement a formal agreement between all relevant parties in the hotel quarantine system and Ambulance Victoria regarding the ambulance service requirements of returned travellers. This agreement must provide specific guidance to support decision-making by frontline staff; reflect the rights and role of consumers (returned travellers or their significant others) in participating in these decisions; and provide clear guidance on ambulance dispatch and cancellation.	Findings 7 &11 Learning 1	Weak
Q	On arrival, all returned travellers and their external family members should be routinely provided with clear information about how to escalate unaddressed or inadequately addressed concerns. This information should be easily accessible for those from culturally and linguistically diverse backgrounds, the elderly, the visually impaired, and be suitable for varying levels of health literacy.	Findings 10 Learnings 2, 3, 4 & 6	Weak
R	On arrival, all returned travellers should have suitable access to a functioning mobile telephone for the duration of their mandatory detention, (e.g. telephone handsets, chargers, Australian SIM cards and access to credit and top-up methods to be able to make calls).	Learnings 3 & 6	Moderate

APPENDIX 1: RECOMMENDATION ACTION PLAN TEMPLATE

Please outline the plan for how recommendations will be enacted.

If a recommendation has been wholly enacted when the report is received, indicate 'wholly' in column two of Table 1. Write N/A in subsequent columns of Table 1. Then complete Table 2 for that recommendation.

If a recommendation has been partly enacted when the report is received, indicate 'partly' in column two of Table 1. Complete the remaining columns in Table 1 for aspects of the recommendation that have not yet been enacted. Then provide details in Table 2 for aspects of the recommendation that have been enacted.

If no part of a recommendation has yet been enacted when the report is received, indicate 'no' in column two of Table 1. Complete the remaining columns in Table 1. Do not use Table 2 for that recommendation.

Table 1.

Recommendation	Already enacted (Write: 'wholly', 'partly' or 'no')	Actions still required to enact recommendation	Outcome measure(s)	Executive position sponsor
A				
B				
C				
D				
E				
F				
G				
H				
I				
J				
K				

RECOMMENDATIONS ALREADY IMPLEMENTED

If any recommendations have been wholly or partly implemented when the report is received, use Table 2 to provide details of what has been done, how implementation has been monitored (e.g. monitoring on-the-ground uptake and impacts – intended and unintended), and outcomes (using appropriate outcome measures).

Table 2.

Recommendation	Actions already completed	Monitoring undertaken

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APPENDIX 2: KEY THEMES FROM HOTEL QUARANTINE INCIDENTS 1 AND 2

Operation Soteria Hotel Quarantine – Common themes arising from two incident reviews as of 15 May 2020.

Below is a summary of key quality and safety issues, and associated contributing factors, identified by Safer Care Victoria during their review of two separate incidents involving returned travellers in hotel quarantine in Victoria.

Based on evidence and information available to Safer Care Victoria at the time of writing, these issues were evident at the time of the two incidents (3 to 13 April 2020). It is noted that certain information sought by the team was unable to be provided or obtained during the data collection period. In addition, some individuals invited for interview in relation to these incidents declined to be interviewed during the data collection period.

Due to the ongoing detention of returned travellers in hotel quarantine as a result of the COVID-19 pandemic, a rapid review method was employed. This review approach has some limitations regarding data collection and scope. These limitations were considered against the need for a rapid review process to inform system improvement in real time. With that approach and goal in mind, the review teams share a summary of issues identified below.

Issue	Comments
Selection of staff	Victorian public sector staff putting themselves forward to take up temporary new roles in the hotel quarantine system did not have an adequate opportunity to pre-emptively nominate the types of roles for which they would or would not be suitable. In selecting and assigning staff to new roles, there were limited checks regarding their relevant skills, experience, education or professional background, in order to assess their suitability for particular roles. As a result of the above (and possibly other situational factors arising from the state of emergency declared in Victoria) some staff were assigned to roles for which they did not have the appropriate knowledge base, skill set or relevant experience.
Onboarding and training of staff	For many of the new roles created for the hotel quarantine system, there was a lack of clear and detailed job descriptions and/or job cards available to staff when they commenced in their roles. This resulted in a lack of clarity about individual roles and responsibilities. There was limited to no formal and standardised training, orientation or opportunities for mentoring available to staff commencing new roles within the hotel quarantine system. Some individuals reported taking the initiative to develop and provide training for their teams. However, these efforts were individually driven by frontline staff and were therefore not consistently adopted across the system. On the day of their first shift in their new role, some staff did not experience adequate handover from their counterpart who had worked the previous shift.
Continuity of staffing	Continuity of staff rostered at hotel locations was limited. This resulted in staff reporting challenges relating to their roles. These included issues relating to hotel familiarity, teamwork, clarity regarding roles and responsibilities, and continuity of support provided to returned travellers. Some staff reported requesting to be rostered at the same location and/or team. However these efforts were individually-driven by frontline staff, and therefore were not consistently adopted across the system.
Collection, storage and access to personal information about returned travellers	There were reports of inadequate and inconsistent systems and resources (paper or electronic) available for the recording information about returned travellers. As a result, such information (e.g. health and welfare notes, returned traveller requests and concerns) was commonly recorded in ad hoc ways (e.g. staff member's personal note books, post-it notes, whiteboards etc). During a returned traveller's period of detention, they were required to complete (either on paper or via phone) a variety of forms, questionnaires and assessments. These were administered by multiple entities and teams (i.e. nursing staff, welfare check team, hotel staff and the Department of Jobs, Precincts and Regions).

Issue	Comments
	The information gathered through the multitude of channels was not centrally coordinated and stored, and thus was not available to all staff who required it. As a result, staff often did not have the information needed to perform their roles optimally and provide adequate support and care to returned travellers. For example, welfare check callers did not have access to nursing notes or the hotel questionnaire when making calls to returned travellers.
Policies and procedures	Several policies and procedures considered necessary to ensure safe operation of the hotel quarantine system were reported to be either under development or not readily accessible by frontline staff at the time these incidents occurred. For example, policies regarding appropriate use of personal protective equipment, escalation of concerns about returned travellers not answering calls, how to conduct handovers, record-keeping and issues tracking, or managing ambulance attendance. Some policies or procedures reflected plans and intentions that were not operationalised or achieved in practice (e.g. differences between planned frequency of welfare checks and actual frequency of these).
Escalation and leadership responsibilities	There was a reported lack of clarity among frontline staff about escalation processes and pathways, and the circumstances under which they should be utilised. Where formal policies or processes had been formulated, frontline staff reported being either unaware of these, or these were not operationalised fully. There was a reported lack of understanding amongst frontline staff in relation to decision-making hierachies in complex and unprecedented situations. For example, deciding on the appropriate level of clinical care, or when to escalate concerns about a returned traveller not responding to phone calls and door knocks. There was no dedicated role on-site with specific responsibility for decision-making regarding returned traveller health and wellbeing. This role was often either shared between nurses, or an informal 'lead' nurse was appointed for the shift by the nursing team, with access to consultation with a doctor (most often off-site) if required. Some team leaders, authorised officers and nurses reported not receiving adequate information about to whom they should escalate concerns (e.g. specific names, roles and direct phone numbers). Staff sometimes had to use indirect means to request escalation and assistance about issues and concerns (such as use of general email or 'helpline' phone numbers), leading to reported delayed or no response or definitive action.

Safer Care Victoria

APPENDIX 3: REPORT VERSION TRACKING

Date	Action
2 June 2020	Draft report (V1.5) approved by Euan Wallace, CEO, Safer Care Victoria. Sent to REDACTED, Director, Centre of Patient Safety and Experience.
2 June 2020	Draft report shared with Merrin Bamert, Commander, Operation Soteria, requesting fact checking.
7 June 2020	Feedback on draft report received from Merrin Bamert.
12 June 2020	Fact checking completed and report finalised (V2)

Accimaps

Background and Applications

Accimaps (Rasmussen, 1997; Svedung & Rasmussen, 2002) is an accident analysis method that is used to graphically represent the network of contributory factors involved in accidents and incidents. The Accimap method differs from typical accident analysis approaches in that, rather than identifying and apportioning blame at the sharp end, it is used to identify and represent the causal flow of events upstream from the accident and looks at the planning, management and regulatory bodies that may have contributed to the accident (Svedung & Rasmussen, 2002).

Based on Rasmussen's risk management framework, Accimap uses the following six hierarchical levels: government policy and budgeting; regulatory bodies and associations; local area government planning & budgeting (including company management, technical and operational management; physical processes and actor activities; and equipment and surroundings). Contributory factors at each of these six levels are identified and linked between and across levels based on cause-effect relations.

Starting from the bottom of the graph, the equipment and surroundings level provides a description of the accident scene in terms of the configuration and physical characteristics of the landscape, buildings, equipment, tools, and vehicles involved. The physical processes and actor activities level provides a description of events at the sharp end immediately prior to the accident. The remaining levels above the physical processes level enable analysts to identify the decisions and actions by supervisors, managers, executives and actors at the regulatory and government levels that played a role in the incident. A key strength of Accimap is that the relationships between contributory factors are identified and included in the diagram.

Domain of Application

Accimap analysis is a generic approach that has been applied in many domains, including healthcare, aviation, road and rail safety, led outdoor recreation, process control, emergency response, and space travel.

Procedure and Advice

Step 1: Determine the Aims and Objectives of the Analysis

The first step in applying Accimap involves clearly defining the incident under analysis along with any analysis boundaries. In addition, the aim(s) of the analysis should be clearly defined. Defining the boundaries of the analysis are important as project constraints will dictate how deep the analysis can go in terms of the parts of the system considered and how far back in time the analysis will go. It may be, for example, that an analysis may be limited to the organizational level only. Further, post incident response may or not be of interest.

Step 2: Data Collection

Accimap is entirely dependent upon accurate data regarding the incident under analysis. The next step therefore involves collecting data regarding the incident in question. Three broad forms of data are required:

- Data on the work activities or processes in which the accident occurred;
- Data on the accident itself and any contributory factors that played a role in its occurrence; and
- Data on the system in terms of who resides in the system and shares the responsibility for safety during the work activities or processes in which the accident occurred.

Data collection for Accimaps can involve a range of activities, including interviews with

those involved in the incident or Subject Matter Experts (SMEs) for the domain, work, or type of incident under analysis, reviewing reports or inquiries into the incident, and observing recordings of the incident. It is important during data collection to consider all six hierarchical levels of the system. For example, if using interviews as the primary data collection approach it is useful to interview relevant actors from all levels of the system. Likewise, when reviewing procedures this should include the procedures for different actors across all levels of the system.

Step 3: Construct Actor Map

Once the data collection is complete, the analyst should first identify all actors and organizations involved in the work system and annotate these onto an actor map showing where across the six hierarchical levels the different actors reside. It is also often useful to link actors to one another based on the communications structure of the system; however, this is not a requirement.

Step 4: Identify contributory factors

The first stage of Accimap development involves analyzing the data to identify the contributory factors involved. This involves reviewing the data and recording any factors that the analyst feels played a contributory role in the incident in question. Contributory factors are defined as:

"actions, omissions, events, existing and pre-existing conditions or a combination thereof, which led to the causality or incident" (IMO)

In addition, they have been described as:

"any element of an occurrence which, if removed from the sequence, would have prevented the occurrence or reduced the severity of the consequence of the occurrence" (ICAO)

It is recommended that analysts take as broad a view as possible when initially identifying contributory factors. A key requirement here is to consider or search for contributory factors across all six levels of the system hierarchy and also to look for contributory factors associated with all of the actors and organizations identified in the Accimap.

Step 5: Place contributory factors on Accimap

Once the analyst has identified the contributory factors involved, the next step involves placing them on the Accimap diagram. This process should be informed by the Actormap diagram as this shows where different actors and organizations reside in the system. The analyst should take each contributory factor, identify which actor and organization it is associated with, and place at the corresponding level on the Accimap diagram. This process should continue until all contributory factors have been placed on the Accimap.

Step 6: Identify and add relationships between contributory factors

The most important step in the Accimap construction process involves identifying the relationships between contributory factors. This involves taking each contributory factor in turn and considering:

a. whether it had an influence on any of the other contributory factors in the Accimap; and
b. whether it was influenced by any of the other contributory factors in the Accimap.

When a relationship is found the analyst draws a line to depict the relationship on the Accimap, with an arrow showing direction of influence. Again it is recommended that a broad view is taken when considering relationships. For example, relationships might include the following:

- One factor either on its own or in combination with other factors led to the occurrence of another factor;
- One factor either on its own or in combination with other factors strengthened another factor;
- One factor either on its own or in combination with other factors degraded another factor.

Step 7: Finalize and Review Accimap Diagram

At this point a draft Accimap diagram has been developed. At this stage, the analyst should review the Accimap and ensure that all contributory factors and relationships between them have been identified. It is useful during this step to return to the data and review it to verify the contributory factors and relationships identified. It is normal to identify new contributory factors and relationships during this step of the analysis. It is recommended that multiple reviews are undertaken by multiple analysts during this step.

Step 8: SME review

The final stage of the process involves asking appropriate SMEs to review the final Actormap and Accimap diagrams. It is best practice to use SMEs who were either involved in the incident or who have extensive knowledge of the system and work in question. The Accimap should be updated and finalized based on the feedback provided by the SMEs.

Advantages

- Accimap enables the identification of the network of contributory factors underpinning the incident in question. The complete accident aetiology is exposed.
- The method is simple to learn and use.
- It is based upon a sound theoretical model.
- It considers contributory factors across the overall system of work.
- Its output offers an exhaustive analysis of accidents and incidents.
- It provides a clear visual interpretation of the accident aetiology.
- It is a generic approach which has been applied across many domains.
- It focuses on systematic improvements rather than on blaming individuals.

Disadvantages

- The method can be time-consuming to apply.
- The quality of the analysis produced is entirely dependent upon the quality of the data collected.
- Accimap does not provide a method to identify and develop corrective measures; these are based on the judgment of the analyst.
- It does not provide a structured taxonomy for classification of contributory factors, which raises concerns regarding reliability.
- Its graphical output can become complex and hard to decipher when used to analyse large-scale incidents.

Related Methods

Accimap often involves the use of various data collection methods such as interviews, observation, and document review.

Approximate Training and Application Times

Accimaps is a simple method to learn and apply, but can become time-consuming when applied to complex incidents. For such incidents estimated timescales are expected to be around one to two weeks for data collection and a further week for the initial construction of the Accimap. However, the final procedural stage of review can take additional time. For smaller incidents, however, it is often possible to construct draft Accimaps in 1-2 hours.

Tools Needed

Accimaps can be constructed simply using pen and paper; however, drawing software packages such as Microsoft Visio are often used to construct Accimap diagrams.

Example

Figure 1 presents an Accimap of the Murrindindi bushfire response during the devastating February 2009 bushfires in Victoria, Australia. The Accimap was developed based on the information contained in the *Victorian Royal Bushfires Commission, 2010. Final report, vol. II – fire preparation, response and recovery*.

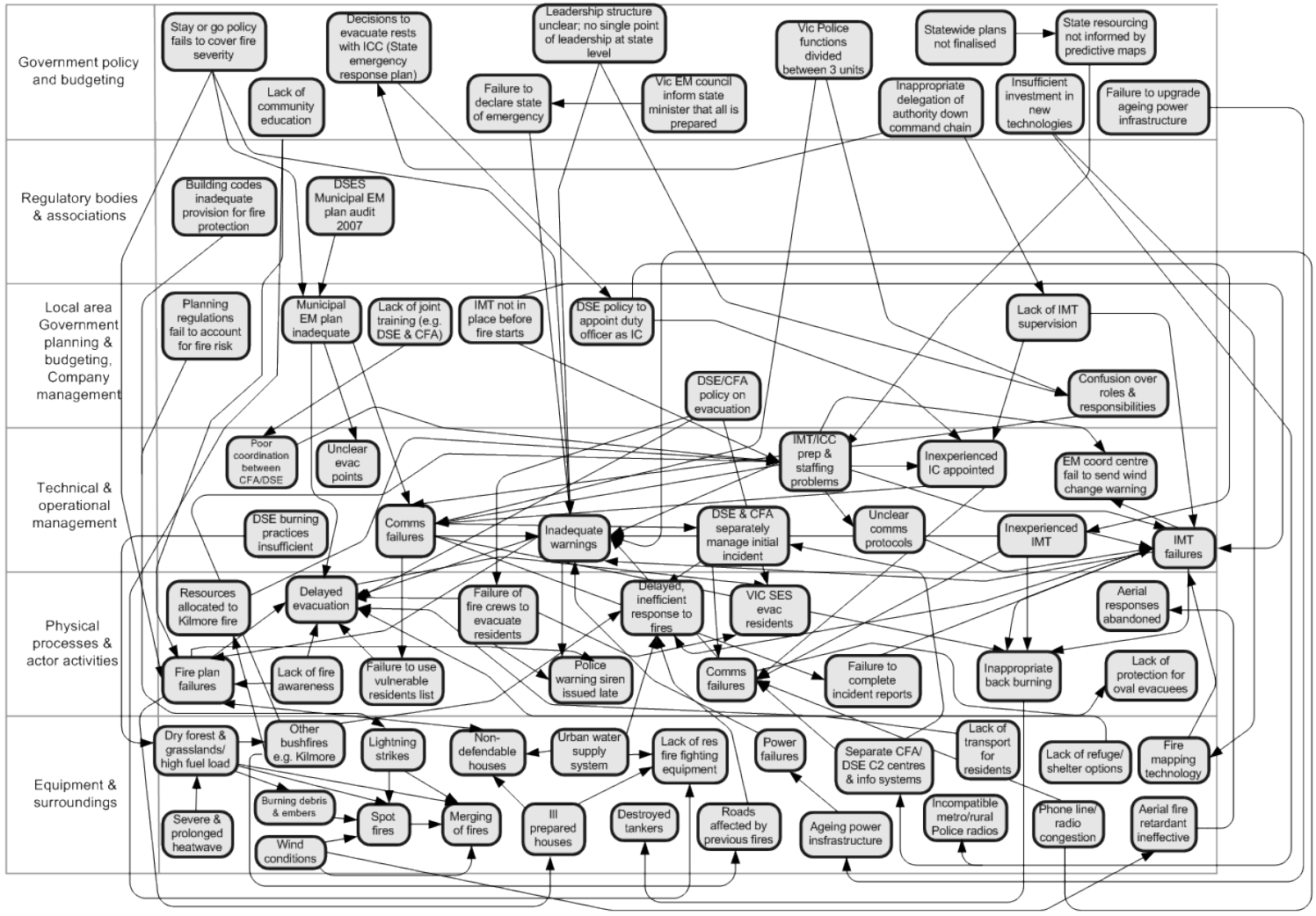

Figure 1. Murrindindi Bushfire response Accimap

Recommended Text(s)

Svedung, J. & Rasmussen, J. (2002). Graphic representation of accident scenarios: mapping system structure and the causation of accidents. *Safety Science*, 40, 397-417.

Rasmussen, J. (1997). Risk management in a dynamic society: A modelling problem. Safety Science, 27:2/3, pp. 183-213.

SYSTEMS ANALYSIS OF CLINICAL INCIDENTS

THE LONDON PROTOCOL

Sally Taylor-Adams & Charles Vincent

Clinical Safety Research Unit
Imperial College London
Department of Surgical Oncology and Technology
10th Floor QEQM Building
St Mary's Hospital
Praed Street
London
W2 1NY
Email: c.vincent@imperial.ac.uk

Contributors

Principal Authors

Sally Taylor-Adams, PhD – is Assistant Director of Patient Safety (Midland and East Region) at the National Patient Safety Agency, UK (NPSA)

Charles Vincent, PhD – is Director of the Clinical Safety Research Unit and the Smith and Nephew Foundation Professor of Clinical Safety Research at Imperial College, London.

Other Contributors

Stephen Rogers, FRCGP, University College London
Maria Woloshynowych, PhD, Imperial College London

ALARM Research Group
David Hewett
Jane Chapman
Sue Prior
Pam Strange
Ann Tizzard

Mental Health Research Group
Alison Prizeman
Yvonne Connolly
Mohamed Sheikh
Ann Rozier
Valli Agbolegbe

Primary Care Research Group
Kathy Caley
Louise Worswick,
Janet Cree
Greg Cairns
Andrew Harris
Juliet Swanwick
Kim Allen
Sarah Raymond
Amee Fairburns
Pauline Grace

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Figures and Tables

1 INTRODUCTION

The London Protocol is the revised and updated version of our original 'Protocol for the Investigation and Analysis of Clinical Incidents'[1]. The protocol outlined a process of incident investigation and analysis developed in a research context, which was adapted for practical use by risk managers and others trained in incident investigation. This approach has now been refined and developed in the light of experience and research into incident investigation both within and outside healthcare.

The purpose of the protocol is to ensure a comprehensive and thoughtful investigation and analysis of an incident, going beyond the more usual identification of fault and blame. A structured process of reflection is generally more successful than either casual brainstorming or the suspiciously quick assessments of 'experts'. The approach described does not supplant clinical expertise or deny the importance of the reflections of individual clinicians on an incident. Rather the aim is to utilise clinical experience and expertise to the fullest extent. The approach we describe assists the reflective investigation process because:

- While it is sometimes straightforward to identify a particular action or omission as the immediate cause of an incident, closer analysis usually reveals a series of events leading up to adverse outcome. The identification of an obvious departure from good practice is usually only the first step of an investigation.
- A structured and systematic approach means that the ground to be covered in any investigation is, to a significant extent, already mapped out. This guide can help to ensure a comprehensive investigation and facilitate the production of formal reports when needed.
- If a consistent approach to investigation is used, members of staff who are interviewed will find the process less threatening than traditional unstructured approaches.
- The methods used are designed to promote a greater climate of openness and to move away from finger pointing and the routine assignation of blame.

1.1 Changes to the Second Edition

The first edition of the protocol was primarily aimed at the acute medical sector. The present edition can be applied to all areas of healthcare including the acute sector, mental health, ambulances and primary care. We have found the basic method and concepts to be remarkably robust when tested in these different contexts.

Those familiar with the first edition will find that the basic process is unchanged, though there is more emphasis on following through with recommendations and action. We have endeavoured to simplify both the structure and the language of the protocol where possible. We have abandoned the absolute distinction between 'specific' and 'general' contributory factors as unworkable, although the importance of identifying contributory factors that are of wider significance remains. Finally, we have removed the forms used for recording data in this edition, to allow teams and individuals more flexibility when producing case summaries. However, we have

attempted to summarise cases in a standard manner, using a template which we have found straightforward and helpful.

1.2 Is this approach a Root Cause Analysis?

The term 'root cause analysis' originates from industry, where a group of tools are used to identify root causes from the investigation and analysis of incidents. To us the term root cause analysis, while widespread, is misleading in a number of respects. To begin with it implies that there is a single root cause, or at least a small number. Typically however, the picture that emerges is much more fluid and the notion of a root cause seems a gross oversimplification. Usually there is a chain of events and a wide variety of contributory factors leading up to the eventual incident. The investigation team needs to identify which of these contributory factors have the greatest impact on the incident and, more importantly still, which factors have the greatest potential for causing future incidents[2].

A more important and fundamental objection to the term root cause analysis relates to the very purpose of the investigation. Surely the purpose is obvious? To find out what happened and what caused it? We believe that this is not the most penetrating perspective. Certainly it is necessary to find out what happened and why in order to explain to the patient and family and others involved. However, if the purpose is to achieve a safer healthcare system, then finding out what happened and why is only a way station in the analysis. The real purpose is to use the incident to reflect on what it reveals about the gaps and inadequacies in the healthcare system. This proactive, forward-looking approach is more strongly emphasised in this second edition. Because of this orientation we have called our approach a `systems analysis', by which we simply mean a broad examination of all aspects of the healthcare system in question. We emphasise that this includes the people involved throughout the system (from management to those working at the sharp-end), and how they communicate, interact, work as a team, and work together to create a safe organisation.

1.3 Different ways of using the protocol

The original protocol was designed at a time when investigations were generally carried out by individual risk managers. It was therefore 'investigator led', in that the description and format assumed that one or two individuals would assemble and collate the information, carry out interviews and then report back to the board or the clinical team to consider what action should be taken. However, many organisations now prefer to assemble a team of individuals with different skills and backgrounds. Serious incidents are certainly likely to require a team of people using both interviews and other documents as their sources of information. This version of the protocol can be used by either individuals or teams.

This document describes a full investigation, but we wish to emphasise that much quicker and simpler investigations can also be carried out using the same basic approach. Experience has shown that it is possible to adapt the basic approach of the protocol to many different settings and approaches. For instance it can be used for quick 5 or 10-minute analyses, just identifying the main problems and contributory

factors. The protocol can also be used for teaching, both as an aid to understanding the method itself and as a vehicle for introducing systems thinking. While reading about systems thinking is helpful, taking an incident apart in a structured manner brings the approach alive for a clinical team.

1.4 Context of the guide's use

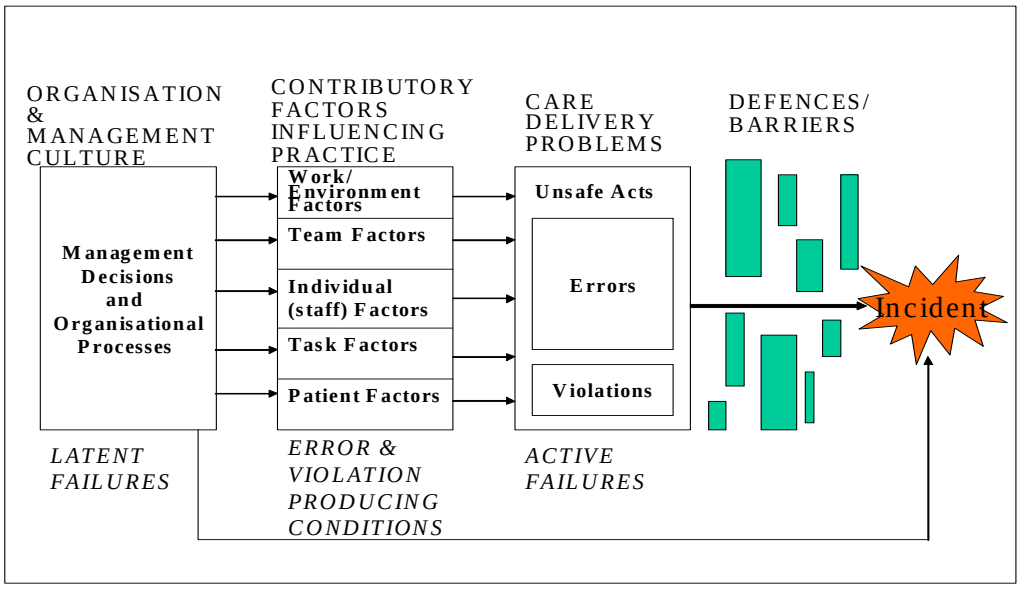
This protocol covers the whole process of investigation, analysis and recommendations for action. In practice, this process will be set, and perhaps constrained, by the local context and conditions of use. We have deliberately not discussed the broader context of clinical governance or other arrangements for assuring the quality of care. We intend that this document should be a stand alone module set within other procedures for the reporting of incidents, reporting to the team or board and so on. We have not been prescriptive about how incidents should be identified or which should be investigated, as this will vary depending on local circumstances and national priorities, which will vary from country to country. Whatever the local circumstances however, we believe that decisions and actions following inquiries would be more effective if grounded in a thorough and systematic investigation and analysis, irrespective of the nature of the incident and the complexity of the issues stemming from it.

We emphasise that this approach needs, as far as possible, to be separated from any disciplinary or other procedures used for dealing with persistent poor performance by individuals. All too often when something goes wrong in healthcare those in charge will over emphasise the contribution of one or two individuals and pin the blame for the incident on them. While blame may be appropriate in some circumstances, it should not be the starting point. Immediate blame will put paid to any chance of a serious and thoughtful investigation. Effective risk reduction means taking account of all the factors and changing the environment as well as dealing with personal errors and omissions. This cannot take place in a culture where disciplinary considerations are always put first. Accident investigation can only be fully effective within an open and fair culture.

2 RESEARCH FOUNDATIONS

The theory underlying the protocol and its application is based on research in settings outside healthcare. In the aviation, oil and nuclear industries for instance, the formal investigation of incidents is a well established procedure. Researchers and safety specialists have developed a variety of methods of analysis, some of which have been adapted for use in medical contexts though few have been explored in depth[3-5]. These and other analyses have illustrated the complexity of the chain of events that may lead to an adverse outcome[6-10].

Figure 1: Adapted Organisational Accident Causation Model



2.1 Organisational Accident Causation Model

Studies of accidents in industry, transport and military spheres have led to a much broader understanding of accident causation, with less focus on the individual who makes the error and more on pre-existing organisational factors. Our approach is based on James Reason's model of organisational accidents (Figure 1). In this model fallible decisions at the higher echelons of the management structure are transmitted down departmental pathways to the workplace, creating the task and environmental conditions can promote unsafe acts of various kinds. Defences and barriers are designed to protect against hazards and to mitigate the consequences of equipment and human failure. These may take the form of physical barriers (e.g. fence), natural barriers (e.g. distance), human actions (e.g. checking) and administrative controls (e.g. training). In the analysis of an incident each of these elements is considered in detail, starting with the unsafe acts and failed defences and working back to the organisational processes. The first step in any analysis is to identify active failures - unsafe acts or omissions committed by those at the `sharp end' of the system (pilots, air-traffic controllers, anaesthetists, surgeons, nurses, etc) whose actions can have immediate adverse consequences. The investigator then considers the conditions in which errors

occur and the wider organisational context, which are known as contributory factors. These conditions include such factors as high workload and fatigue; inadequate knowledge, ability or experience; inadequate supervision or instruction; a stressful environment; rapid change within an organisation; inadequate systems of communication; poor planning and scheduling; inadequate maintenance of equipment and buildings. These are the factors which influence staff performance, and which may precipitate errors and affect patient outcomes.

We have extended Reason's model and adapted it for use in a healthcare setting, classifying the error producing conditions and organisational factors in a single broad framework of factors affecting clinical practice[11], see Table 1.

Table 1: Framework of Contributory Factors Influencing Clinical Practice

FACTOR TYPES	CONTRIBUTORY INFLUENCING FACTOR
Patient Factors	Condition (complexity & seriousness) Language and communication Personality and social factors
Task and Technology Factors	Task design and clarity of structure Availability and use of protocols Availability and accuracy of test results Decision-making aids
Individual (staff) Factors	Knowledge and skills Competence Physical and mental health
Team Factors	Verbal communication Written communication Supervision and seeking help Team structure (congruence, consistency, leadership, etc)
Work Environmental Factors	Staffing levels and skills mix Workload and shift patterns Design, availability and maintenance of equipment Administrative and managerial support Environment Physical
Organisational & Management Factors	Financial resources & constraints Organisational structure Policy, standards and goals Safety culture and priorities
Institutional Context Factors	Economic and regulatory context National health service executive Links with external organisations

2.2 Framework of Contributory Factors

At the top of the framework are patient factors. In any clinical situation the patient's clinical condition will have the most direct influence on practice and outcome. Other patient factors such as personality, language and psychological problems may also be important as they can influence communication with staff. The design of the task, the availability and utility of protocols and test results may influence the care process and affect the quality of care. Individual factors include the knowledge, skills and experience of each member of staff, which will obviously affect their clinical practice. Each staff member is part of a team within the inpatient or community unit, and part of

the wider organisation of the hospital or mental health service. The way an individual practises, and their impact on the patient, is constrained and influenced by other members of the team and the way they communicate, support and supervise each other. All members of the team are influenced by the working environment, both the physical environment, (light, space, noise) and factors which affect staff morale and ability to work effectively. The team is influenced in turn by management actions and by decisions made at a higher level in the organisation. These include policies for the use of locum or agency staff, continuing education, training and supervision and the availability of equipment and supplies. The organisation itself is affected by the institutional context, including financial constraints, external regulatory bodies and the broader economic and political climate.

Each level of analysis can be expanded to provide a more detailed specification of the components of the major factors. For example, team factors include verbal communication between junior and senior staff and between professions, the quality of written communication such as the completeness and legibility of notes, and the availability of supervision and support. The framework provides the conceptual basis for analysing adverse incidents. It includes both the clinical factors and the higher-level, organisational factors that may be influential. In doing so, it allows the whole range of possible influences to be considered and can therefore be used to guide the investigation and analysis of an incident.

2.3 How the concepts translate into practice

Active failures in health care come in various forms. They may be slips, such as picking up the wrong syringe, lapses of judgement, forgetting to carry out a procedure or, rarely, deliberate departures from safe operating practices, procedures or standards. In our work we have substituted the more general term `care delivery problems' (CDP) for unsafe acts. This is because we have found, in healthcare that this more neutral terminology is helpful and because a problem often extends over some time and is not easily described as a specific unsafe act. For instance a failure of monitoring of a patient may extend over hours or days.

Having identified the CDP, the investigator then considers the conditions in which errors occur and the wider organisational context, which are known as contributory factors. These are the factors which influence staff performance, and which may precipitate errors and affect patient outcomes.

3 ESSENTIAL CONCEPTS

Reason's model and our framework provide the conceptual foundations of the investigation and analysis process. However, before incident investigation can be undertaken, key essential concepts need to be defined.

3.1 Care Delivery Problems (CDPs)

CDPs are problems that arise in the process of care, usually actions or omissions by members of staff. Several CDPs may be involved in one incident. They have two essential features:

- Care deviated beyond safe limits of practice
- The deviation had at least a potential direct or indirect effect on the eventual adverse outcome for the patient, member of staff or general public.

Examples of CDPs are:

- Failure to monitor, observe or act
- Incorrect (with hindsight) decision
- Not seeking help when necessary

3.2 Clinical Context

Salient clinical events and the clinical condition of the patient at the time of the CDP (e.g. bleeding heavily, blood pressure falling). The essential information required to understand the clinical context of the CDP.

3.3 Contributory Factors

Many factors may contribute to a single CDP. For example:

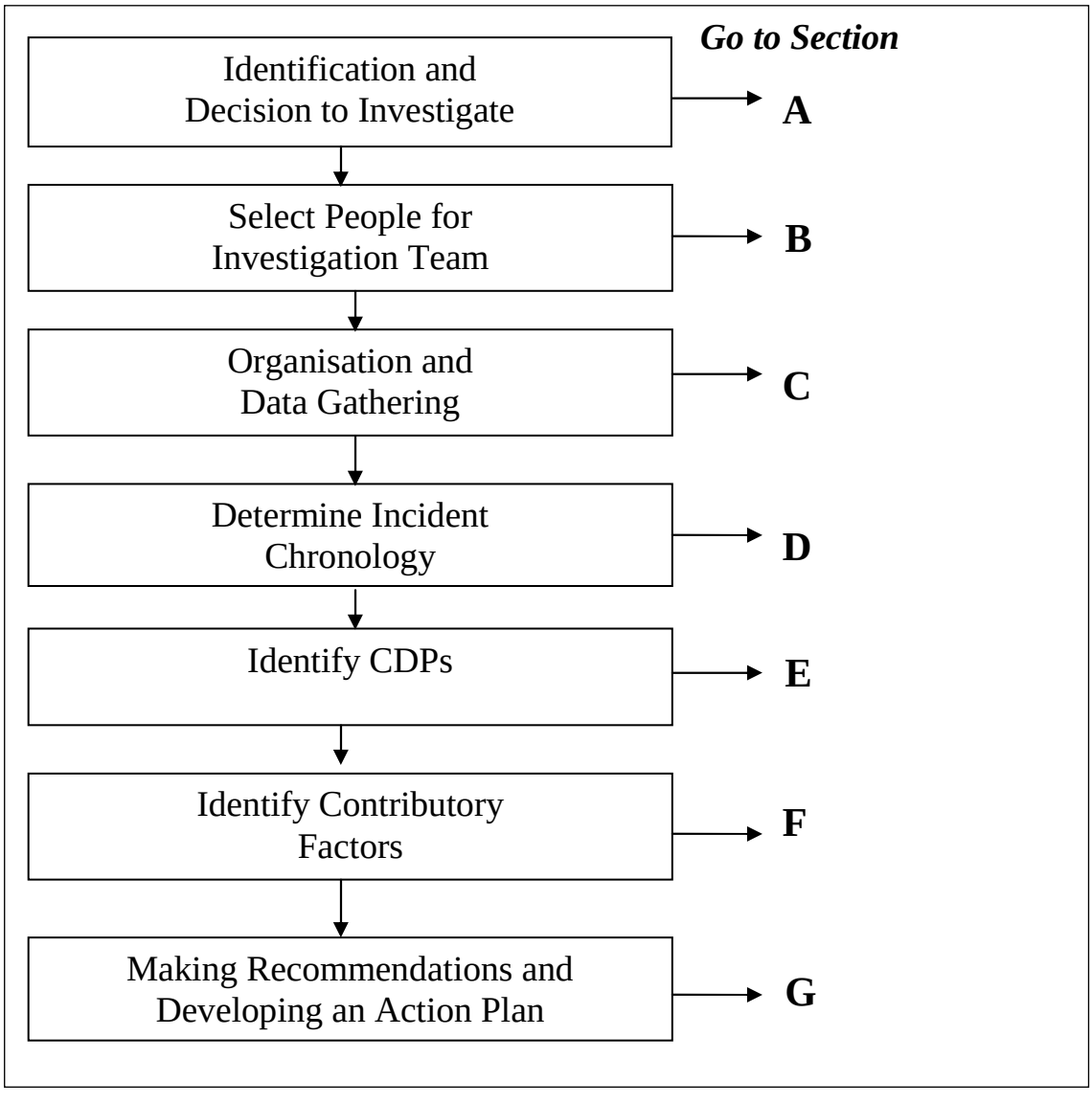
- Patient factors might include that fact that the patient was very distressed or unable to understand instructions.
- Task and technology factors might include poor equipment design or the absence of protocols
- Individual factors may include lack of knowledge or experience of particular staff
- Team factors might include poor communication between staff
- Work environment factors might include an unusually high workload or inadequate staffing.

4 ACCIDENT INVESTIGATION & ANALYSIS PROCESS FLOWCHART

The accident investigation and analysis process flowchart (see figure 2) provides a overview of all the stages of the incident investigation and analysis process. The flowchart shows the objectives of each stage and how each objective is achieved.

The basic process of incident investigation and analysis is relatively standardised, and will be followed whether investigating a minor incident or a very serious adverse outcome; the process is essentially the same where an individual or a large team are responsible for the investigation. However, the team can choose whether to quickly run through the main issues in a short meeting or to carry out a full, detailed investigation over several weeks, making full use of all associated techniques to comprehensively examine the chronology, CDPs and contributory factors. The decision on the time taken will depend on the seriousness of the incident, potential for learning and the resources available.

Figure 2 – Accident Investigation and Analysis Process Flowchart



SECTION A: Identification and Decision to Investigate

There are a number of reasons for considering that an incident warrants detailed investigation. Broadly speaking the incident will either be investigated because of its seriousness for the patient and family, for the staff or the organisation, or because of its potential for learning about the functioning of the department or organisation. Many incidents will not have serious repercussions, but nevertheless have great potential for learning.

Serious incidents will always, by definition be reportable on incident forms. What marks out a serious incident as requiring detailed investigation is the nature and scale of the consequences. Some incidents require immediate initial investigation, whilst others can wait a few hours (for example until the following morning). The precise action to be taken is a decision for the most senior person on duty at the time. In deciding whether and when to investigate an incident account will need to be taken of what has actually happened, the patient's clinical status and emotional state, how the staff who were involved are feeling, and external pressures such as media interest. Each organisation needs to clearly specify the circumstances that initiate an incident investigation.

The reported incident may not reveal the final outcome for the patient. For instance a patient may assault another patient (and this maybe reported), but the subsequent fracture may not be diagnosed for three days and the final outcome for the injured patient may not be known for some months. The investigator needs to take a pragmatic look at the problem and decide what timescale is to be the focus of immediate attention, while allowing that a more elaborate and complex story may unfold. Analysis should initially focus on the time period where problems were most apparent.

SECTION B. Select the People for the Investigation Team

Appropriate experts are essential for investigation of serious incidents. Ideally, an investigation team should consist of 3 or 4 people facilitated by the investigation leader. It is important to identify team members with multiple skills and the time to commit to the process. For very serious incidents, the investigation team may need to be given leave from 'their usual duties' to focus on incident investigation and analysis.

An ideal team to investigate a serious incident might include:

- Incident investigation and analysis experts.
- External expert(s) view (this can be a non-executive board member with no specific medical knowledge).
- Senior management expertise (e.g. medical director, director of nursing, chief executive).
- Senior clinical expertise (medical director or senior consultant).
- It is also valuable to have someone with knows the relevant unit or department well, though they should not have been directly involved in the incident.

The protocol can also be used to investigate less serious incidents and near misses. In this situation it might be that a departmental or ward manager with appropriate training would facilitate the incident investigation and analysis. They would lead the process, but would call on relevant clinical and other expertise as necessary.

SECTION C. Organisation and Data Gathering

Documenting the Incident

All facts, knowledge and physical items related to the incident should be collected as soon as possible. This may include:

- All medical records (e.g. nursing, medical, community, social workers, general practitioner, etc).
- Documentation and forms related to the incident (e.g. protocols and procedures).
- Immediate statements and observations.
- Conduct interviews with those involved in the incident.
- Physical evidence (e.g. ward layout schematics, etc).
- Secure equipment involved in incident (e.g. shower rail used to commit suicide).
- Information about relevant conditions affecting the event (e.g. staff rota, availability of trained staff, etc).

Statements can be a useful data source, but only if guidance is provided on the type of information needed, otherwise they tend to be just summaries of the medical records. The statement needs to contain the individual's account of the sequence and timing of events, a clear account of their involvement in the case and an account of any difficulties they faced and problems (such as faulty equipment) that may not be detailed in the medical notes. Some issues, such as not being properly supported or supervised, may be best discussed in interviews. Information from statements will be integrated with other data sources such as audit reports, quality initiatives, maintenance logs, medical notes, prescription charts, etc to get a complete picture of the factors likely to have impacted the incident

Information is best collected as soon after the incident has occurred. The use of a numbering system or referencing system may assist in referring to and tracking information easily. The following is an example of a referencing system and tracking form, but it can be adapted to suit organisational need:

Ref Nos	Information/Data Source	Date requested	Date received	Stored?
Case 25/02	*Copy of incident form*	*24/10/01*	*24/10/01*	*Cabinet A RM Office*
Case 25/02	*Nursing notes*	*24/10/01*	*25/10/01*	*Cabinet A RM Office*
Case 25/02	*Medical notes*	*24/10/01*	*26/10/01*	*Cabinet A RM Office*
Case 25/02	*Shower curtain*	*24/10/01*	*26/10/01*	*Cupboard G Legal Office*

The purpose for collecting information at this stage is to:

- Secure information to ensure it is available for use during the investigation and later if the case was to go to court.
- Allows an accurate description of the incident, including the sequence of events leading up to the incident.
- Organisation of the information.
- Provides initial direction to the investigation team.
- Identifies relevant policies and procedures.

Conducting Interviews

One of the best means of obtaining information from staff and other persons involved regarding the incident is through interviews. The investigation team will need to determine who needs to be interviewed and arrange for these interviews to take place as early as possible. Interviews lie at the heart of effective investigation.

While a considerable amount of information can be gleaned from written records and other sources interviews with those involved are the most important route to identifying the range of background contributory factors to an incident. Interviews are especially powerful when they systematically explore these factors and allow the member of staff to effectively collaborate in the process of investigation and analysis. In the interview sequence that follows the story and `the facts' are just the first stage. The staff member is then encouraged to identify both the CDPs and the contributory factors which greatly enriches both the interview and investigation. It would also be possible, and usually desirable, to interview the patient and the family, though it is vital to consider whether the interview may distress them unduly and cause additional trauma. They should of course be informed of the results of the inquiry, but again care should be taken that the timing is right and that they have the necessary support.

Setting the scene

Interviews should be undertaken in private and, if at all possible, away from the immediate place of work in a relaxed setting. It may be helpful to have two interviewers, so that one is always able to listen and record responses and subtle points that may otherwise be missed. Ask the member of staff if they would like a friend or colleague to be present.

The style adopted should be supportive and understanding, not judgmental or confrontational. Where it becomes clear that a professional shortcoming has occurred, this should be allowed to emerge naturally from the conversation, and should not be extracted by cross examination. Errors and mistakes in clinical care are rarely wilful and most staff are genuinely disturbed when it becomes clear that something they have done has contributed to an incident. The staff member should be allowed, through supportive discussion, to start to come to terms with what has happened. Adverse comment and judgement at this stage is most unhelpful as it leads to demoralisation and defensiveness.

There are several distinct phases to the interview and it is generally most effective to move through these phases in order.

Establishing the Chronology
First, establish the role of the member of staff in the incident as a whole. Record the limits of their involvement. Next establish the chronology of events as the staff member saw them. Record these. Compare this new information with what is known of the overall sequence.

Identifying the Care Delivery Problems
In the second phase, first explain the concept of a Care Delivery Problem and possibly provide an example of a CDP. Then ask the member of staff to identify the main Care Delivery Problems as they see them, without concerning themselves about whether or not anyone is or is not to blame for any of them. Identify all important acts or omissions made by staff, or other breakdowns in the clinical process, that were (with hindsight) important points in the chain of events leading to the adverse outcome. These are the CDPs. Clinicians, whether those involved or those advising, will have an implicit knowledge of the clinical process as it should ideally occur, allowing for acceptable levels of variation in clinical practice. Where there are disagreements between accounts as to the course of events these should be recorded.

If clinical practice is specified by guidelines, protocols or pathways, it may be possible to specify major departures with some precision. Generally however there will be a degree of acceptable variation in practice. Look for points in the sequence of events when care went outside acceptable limits.

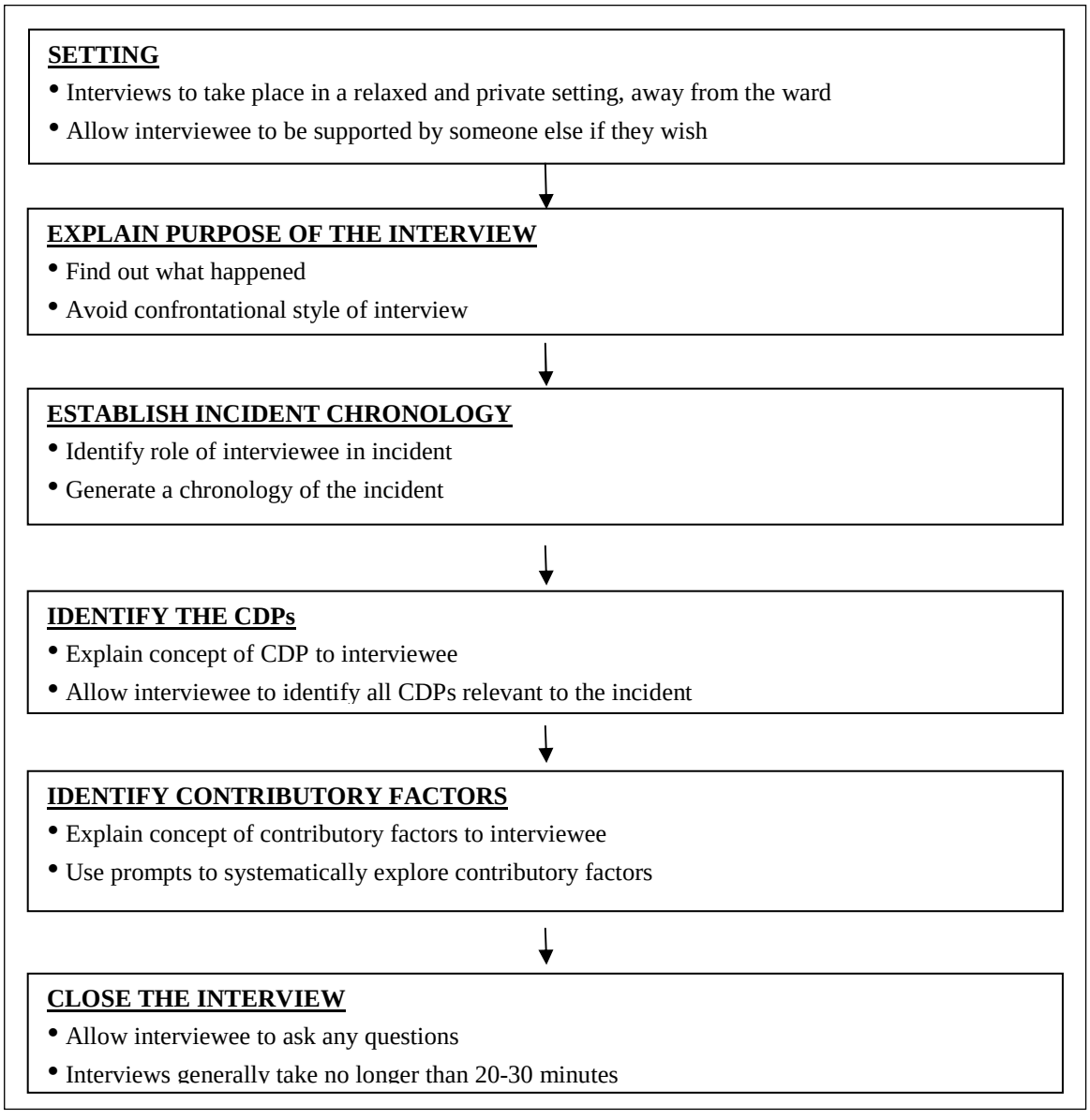
Identifying the Contributory Factors
In the third phase, go back and ask specifically about each of the CDPs separately. Ask questions related to each CDP based on the framework, see table 1. Suppose, for instance, the person identifies a failure in the routine observation of a disturbed patient. The interview can prompt the staff member by asking in turn about the relevance of patient factors, the clarity of the task, individual staff factors, team factors and so on. If necessary pose specific questions, again following the general framework. Was the ward particularly busy or short staffed? Were the staff involved sufficiently trained and experienced?

Where a member of staff identifies a clearly important contributory factor be sure to ask a follow-up question. For example, was this factor specific to this occasion or would you regard this as a more general problem on the unit?

Closing the Interview
A complete interview should take between twenty and thirty minutes depending on the degree of involvement. However they may be much longer if the member of staff is distressed and needs to talk to explore their own role, assess their own responsibility and express their feelings about what has happened. Finally ask the staff member if they have any other comments to make or questions to ask.

Figure 3 provides a summary of the interview process and the information to be obtained during the interview.

Figure 3: Summary of the Protocol's Interview Process



Conducting interviews is resource intensive and it may be that this approach to data gathering can either only be applied to very serious incidents or where only the key persons involved in an incident can be interviewed. If interviews cannot be used fully the protocol investigation process can still be followed, by relying more on other data sources.

SECTION D. Determine the Chronology of the Incident

The next step in the investigation is to establish a clear and reasonably detailed chronology of the incident. Interviews, statements from persons involved in the incident, and a review of the medical records identify what happened and when. The investigation team will need to ensure that this information is integrated and that any disagreements or discrepancies are clearly identified. When a group is working together it is useful to map the chronology on a wall chart, to which CDPs and

contributory factors can be added once the chronology is complete. There are various ways of doing this.

- **Narrative of chronology** – both interviews and medical records will generate a narrative of events, which allows one to show how events unfolded and the roles and difficulties faced by those involved. A narrative chronology is always necessary in any final report of an incident

> **Monday 17th March 2001, 9.15am**
> Patient A absconded from secure unit. Police informed that Patient A was missing
> **Monday 17th March 2001, 10.25am**
> Patient A had been found by the Police. He was located at home, covered in blood as he had killed his common-law wife.

- **Timeline** – tracks the incident and allows the investigators to discover any parts of the process where problems may have occurred. This approach is particularly useful when a team works together to generate the chronology.

Pre-prepare drugs → 12.00noon	Prepared medications disrupted → 12.45pm	Wrong medication given → 1.15pm	Respiratory Arrest → 1.30pm	Patient dies 1.45pm

- **Time Person Grids** – allows you to track the movements of people before during and after an incident.

	9.02am	9.04am	9.06am	9.08am
SHO	With patient	At Drs station	At Drs station	With patient
Ward Manager	In office	In office	With patient	With patient
Nurse	With patient	With patient	With patient	With patient

- **Flow Charts** – draw a picture of the movement of people, materials, documents or, information within a process. In determining the sequence of events it may be useful to develop separate flow charts that illustrate (a) the sequence of events as documented in the policies and procedures; (b) the sequence of events that occurred during the incident.

SECTION E. Identify CDPs

Having identified the sequence of events that led to the incident, the investigation team should now identify the CDPs. Some will have emerged from interviews and records but may need to be discussed more widely. It is often useful to organise a meeting with all the people (consultant to porter) involved in the incident to let them tease out the CDPs. The people involved in an incident are often able to identify what went wrong and why, and can assist in the development of improvement strategies. The views and opinions of all participants need to be elicited in a supportive setting. The skill of the facilitator in choosing and using the methodologies appropriately is vital to the successful management of these meetings.

Ensure that all CDPs are specific actions or omissions on the part of the staff, rather than more general observations on the quality of care. It is easy for example to put down 'poor teamwork' as a CDP which maybe a correct description of the team, but should be recorded as a contributory factor as it was likely that poor teamwork influenced the CDP. Although in practice CPDs and contributory factors may engage together, it is best not to explore the contributory factors until the team is sure they have a complete list. A variety of techniques are available to both an individual investigator or team to tease out the CDPs, such as brainstorming, brain writing and failure modes and effects analysis.

SECTION F. Identify the Contributory Factors

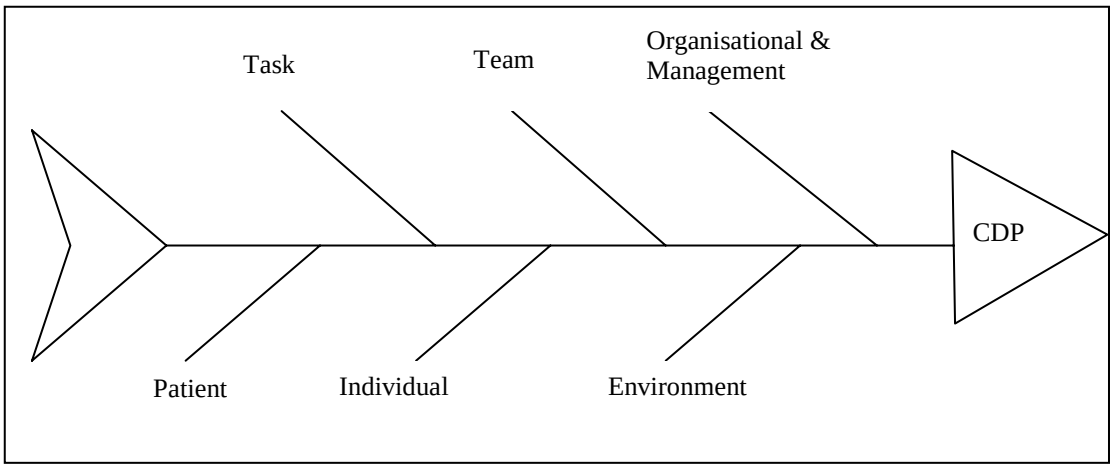
The next step is to specify the conditions associated with each of the CDPs, using Figure 1 as a guide and as away of reflecting on the many factors that may affect the clinical process. With a large number of CPDs, it is best to select a small number of these regarded as most important. Note that each CPDs are analysed one at a time as each will have their own set of contributory factors.

Each CDP maybe associated with several factors at different levels of the framework (e.g. poor motivation *Individual*, lack of supervision *Team,* inadequate training policy *Organisation and Management).* A variety of methods can be used to record the contributory factors associated with a specific CDP, though two main approaches seem to be favoured. Figure 4 (best placed on A3 paper in landscape format) provides a means of recording the basic incident chronology along with the CDPs and associated contributory factors as a sequence. Figure 5 shows a fishbone diagram associated with one CDP, which represents the same contributory factor information, in an alternative format.

Figure 4: Chronological Mapping of CDPs and Associated Contributory Factors

	CHRONOLOGY
	→ → → → → → → →
	TIME
CDPs	
Contri-Butory Factors	
Recom-menda-tions	

Figure 5: Fishbone Diagram CDP



SECTION G. Making Recommendations and Developing an Action Plan

Once the CDPs and their associated contributory factors have been identified the analysis of the incident is complete. The next step is to generate a set of recommendations/improvement strategies to tackle the system weaknesses that have been revealed.

The action plan should include the following information:

- Prioritise the contributory factors in terms of their importance for the safety of future healthcare delivery.
- List the actions to address these contributory factors as determined by the investigation team.
- Identify who is responsible for implementing the actions
- Identify the timeframe for implementation
- Identify any resource requirements
- Evidence of completion. Formal sign-off of actions as they are completed
- Identify the date to evaluate the effectiveness of the Action Plan

Many incident investigators focus on very complex, resource intensive solutions or recommendations that are outside their own remit or control. To improve the uptake and implementation of recommendations, they should be categorised as being under the control of the individual/group, local (team), department/directorate or organisation and people from the correct management strata should be tasked with implementing recommendations relevant to their own area. This ensures ownership and appropriate implementation of recommendations, and also promotes a positive safety culture as people see positive actions coming from the accident investigation process.

Table 2 provides a recommendation/improvement strategy recording and tracking system, which maybe useful to ensure implementation has taken place. The organisation can immediately identify where the main emphasis of change management needs to occur. As previously mentioned it is normal to identify more factors that contributed to an incident and the investigation team will need to prioritise the solutions proposed.

Table 2: Proposed Action Plan Summary Document

Contributory Factors	Actions to Address Factors	Level of Recommendation (Individual, Team, Directorate, Organisation	By Whom	By When	Resource Requirements	Evidence of Completion	Completion Sign-off

5 REFERENCES

1. Vincent, C., Taylor-Adams, S., Chapman, E.J., Hewett, D., Prior, S., Strange, P. et al. How to investigate and analyse clinical incidents: Clinical Risk Unit and Association of Litigation and Risk Management Protocol, Br Med J. 2000;320:777-81
2. Vincent, C.A. Understanding and responding to adverse events, N Engl J Med. 2003; 348: 1051-56
3. Eagle, C.J., Davies, J.M. and Reason, J.T. Accident analysis of large scale technological disasters: applied to anaesthetic complications. Can J Anaesth. 1992; 39: 118-22
4. Reason, J.T. The human factor in medical accidents. In Vincent C.A. editor. Medical Accidents. Oxford: Oxford Medical Publications; 1993
5. Reason, J.T. Understanding adverse events: human factors. In Vincent C.A. editor. Clinical Risk Management. London: BMJ Publications; 1995
6. Cooper, J.B., Newbower, R.S. and Kitz, R.J. An analysis of major errors and equipment failures in anaesthesia management considerations for prevention and detection. Anesthesiology, 1984; 60: 34-42.
7. Cook, R.I. and Woods, D.D. Operating at the sharp end: the complexity of human error. In: Bognor M.S. editor. Human Error in Medicine. Hillsdale, New Jersey; Lawrence Erlbaum Associates Publishers: 1994
8. Vincent, C.A., Bark, P. Accident analysis. In Vincent CA editor. Clinical Risk Management. London; BMJ Publications: 1995.
9. Stanhope, N, Vincent, C.A., Taylor-Adams, S., O'Connor, A., Beard, R. Applying human factors methods to clinical risk management in obstetrics. BJOG. 1997; 104: 1225-32.
10. Taylor-Adams, S.E., Vincent, C., and Stanhope, N. Applying Human Factors Methods to the Investigation and Analysis of Clinical Adverse Events. Safety Science. 1999; 31: 143-159.
11. Vincent, C.A., Adams, S. and Stanhope, N. A framework for the analysis of risk and safety in medicine. Br Med J. 1998; 316: 1154-7

Acknowledgements

Over the years the research that led to this protocol has been supported by a number of organisations and charities. In particular, we thank BUPA Foundation, UK Department of Health Patient Safety Programme and the Nuffield Trust and the Smith and Nephew Foundation.

URGENT: Fact-checking of draft report for hotel quarantine incident 1.

From: REDACTED (DHHS)" <REDACTED

To: "Merrin Bamert (DHHS)" <REDACTED

Cc: "REDACTED (DHHS)" <REDACTED REDACTED
REDACTED (DHHS)" <REDACTED

Date: Thu, 21 May 2020 10:08:51 +1000

Attachments: PDF_DRAFTHQI1 Report with cover letter 20200515.pdf (623.99 kB)

Good morning Merrin,

Thanks once again for your assistance while we have been undertaking two reviews relating to incidents in hotel quarantine. We appreciate your time and your efforts in assisting us to access the evidence and information required for the review.

Attached is a draft report in relation to what we refer to as incident one (involving the person CP), which we are providing first. The report relating to the other incident (involving the person EC) will follow shortly. We are providing this draft to you for the purposes of fact-checking, prior to the draft being finalised. Please do not distribute the draft any further.

We ask that you provide feedback specifically about any factual inaccuracies in the report's content. Should you highlight any inaccuracies, please note that we may require further information to assist us in contextualising and verifying the new information.

Please keep in mind that, as per standard incident review methodology, the information in the report describes – based on the evidence examined by the review team – events and circumstances as they relate to what happened 'on-the-ground' on the specific days in question, involving the specific individuals and the specific hotel. The information may be accurate, while also differing from your own high-level understanding of how the system operated more generally at the time (e.g. as you would have expected, or at different hotels, or in other circumstances).

Please also keep in mind that, as per standard incident review methodology, the information in the report refers to the state of the hotel quarantine at the time of the incident, and intentionally does not describe any changes that may have occurred since that time. Once the report is finalised and provided to the agreed receivers, Appendix 1 provides the opportunity for any changes in the system since the incident to be recorded and explained, including noting any recommendations already actioned.

To facilitate us providing the report to the Operation Soteria Working Group by early next week, please provide any feedback by COB Friday 22 May 2020.

Regards,

REDACTED
Safer Care Victoria Academy

T REDACTED
E REDACTED REDACTED
W safercare.vic.gov.au

Safer Care Victoria

Safer Care Victoria report on clinical incidents occurring in hotel quarantine in Victoria

At the request of the Secretary of the Department of Health and Human Services, Safer Care Victoria undertook reviews into two serious clinical incidents involving detainees in hotel quarantine in Victoria. The first incident involved the apparent suicide death of REDACTED (Hotel Quarantine Incident 1), and the second incident involved the care of RE year old REDACTED who developed COVID-19 symptoms and deteriorated rapidly, requiring intensive care unit admission at the Alfred Hospital (Hotel Quarantine Incident 2).

Two teams of reviewers with relevant incident review and subject matter expertise were convened to undertake the reviews. The purpose of the reviews was to identify contributing factors relevant to the specific incidents, as well as provide insights into issues affecting the operation of hotel quarantine in Victoria, with the view to facilitating timely system improvements. To this end, the final output will be two separate reports, each detailing the contributing factors relevant to the incident, along with a summary of key high-level themes identified in both reviews which are relevant to the overall operation of hotel quarantine. These will be shared with the Secretary as well as the Operation Soteria Working Group, which includes representatives from Public Health, Emergency Operation Centre, Accommodation Commander, Welfare Cell, Office of Chief Psychiatrist and Safer Care Victoria. The Operation Soteria Working Group will be responsible for monitoring the implementation of the recommendations.

Herewith please find a draft report detailing the contributing factors for Hotel Quarantine Incident 1, along with a summary of key themes relevant to the overall operation of hotel quarantine in Victoria that have so far been identified across both reviews (see Appendix 2). The draft report for Hotel Quarantine Incident 2 will follow shortly.

The findings and recommendations provided are based on evidence and information available to the review teams at the time of writing and relate to issues and circumstances at the times and places the incidents took place (i.e. 3 to 13 April 2020). It is also noted that certain information sought by the review teams was not able to be provided or obtained, or was conflicting, and some individuals with potentially relevant information declined to be interviewed. It is further acknowledged that a number of recommendations and key themes may have since been addressed.

Yours sincerely,

Louise McKinlay

Director, Patient Safety and Experience

Safer Care Victoria

Date: / /2020

VICTORIA State Government

Safer Care Victoria

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Incident review report: Hotel Quarantine Incident One

ENDORSEMENT

Review lead

Signature: REDACTED **Date:**

Executive sponsor

Signature: **Date:**

REVIEW TEAM

Executive sponsor	Director, Centre for Patient Safety and Experience, Safer Care Victoria
Review project manager	Senior Project Officer, Centre for Patient Safety and Experience, Safer Care Victoria
Review lead	Safer Care Victoria Academy Member
Human factors / methodology lead	Manager, Patient Safety Review, Centre for Patient Safety and Experience, Safer Care Victoria
Review coordinator	Senior Project Officer, Centre for Patient Safety and Experience, Safer Care Victoria
Team member	Safer Care Victoria Academy Member
Team member	Chair, Mental Health Clinical Network, Safer Care Victoria
Review team support	Senior Project Officer, Safer Care Victoria
Administrative support	Project Officer, Centre for Patient Safety and Experience, Safer Care Victoria

Safer Care Victoria

ABOUT THE REVIEW

Background

On 11 April 2020, REDACTED was found deceased in his room at the Pan Pacific Hotel, Docklands, while in mandatory detention as part of Operation Soteria. As part of the response to REDACT death, the Secretary of the Department of Health and Human Services requested that Safer Care Victoria undertake an independent review into the incident. This report pertains to that review. We acknowledge that REDACT death will be examined by the Coroner, who is the authority on his official cause of death. However, for the purposes of this review, the review team considered his death as though it were a suicide.

Unless otherwise specified or indicated by grammatical tense, the information in this review describes and relates to the period of the incident, being 3 April 2020 to 11 April 2020. The team acknowledges, based on evidence provided during the review, that some systems and processes have changed since that time. This may mean that certain recommendations have since been addressed, or some findings do not reflect the current state. However, the methodology requires that the review address the events and circumstances as they were at the time.

Methodology

The ongoing detention of people in hotel quarantine, and need to identify and address any ongoing risks to these individuals in real time, necessitated a rapid review methodology. This methodology has certain limitations regarding data collection and scope. These limitations were weighed against the need for a rapid review process in making final determinations about the methodological approach and scope of the review. The review used a version of the AcciMap method, customised to use the London Protocol – both widely-recognised and validated approaches to rigorous incident review.

The review team notes that in cases of suspected suicide, the review team cannot determine for certain whether changes to the contributing factors would have ultimately contributed to a different outcome. Therefore, the review team has focused on addressing whether care of REDAC and management of his quarantine, corresponded to an adequate standard of care. The team had done so without making conclusions about whether any changes to the contributing factors would or would not have prevented his death.

Evidence

The team has collected and considered a variety of evidence, including (but not limited to):

- Interviews with staff from the following categories: DHHS/Operation Soteria management, welfare check team members, hotel team leaders, nursing staff, Authorised Officers and REDACT family.
- Templates, forms and questionnaires pertaining to detainee health and wellbeing including the 'Welfare Check – Initial long form survey', 'Confidential Hotel Questionnaire', 'DHHS Hotel Isolation Medical Screening Form' and 'COVID-19 Assessment Form'.
- Copies of the above containing REDACT information. Except for the 'Confidential Hotel Questionnaire', for which only a blank template was provided, despite the completed version being requested.
- Other ad hoc records including an incident report, Victoria Police witness statement, handwritten on-site nurse notes, Post-it notes, Pan Pacific Room Request records (provided for 5-7 April 2020).

- Plans, policies and procedures including 'Operation Soteria – Operations Plan', 'COVID-19 – Interim Healthcare and Welfare Mandatory Quarantine Plan (Draft)', 'Team Leader Pack – Hotels' and 'Referral Pathways for people issued COVID-19 quarantine orders'.
- Information for detainees including 'Mental Health and coronavirus (COVID-19) – Information for those in isolation' and 'Mental Health and Wellbeing'.

We acknowledge the cooperation and openness of the Operation Soteria staff who shared their experiences with us, and their willingness to do so despite the significant emotional impact the event had on some of them. We are especially grateful to REDACTED for providing information about REDAC who he was to those who loved him, his life, and the events surrounding his death, during their time of grief.

The information in this report is based on evidence and information available to the team at the time of review. It is noted that certain information sought by the team was not able to be provided or obtained, and some individuals with potentially relevant information declined to be interviewed. Therefore, the review team acknowledges that there may be unintended gaps or inaccuracies in the report that the team's reasonable efforts to seek required information were unable to rectify. The information presented was accurate - to the best of the team's knowledge – at the time of writing, given the information available to us, and with an eye to the potential limitations identified above.

Safer Care Victoria

Incident review

Analysis, findings and learnings

DESCRIPTION OF THE INCIDENT

On 03/04/2020 REDACTED was issued a detention notice after arriving from REDA where he normally resided. The detention notice required him to remain in hotel quarantine for 14 days.

REDAC was detained as part of the Victorian government's response to the COVID-19 pandemic (Operation Soteria), in line with a national agreement to require mandatory quarantine of any international arrivals after midnight 28/03/2020. REDAC was detained alone in REDACTE at the Pan Pacific Hotel in Docklands, Melbourne.

REDACTED

REDACTED on-site nurses phoned him daily to complete the COVID-19 Assessment form (to screen for COVID-19 symptoms). He completed this assessment daily, and did not report COVID-19 symptoms during his detainment. The 'Welfare Check – Initial long form survey' was completed on day five of REDACT REDACTED No concerns were identified. REDACTED

REDACTED

On 10/04/2020, there was a serious incident involving another detainee barricading themselves in their room. The incident resulted in significant police attendance and activity at the hotel. That incident continued into 11/04/2020 – the day REDAC was found deceased REDACTED

Throughout day nine of his detainment (11/04/20), REDAC did not answer repeated calls to his room from nursing staff attempting to complete the COVID-19 Assessment form. Nursing staff escalated the issue of R REDACTED to the Authorised Officer. The Authorised Officer attended to some other matters, including the barricading incident and other detainees with identified significant mental health concerns, before turning his attention to the concerns raised REDACTED . On the basis of the repeated unanswered calls, at approximately 17:30 on 11/04/2020, the Authorised Officer, a security guard and on-site nurse attended RE REDA room, and obtained entry. They found REDAC deceased. It appeared he had died by suicide, RED REDACTED

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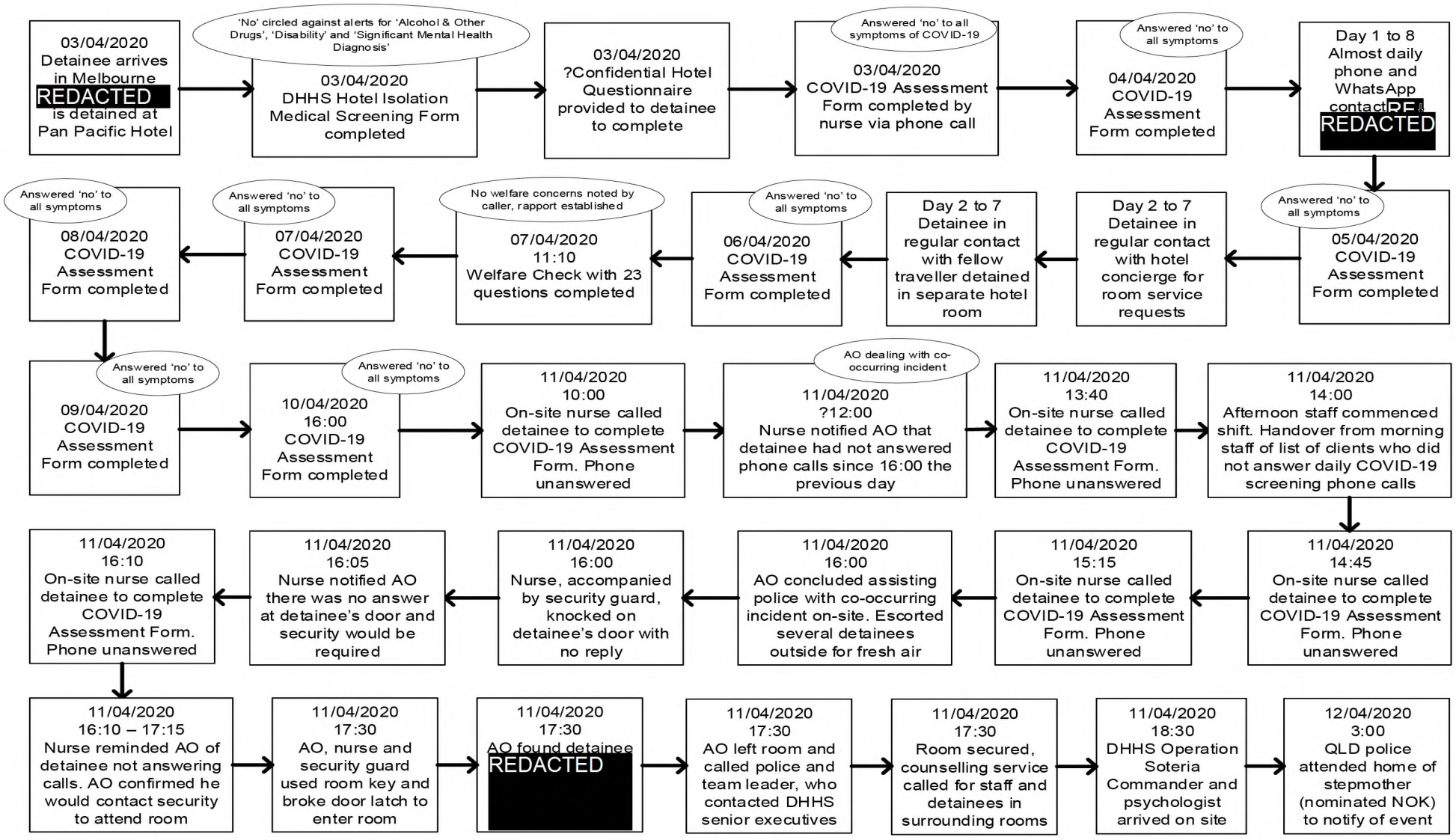
TIMELINE OF EVENTS



PROTECTED

ACTORMAP

Institutional context	Victorian Government	Department of Health and Human Services	Department of Jobs, Precincts and Regions	State Emergency Management Centre (SEMC)		
Organisation and management	DHHS management	Commander, Operation Soteria	Deputy Commander, Operation Soteria			
Work environment	Hotel public areas	Hotel room	Hotel work areas	DHHS offices		
Team	DHHS Authorised Officer Team Leader					
Task and technology	DHHS Hotel Isolation Medical Screening Form	Welfare check - initial long form survey	COVID-19 Assessment Form	Confidential Hotel Questionnaire		
Staff	Welfare check caller	DHHS Authorised Officer	Nurse 1	Nurse 2	Nurse 3	Team Leader
Detainee	Detainee	REDACTED	REDACTED	Fellow detainee involved in major incident		

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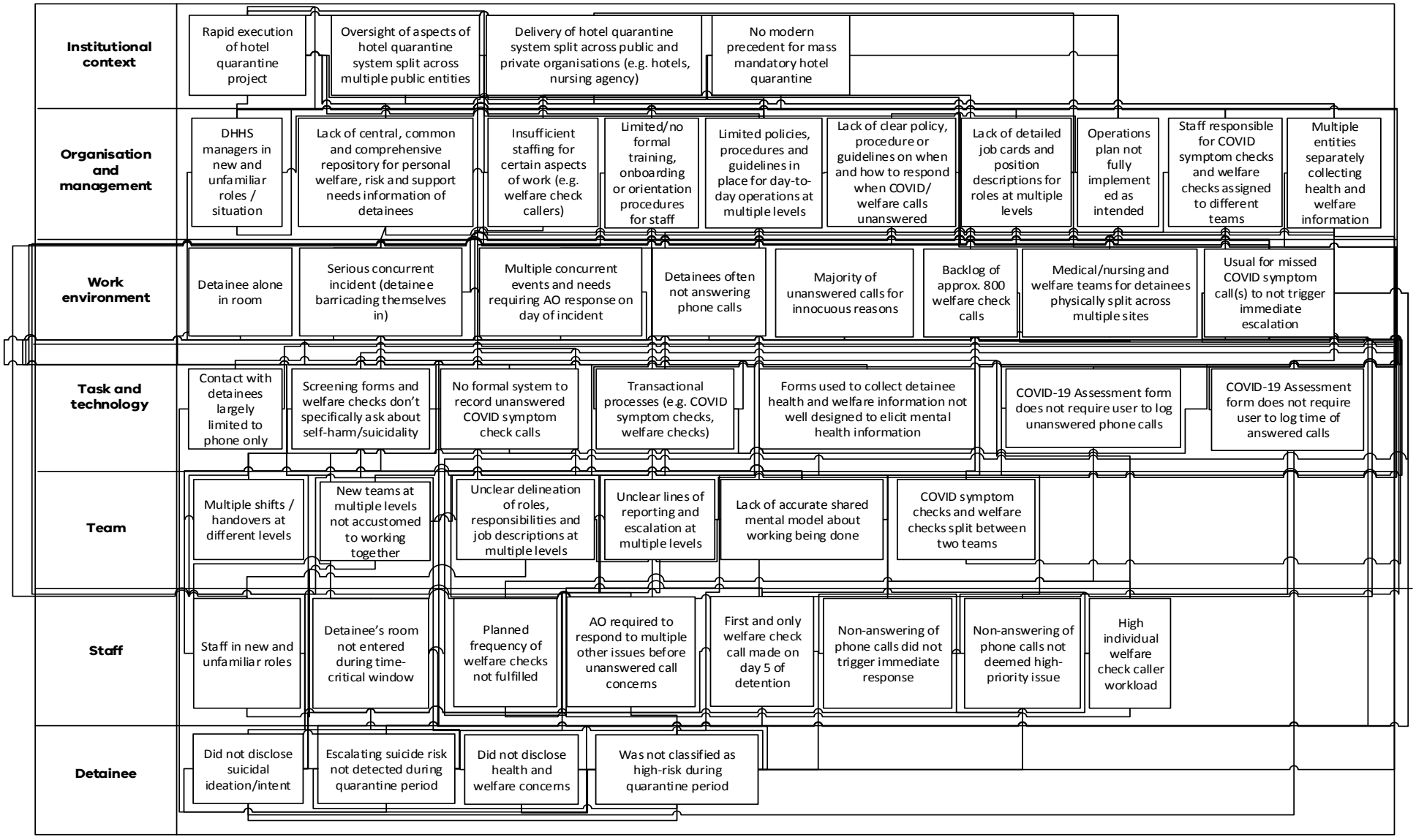
ACCIMAP



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ANALYSIS OUTCOMES

The review team has identified system and process improvement opportunities. Some are directly related to the event. These are described in 'Findings'. Others were identified in the course of reviewing the event, but the review team did not establish that they played a direct role in the events surrounding REDACTE death. These are described in 'Learnings'.

FINDINGS

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

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

Reasoning

The Operation Soteria 'Operations Plan' notes that DHHS is responsible for the "provision of regular welfare calls to all quarantined passengers". The meaning of "regular" is not further specified. Interviewees advised the review team that the original intention was that welfare check calls would be made daily. Staff from outside the welfare check team indicated they believed or assumed that welfare check calls were and had always been made daily to all detainees.

Staff reported that at the time of the first and only welfare check call to REDACTED the welfare check team had a backlog of approximately 800 calls to work through. In interview, staff also noted that the script/form provided to welfare check staff for making initial calls to detainees included a paragraph – to be read to the detainee – telling the detainee to expect welfare calls "regularly". This script has been sighted by the review team. They told the review team that staff were instructed not to convey this information, as it was no longer accurate. In interview, staff indicated that due to the backlog, the revised aim was for two welfare calls to be made to detainees throughout their detainment.

Due to the backlog, the first welfare check call (to administer the 'Welfare Check – Initial long form survey') was not made to REDAC until day five of his detainment. It was the only welfare check call made during the nine days of detainment before his death. Evidence obtained in interview indicated that it was not unusual for detainees who were not already identified as high risk to receive their first welfare check call around detainment day 5-7.

Detainee safety implications

The delayed and infrequent welfare check calls resulted in missed opportunities to monitor detainee welfare and meet duty-of-care obligations in a timely and consistent manner. It also resulted in missed opportunities for detainees to request support or disclose health and welfare concerns.

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

Reasoning

Safer Care Victoria

Welfare check team members reported that they had access to minimal information about detainees prior to calling them for the first time (by then, often day 5-7 of the detainee's detention). Information available to staff making these calls was typically only the detainee's name, date of birth, and expected detention period. Therefore, any information already collected about the detainee's health, welfare and support needs through other channels (including information in the 'welfare questionnaire' referenced in the 'Team Leader Pack – Hotels and Confidential Hotel Questionnaire'), was not accessible to welfare check callers.

The review team has sighted a template of the 'Confidential Hotel Questionnaire' provided to detainees. The template advises detainees that "the information [they] provide will be used to help support [them] during [their] quarantine period". However, the information gathered was not systematically shared with key teams responsible for detainee health and welfare, including welfare check callers and medical staff. The review team requested a copy of the completed 'Confidential Hotel Questionnaire' for REDAC. However, it was not provided. Therefore, it is unclear if REDAC received and/or completed this questionnaire, or what answers and information he provided on it.

Similarly, staff reported generating and having access to health and welfare information about detainees that was not systematically made readily available to other teams and individual staff members. For example, information about detainee responses to daily COVID-19 Assessment Form calls was available to nurses, but not the welfare check team. In addition, some detainee health and welfare information was written on a whiteboard (visible only to some on-site staff), in staff member's personal notebooks (not visible to others), and on 'Post-it' notes.

Detainee safety implications

The lack of central, comprehensive and accessible repository for detainee health and welfare information resulted in inadequate communication about detainee health and welfare concerns and needs within and between teams. It also resulted in staff being unable to have holistic and global oversight to adequately identify, assess and manage health and welfare risks for individual detainees.

3. **Detainee health and welfare information was collected in a fragmented manner, involving multiple entities and teams and multiple formats.**

Reasoning

The review team has sighted multiple templates/forms/questionnaires/surveys, some of which have been completed about, for or by REDAC. Examples include the 'COVID-19 Assessment Form', 'Hotel Isolation Medical Screening Form', 'Welfare Check – Initial long form survey' and 'Confidential Hotel Questionnaire'. The content of these forms is not complementary – with evidence of both duplication and, in the view of the review team, notable omissions (see Finding 7).

For example, both the 'DHHS Hotel Isolation Medical Screening Form' and 'Welfare Check - Initial long form survey' ask detainees to answer questions about allergies and "immediate" health/medical conditions. And both the 'Welfare Check - Initial long form survey' and the 'Confidential Hotel Questionnaire' ask the detainee how children/others travelling with them are "coping". And the 'COVID-19 Assessment Form' and 'Welfare Check - Initial long form survey' both ask detainees about symptoms of COVID-19. By contrast, none of the forms sighted by the review team directly and clearly ask the detainee if they have mental health concerns aside from those attached to a formal medical diagnosis, if they are a smoker (there is a question about requiring nicotine patches, but the two are not synonymous), or if they would like to speak with someone about any issues of concern regarding their health and welfare.

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The review team requested a copy of REDACTED 'Confidential Hotel Questionnaire', but this was not provided. It is therefore unclear if REDACTED received and/or completed this questionnaire, or what answers and information he provided on it.

The review team noted that day-to-day operations were marked by a lack of communication and coordination regarding detainee information collected through these fragmented channels. The review team also noted that the content of each form is focused on issues which match the specific functions of each of the entities and teams administering them. In interview, staff indicated that detainee health and welfare information was collected on separate forms because individual entities and teams were separately collecting only information required to fulfil their designated function. For example, the nursing team received the 'Hotel Isolation Medical Screening Form', the hotel received the 'Confidential Hotel Questionnaire', and the welfare check team conducted their own 23-question survey in the first call (therefore not receiving substantive information about individual detainees beforehand).

The review team's view is that, most detainees were most likely unaware of the nuances of the complex structure of the hotel quarantine system and its many teams and entities. Therefore, it would have been unclear that information they provided in the varying forms was not shared among all those who had responsibility for their health and welfare. It would also have been unclear which form or team was most appropriate for raising concerns that were not explicitly addressed by the pre-formulated questions.

Detainee safety implications

The lack of a coordinated and consistent method for collecting detainee health and welfare information, and collating and sharing it, compromised staff members' ability to adequately identify and manage health and welfare risks for individual detainees. It also compromised detainee's ability to direct their health and welfare questions, support needs and concerns to the individuals and teams best suited to address them.

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

Reasoning

In interview, on-site staff tasked with completing daily COVID-19 Assessment symptom screening calls articulated a shared mental model that unanswered calls to detainees were almost never a cause for health and welfare concerns. They noted that most unanswered calls were the result of detainees being engaged in innocuous activities such as sleeping (they specifically sighted the effects of jet lag), bathing, talking on the phone or online, or using headphones. Staff reported that the daily transactional nature of the COVID-19 Assessment symptom screening calls became predictable to detainees, contributing to some who were asymptomatic not answering the calls, or taking the in-room landline phone off the hook.

The review team heard that on average, by the end of a typical day, between 5-15 detainees had not answered repeated COVID-19 Assessment symptom screening calls, and a nurse was required to knock on their door to elicit a response. Between them, staff reported that in their personal experiences of such follow-up 'door knocks', only one had uncovered a serious reason for the unanswered calls. Nursing staff and AOs reported that as a result, they did not routinely prioritise or escalate unanswered calls (beyond follow-up calls) until the end of the day, or even later.

In REDACTED case, there were at least five unanswered calls throughout 11/04/2020. Due to a lack of formal system for documenting these unanswered calls (see Finding 5), the review team could not be certain if there

were more unanswered calls. There was a delay of more than 24 hours from the time REDACTED last answered a COVID-19 Assessment symptom screening call (approximately 16:00 on 10/04/2020 - as per police witness statement) to when the AO, nurse and security guard forced entry to his room at approximately 17:30 on 11/04/2020.

It is the view of the review team that the frequency of unanswered calls, and the pattern of these unanswered calls not indicating serious issues, resulted in less priority being placed on following up unanswered calls compared with other tasks. In REDACTED case, the AO noted the issue of REDACTED unanswered calls was escalated to him, but he was required to deal with multiple competing issues that he deemed to be of higher priority, before attending REDACTED room for follow-up. The other matters deemed to be of higher priority included the concurrent serious barricading incident, and providing assistance to several detainees with anxiety who has previously been identified as high risk.

Detainee safety implications

The shared mental model that unanswered COVID-19 Assessment symptom screening calls mostly did not indicate significant concerns increased the risk that a definitive response may be delayed. This posed a risk to safety in instances where the main indicator of a detainee's need for urgent assistance was unanswered calls.

5. **There was a lack of specific formal policy about the threshold for escalating concerns about repeated unanswered COVID-19 Assessment calls, and a lack of formal procedure for tracking these.**

Reasoning

In interview, staff stated there was no formal policy about when to escalate instances of repeated unanswered COVID-19 Assessment symptom screening calls for more definitive action (e.g. knocking on or opening the detainee's door), and no formal procedure for tracking unanswered calls. This lack of formal policy was corroborated by an email (sighted by the review team) from the Director, Emergency Management to DHHS senior executive on 12/04/2020 (the day after REDACTED was found deceased). In that email, the Director cited the lack of such a policy, and the need for one to be developed.

The lack of clarity about the threshold for escalating unanswered calls was evident when the review team asked staff to describe the escalation process for unanswered calls. They gave variable answers as to when escalation should occur (e.g. after two calls, after four hours), but were clear that the AO was the appropriate line of escalation. They noted that when to act was a matter of judgement (in the absence of a formal policy), and their decisions took into account perceptions that AOs sometimes had high workloads and competing priorities.

In the absence of a formal policy or procedure, nursing staff described having developed a work-around to track and follow-up unanswered calls. If a call was not answered the first time, nursing staff would place the detainee's COVID-19 Assessment Form in a designated box. Nurses would later revisit that box "if [they] had time" and make the follow-up calls. The forms of detainees who answered follow-up calls were removed from the box. The forms of those who did not answer were returned to the box, and were revisited again when a nurse had time available. Post-it notes/whiteboard notes were also used to record the names of detainees with repeated unanswered calls. This cycle continued until the end of the day, when staff would attend the rooms of any detainees whose forms remained in the box, to knock on their doors.

The lack of policy and process for tracking unanswered calls was also evident in the COVID-19 Assessment Form, which does not require (or provide specific space for) the caller to log unanswered calls. It also does not

provide space for callers to log the times of answered calls (only the dates). This issue was evident in RE REDA case, where the date of his last answered COVID-19 Assessment was recorded on his form, but not the time. Therefore, the extended time since his last answered call was not readily evident to all relevant staff.

Detainee safety implications

A lack of formal policies and processes around tracking and responding to unanswered COVID-19 Assessment calls increased the risk that a definitive response may be delayed. This posed a risk to safety in instances where the main indicator of a detainee's need for urgent assistance was unanswered calls.

6. **Due to workload and delegation challenges, Authorised Officers (AOs) were sometimes required to prioritise multiple competing demands, resulting in delays in attending to potential detainee health and welfare concerns.**

Reasoning

Due to the strict legal requirements around detention procedures, and the AOs specific legal role, they had limited ability to delegate tasks required of them under the Health and Wellbeing Act 2008. In addition, the ability to accurately predict any AO's workload from day-to-day was limited. This was due to multiple factors including a reported lack of prior information about the needs of the detainee cohort (and individual detainees) before arrival, and uncertainty about how these needs may arise and change over time. In interview, on-site staff reported that AOs were frequently very busy, juggling multiple competing demands for their time and attention.

This was seen in REDACT case, as evident in interviews, as well as the AO's statement to police. On the day nurses escalated their concerns about REDACT unanswered calls to the AO, he was required to deal with a serious concurrent multi-day incident involving a detainee who had barricaded himself in his room, requiring significant police presence. Concurrently, the AO was required to attend at the rooms of multiple people identified as high risk due to anxiety-related issues. He attended to these issues before attending REDACTE room to follow-up the unanswered calls.

Detainee safety implications

Because AOs sometimes face complex competing demands and priorities with limited opportunities to delegate to non-AO staff, this may limit their ability to respond to detainee health and welfare needs or incidents in a timely manner.

7. **The forms for collecting detainee information were not well designed to readily elicit specific and detailed information regarding past or current mental health concerns, self-harm or suicidal ideation.**

Reasoning

The review team has sighted multiple templates, forms and questionnaires used to gather information from and about individual detainees. None of those sighted by the review team directly and specifically asked about past or current self-harm or suicidal ideation. Welfare check staff also reported they did not routinely ask such questions of detainees.

Overall, the forms sighted contained limited questions that addressed mental health. In the view of the review team, questions that did allude to mental health generally were not direct, in plain language, or written in a manner that was relatable and understandable to the general public. Where mental health was mentioned, this

was typically done using a 'medical model' approach, focused on identifying diagnoses, but not more general issues about mental distress, risk factors or concerns that may not specifically correlate to a 'diagnosis'. For example, the questions may not have captured the concerns and risks associated with people worried about managing grief in quarantine. For example, the one direct mental health question in the 'DHHS Hotel Isolation Medical Screening Form' read "Significant mental health diagnosis Y/N". This question only clearly applied to those with a formal diagnosis, used the subjective word 'significant', and only provided for a binary yes/no answer (without encouraging further elaboration or disclosure). In another example, the 'Confidential Hotel Questionnaire's' possible allusions to mental health are vague and indirect (e.g. "are you feeling well at the moment?" and "do you or anyone in your group have any immediate health or safety concerns?"). It also contained questions about how children/people accompanying the detainee were "coping", but did not ask the same about the detainee themselves.

In the forms sighted, questions about their support needs place a significant onus on detainees to anticipate their psychological response to, and needs in an unfamiliar, uncertain and potentially stressful situation. And did so prior to detainees having spent any significant time in that situation. Of note is that the forms do not include a list of common support needs to select from (alongside free text space for other needs), which may otherwise assist detainees in identifying their likely support needs.

Detainee safety implications

Not routinely asking a specific question(s) about past or current mental health concerns, self-harm or suicidal ideation represented a missed opportunity for detainees to disclose this information, and thus the opportunity for their welfare and safety to be adequately supported. Forms designed in a way that did not readily elicit information about mental health information and associated risk factors compromised staff members' ability to adequately identify and manage health and welfare risks for individual detainees. It also resulted in missed opportunities for detainees to request support or disclose health and welfare concerns.

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LEARNINGS

Learnings describe system issues that were not been shown by the review to substantially and specifically contribute to the incident under review, but which nonetheless provide important learning and systems improvement opportunities.

	Learnings
1	Separate welfare check calls and COVID-19 Assessment symptom screening calls were made to the same detainees by separate teams located at different sites (welfare check team and nursing team respectively). These teams had ostensibly different remits (general welfare checks vs COVID symptom screening), although the distinction was blurred in practice. This duplication of effort decreased the opportunity for holistic oversight of detainee health and wellbeing. It may also have increased the probability a detainee would mention concerns or issues during a call from one team, where those issues were within the remit of the other team, and the information would not be definitively acted upon.
2	Staff sometimes had to use (or felt they had to use) indirect means to request escalation and assistance regarding issues and concerns (such as use of general email addresses or helpline-like phone numbers). This lead to a delayed response or definitive action, or none at all. This was exacerbated by escalated issues being 'lost' in generic email inboxes which received copious numbers of emails, or because staff answering calls to generic helpline numbers were unable to provide definitive answers or actions.
3	Welfare check callers had been working remotely (the team understands this began after the incident), reducing the ability for their work interacting with detainees to be supervised and monitored for quality control and training purposes.
4	Staff putting themselves forward to take up temporary new roles in the hotel quarantine system did not have an adequate opportunity to nominate at the outset the types of roles for which they would or would not be suitable. In selecting and assigning the above staff to new roles, there were limited checks regarding their relevant skills, experience, education or professional background to assess their suitability. Therefore, some staff were placed in roles for which they were not suitably knowledgeable, skilled or experienced, or for which they were otherwise ill-suited.
5	For many new roles created for the hotel quarantine system, there was a lack of clear and detailed job descriptions and/or job cards at the outset, resulting in a lack of clarity about roles and responsibilities.
6	There was limited to no standardised formal training, orientation or shadowing for staff starting new roles in the hotel quarantine system.

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RECOMMENDATIONS

Recommendations describe actions that could be taken to address the findings and/or learnings identified in the review, and achieve system improvement.

The strength of recommendations (weak, moderate or strong) describes the overall likelihood that their implementation is likely to succeed in establishing sustained changes in risk and/or behaviour, and achieve the desired outcomes. This likelihood is determined based on general evidence about human factors, systems improvement and change management.

	Recommendation	Associated findings / learnings	Strength
A	Develop and implement a detainee arrival pack that consolidates the current suite of 'onboarding' forms into a single onboarding form (for data entry into the central repository in Recommendation H), alongside printed information for detainees.	Findings 2, 3 and 7	Moderate
B	Design the new onboarding form to: include a specific question(s) about past or current self-harm and suicidal ideation; be clear, direct and use plain language; not use relative, subjective words such as 'significant' to delineate what information is important; encourage disclosure beyond binary answers; address mental wellbeing from both medicalised and non-medicalised perspectives; and provide specific examples of common support needs.	Findings 3 and 7	Moderate
C	Establish a formal process to ensure each (newly consolidated) detainee onboarding form is reviewed by a single staff member within 48 hours, adopting a holistic approach, to identify and act upon any immediate or ongoing support needs or health and welfare risks factors, identify detainees requiring further risk and assign an initial risk level (see Recommendation D).	Findings 2, 3 and 7 Learnings 1 and 5	Weak
D	Establish a formal process for nursing staff (with additional clinical advice if required) to assign and monitor a health and welfare risk level (low, medium or high) for each detainee, based on all information available (e.g. onboarding form, 'initial screening call', staff observations).This level should be dynamic and changeable at any time in the face of new information or circumstances, with a schedule for regular review of each detainee's risk level.	Findings 3 and 7 Learning 1	Weak
E	Replace current daily COVID-19 Assessment symptom screening calls with daily 'health and welfare screening calls', delivered by nursing staff for detainees of **all risk levels**. Include in these calls the COVID-19 Assessment symptoms screening questions, and other basic health and welfare questions to screen for unmet support needs or elevated safety and welfare risks.	Findings 1, 3, 4 and 7 Learnings 1, 2 and 5	Moderate
F	For detainees classified as **medium or high risk** only, extend the purpose of the new daily 'health and welfare screening calls' (see Recommendation E) to specifically discuss, monitor and provide support around their specific health and welfare issues.	Findings 1, 3, 4 and 7 Learnings 1, 2 and 5	Moderate
G	For detainees classified as **low risk**, make the provision of regular 'check-in calls' from the welfare team an optional, opt in addition to receiving the mandatory 'health and welfare screenings calls' (to provide social contact and practical needs-check) (see Recommendation E). Implement processes for welfare team members with concerns to escalate these for potential re-classification of a detainee as higher risk.	Findings 1 and 4 Learning 1	Weak
H	Implement a comprehensive central repository for detainee's personal information (including health and welfare information) accessible to all staff with a role in providing services, care, support and oversight for detainees. Include functionality to provide an 'alerts list' for each shift to identify detainees with a medium or high risk level, and the reasons for those ratings.	Findings 2 and 3 Learning 1	Strong
I	In the central repository of detainee personal information, design the section for logging health and welfare calls (from the nursing and welfare teams) to include	Findings 2, 3 4 and 5	Moderate

	a specific field(s) for users to record the dates *and times* of both answered and unanswered calls to detainees (with the list of unanswered calls automatically visible to users).		
J	Offer detainees the option (at onboarding and throughout their detainment, for example via text message or email) to nominate a time slot each day in which they prefer to take calls from welfare and/or nursing staff, and call detainees during the nominated time slot.	Findings 1 and 4 Learning 1	Weak
K	Implement a formal policy about when to escalate situations in which detainees are not answering calls from nursing or welfare teams – using a decision-tree approach that accounts for factors such as number and frequency of unanswered calls, detainee's existing health and welfare risk factors, and previous behaviour in answering/not answering calls.	Findings 4 and 5 Learning 5	Weak
L	Increase and/or more strategically roster the number of AOs on duty at one time to ensure adequate baseline capacity, and rapid response surge capacity that AOs can directly and immediately request if they are task- or demand-overloaded.	Finding 6 Learning 2	Moderate
M	Establish a formal selection process for staff taking up new roles that accounts for their skills, preferences and attributes. Require that welfare team members have relevant background or experience (e.g. mental health, counselling, social work, peer support etc). Complement this with targeted initial and ongoing training and supervision (including for remote working staff) for all new and current staff.	Learnings 3, 4, 5 and 6	Moderate

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APPENDIX 1: RECOMMENDATION ACTION PLAN TEMPLATE

Please outline the plan for how recommendations will be enacted.

If a recommendation has been wholly enacted when the report is received, indicate 'wholly' in column two of Table 1. Write N/A in subsequent columns of Table 1. Then complete Table 2 for that recommendation.

If a recommendation has been partly enacted when the report is received, indicate 'partly' in column two of Table 1. Complete the remaining columns in Table 1 for aspects of the recommendation that have not yet been enacted. Then provide details in Table 2 for aspects of the recommendation that have been enacted.

If no part of a recommendation has yet been enacted when the report is received, indicate 'no' in column two of Table 1. Complete the remaining columns in Table 1. Do not use Table 2 for that recommendation.

Table 1.

Recommendation	Already enacted (Write: 'wholly', 'partly' or 'no')	Actions still required to enact recommendation	Outcome measure(s)	Executive position sponsor	Position responsible/ accountable	Due date for completion
A						
B						
C						
D						
E						
F						

G						
H						
I						
J						
K						
L						
M						

RECOMMENDATIONS ALREADY IMPLEMENTED

If any recommendations have been wholly or partly implemented when the report is received, use Table 2 to provide details of what has been done, how implementation has been monitored (e.g. monitoring on-the-ground uptake and impacts – intended and unintended), and outcomes (using appropriate outcome measures).

Table 2.

Recommendation	Actions already completed	Monitoring undertaken	Outcomes

APPENDIX 2: KEY THEMES FROM HOTEL QUARANTINE INCIDENTS 1 AND 2

Operation Soteria Hotel Quarantine – Common themes arising from two incident reviews as of 15 May 2020.

Below is a summary of key quality and safety issues, and associated contributing factors, identified by Safer Care Victoria during their review of two incidents involving returned travellers in hotel quarantine in Victoria.

Based on evidence and information available to Safer Care Victoria at the time of writing, these issues were evident at the time of the two incidents (3 to 13 April 2020). It is noted that certain information sought by the team was unable to be provided or obtained during the data collection period. In addition, some individuals invited for interview in relation to these incidents declined to be interviewed during the data collection period.

Due to the ongoing detention of returned travellers in hotel quarantine as a result of the COVID-19 pandemic, a rapid review methodology was employed. This methodology has some limitations regarding data collection and scope. These limitations were considered against the need for a rapid review process to inform system improvement in real time. With that approach and goal in mind, the review teams share a summary of issues identified below.

Issue	Comments
Selection of staff	Victorian public sector staff putting themselves forward to take up temporary new roles in the hotel quarantine system did not have an adequate opportunity to pre-emptively nominate the types of roles for which they would or would not be suitable. In selecting and assigning staff to new roles, there were limited checks regarding their relevant skills, experience, education or professional background, in order to assess their suitability for particular roles. As a result of the above (and possibly other factors) some staff were assigned to roles for which they did not have the appropriate knowledge base, skill set or relevant experience.
Onboarding and training of staff	For many of the new roles created for the hotel quarantine system, there was a lack of clear and detailed job descriptions and/or job cards available to staff when they commenced in their roles. This resulted in a lack of clarity about individual roles and responsibilities. There was limited to no formal and standardised training, orientation or opportunities for mentoring available to staff commencing new roles within the hotel quarantine system. Some individuals reported taking the initiative to develop and provide training for their teams. However, these efforts were individually driven by frontline staff and were therefore not consistently adopted across the system. On the day of their first shift in their new role, some staff did not experience adequate handover from their counterpart who had worked the previous shift.
Continuity of staffing	Continuity of staff rostered at hotel locations was limited. This resulted in staff reporting challenges relating to their roles. These included issues relating to hotel familiarity, teamwork, clarity regarding roles and responsibilities, and continuity of support provided to returned travellers. Some staff reported requesting to be rostered at the same location and/or team. However these efforts were individually-driven by frontline staff, and therefore were not consistently adopted across the system.
Collection, storage and access to personal information about returned travellers	There were reports of inadequate and inconsistent systems and resources (paper or electronic) available for the recording information about returned travellers. As a result, such information (e.g. health and welfare notes, returned traveller requests and concerns) was commonly recorded in ad hoc ways (e.g. staff member's personal note books, post-it notes, whiteboards etc). During a returned traveller's period of detention, they were required to complete (either on paper or via phone) a variety of forms, questionnaires and assessments. These were administered by multiple entities and teams (i.e. nursing staff, welfare check team, hotel staff and the Department of Jobs, Precincts and Regions). The information gathered through the multitude of channels was not centrally coordinated and stored, and thus was not available to all staff who required it. As a result, staff often did not have the information needed to perform their roles optimally and provide adequate support and care to returned travellers. For example, welfare check callers did not have access to nursing notes or the hotel questionnaire when making calls to returned travellers.
Policies and procedures	A number of policies and procedures considered necessary to ensure safe operation of the hotel quarantine system were reported to be either under development or not readily accessible by frontline staff at the time these incidents occurred. For example, policies regarding appropriate use of personal protective equipment, escalation of concerns about returned travellers not answering calls, how to conduct handovers, record-keeping and issues

	tracking, or managing ambulance attendance. Some policies or procedures reflected plans and intentions that were not operationalised or achieved in practice (e.g. differences between planned frequency of welfare checks and actual frequency of these).
Escalation and leadership responsibilities	There was a reported lack of clarity among frontline staff about escalation processes and pathways, and the circumstances under which they should be utilised. Where formal policies or processes had been formulated, frontline staff reported being either unaware of these, or these were not operationalised fully. There was a reported lack of understanding amongst frontline staff in relation to decision-making hierachies in complex and unprecedented situations. For example, deciding on the appropriate level of clinical care, or when to escalate concerns about a returned traveller not responding to phone calls and door knocks. There was no dedicated role on-site with specific responsibility for decision-making regarding returned traveller health and wellbeing. This role was often either shared between nurses, or an informal 'lead' nurse was appointed for the shift by the nursing team, with access to consultation with a doctor (most often off-site) if required. Some team leaders, authorised officers and nurses reported not receiving adequate information about to whom they should escalate concerns (e.g. specific names, roles and direct phone numbers). Staff sometimes had to use indirect means to request escalation and assistance about issues and concerns (such as use of general email or 'helpline' phone numbers), leading to reported delayed or no response or definitive action.

APPENDIX 3: REPORT VERSION TRACKING

Date	Action
21/5/2020	Draft report shared with Merrin Bamert, Commander, Operation Soteria, requesting fact check.

To receive this publication in an accessible format phone 03 9096 1546, using the National Relay Service 13 36 77 if required, or email **info@safercare.vic.gov.au**

Authorised by the Victorian Government, 1 Treasury Place, Melbourne.

Re: URGENT: Fact-checking of draft report for hotel quarantine incident 1.

From: REDACTED (DHHS)" <REDACTED@safercare.vic.gov.au>
To: "Merrin Bamert (DHHS)" <REDACTED
Date: Mon, 25 May 2020 11:55:58 +1000
Attachments: HQI1 Final Report 20200525 (1).pdf (584.88 kB)

Hello Merrin,

Thank you for getting back to us so promptly. Your explanation of what was and was not in place on the exact days of the incident is very useful and valuable, and we have adjusted the content of the report accordingly – including the timeline and actor map as you mention. Thank you for helping us to clarify that.

We acknowledge that you were not in your current role, in its current iteration, at the time of the incident, and that limits the specific knowledge you have about the events. In writing the report, we have relied on the evidence provided by those who were there in establishing those facts. So in sending this to you, we were looking for exactly the kind of higher-level clarifications you provided. Apologies if I didn't make that clear enough. On the basis that you have provided those clarifications, and we have acted on them, we will proceed to the next stage with the report.

In light of your feedback about REDACTED and related issues, I have also provided further clarification and information in the 'background' section of the report. I have noted that REDACT was unexpected for everybody involved. I have also clarified that the intent of the review team, consistent with accepted review methodology, is neither to speculate or draw conclusions about the cause(s) of REDACTED nor about attributing blame or fault for that decision. Rather it is about considering the adequacy of care provided REDAC based on the information available REDACTED and the system at the time. To support this, via the AcciMap, we have acknowledged that the information available to staff at the time was limited REDACTED

I have attached a version of the document with the updates mentioned above for your reference. This is the final version. Please note this document is protected and confidential, and not to be shared. It will now be going to the Operation Soteria Working Group for consideration.

Thank you for your time in providing feedback, and clarifying some facts for us. We appreciate your efforts to facilitate the review process.

Regards,

REDACTED
Safer Care Victoria Academy
REDACTED
E REDACT@safercare.vic.gov.au
W safercare.vic.gov.au

From: Merrin Bamert (DHHS) <REDACTED>
Sent: Thursday, 21 May 2020 9:28 PM
To: REDACTED (DHHS) REDACTED@safercare.vic.gov.au>
Cc: REDACTED (DHHS) REDACTED@safercare.vic.gov.au>; REDACTED (DHHS) REDACTED@safercare.vic.gov.au>
Subject: RE: URGENT: Fact-checking of draft report for hotel quarantine incident 1.

REDACTED

REDACTED

Regards

merrin

Merrin Bamert
Commander, Operation Soteria, Covid - 19
Director, Emergency Management, Population Health and Health Protection
South Division
Department of Health and Human Services
Level 5 / 165-169 Thomas Street, Dandenong, 3175
REDACTED
e: REDACTED

From: Merrin Bamert (DHHS)
Sent: Thursday, 21 May 2020 9:21 PM
To: REDACTED (DHHS) REDACTED@safercare.vic.gov.au>
Cc: REDACTED (DHHS) REDACTED @safercare.vic.gov.au>; REDACTED (DHHS) REDACTED @safercare.vic.gov.au>
Subject: RE: URGENT: Fact-checking of draft report for hotel quarantine incident 1.

Hi

I am not sure how to review the facts of this report as I am only aware of my involvement which was the call at 6pm so not sure how to do what you are asking. I can only confirm that what you have been told about the day is the same as I what I observed in his notes.

I can say however though that the roles listed on page 7 are incorrect – line two under organisation and management.

We did not have the EOC set up and therefore did not have a commander or dep commander at that time.

This operation was being managed out of a range of sites with no clear operational structure (which is why I worked on the Saturday morning) the same day REDACTED to start drafting one.

I am not sure who you would say was in charge at that point however email traffic was going to the SEMT.

I was certainly not the commander (and had no official role on any structure) at the time so the timelines on page 6 need to change I was called by Jason Helps (SCC) to go in on the night and assist as they wanted an exec to help out and I had been assisting the hotels from the commencement of the policy.

The EOC structure did not officially commence till the following week. Its first official day was the following Friday 17 April

Regards

Merrin

Merrin Bamert
Commander, Operation Soteria, Covid - 19
Director, Emergency Management, Population Health and Health Protection

South Division
Department of Health and Human Services
Level 5 / 165-169 Thomas Street, Dandenong, 3175
REDACTED
eREDACTED

From: REDACTED (DHHS) <REDACTED
Sent: Thursday, 21 May 2020 10:09 AM
To: Merrin Bamert (DHHS) <REDACTED
Cc: REDACTED (DHHS) REDACTED @safercare.vic.gov.au>; REDACTED (DHHS) REDACTED @safercare.vic.gov.au>
Subject: URGENT: Fact-checking of draft report for hotel quarantine incident 1.

Good morning Merrin,

Thanks once again for your assistance while we have been undertaking two reviews relating to incidents in hotel quarantine. We appreciate your time and your efforts in assisting us to access the evidence and information required for the review.

Attached is a draft report in relation to what we refer to as incident one (involving the person CP), which we are providing first. The report relating to the other incident (involving the person EC) will follow shortly. We are providing this draft to you for the purposes of fact-checking, prior to the draft being finalised. Please do not distribute the draft any further.

We ask that you provide feedback specifically about any factual inaccuracies in the report's content. Should you highlight any inaccuracies, please note that we may require further information to assist us in contextualising and verifying the new information.

Please keep in mind that, as per standard incident review methodology, the information in the report describes – based on the evidence examined by the review team – events and circumstances as they relate to what happened 'on-the-ground' on the specific days in question, involving the specific individuals and the specific hotel. The information may be accurate, while also differing from your own high-level understanding of how the system operated more generally at the time (e.g. as you would have expected, or at different hotels, or in other circumstances).

Please also keep in mind that, as per standard incident review methodology, the information in the report refers to the state of the hotel quarantine at the time of the incident, and intentionally does not describe any changes that may have occurred since that time. Once the report is finalised and provided to the agreed receivers, Appendix 1 provides the opportunity for any changes in the system since the incident to be recorded and explained, including noting any recommendations already actioned.

To facilitate us providing the report to the Operation Soteria Working Group by early next week, please provide any feedback by COB Friday 22 May 2020.

Regards,

REDACTED
Safer Care Victoria Academy
T REDACTED
E
W safercare.vic.gov.au

Incident review report: hotel quarantine, incident one

From: REDACTED@safercare.vic.gov.au>

To: "Euan Wallace (DHHS)" <REDACTED "Andrea Spiteri (DHHS)" <REDACTED "Meena Naidu (DHHS)" <REDACTED, "Pam Williams (DHHS)" <, "Merrin Bamert (DHHS)" <>, "Colleen Clark (DHHS)" <, "Anita Morris (DHHS)" <, "Nicole Brady (DHHS)" <REDACTED, "Melissa Skilbeck (DHHS)" <REDACTED, "Jacinda de Witts (DHHS)" <

Cc: REDACTED (DHHS)" REDACTED @sREDACTED, "REDACTED (DHHS)" REDACTED @safercare.vic.gov.au>

Date: Thu, 28 May 2020 13:06:55 +1000

Attachments: HQI1 Final Report 20200525.pdf (529.67 kB)

Hi All,
Please find attached the first report from Safer Care Victoria on clinical incidents occurring in hotel quarantine. This report will also be sent to the Secretary.
The Operation Soteria working group will discuss the recommendations.
Thanks

REDA
REDACTED
Principal Advisor, Office of the CEO
REDACTED
W safercare.vic.gov.au
Please note I work part-time hours over 5 days, usually leaving at 2:30pm.

Safer Care Victoria

Safer Care Victoria

Safer Care Victoria report on clinical incidents occurring in hotel quarantine in Victoria

At the request of the Secretary of the Department of Health and Human Services, Safer Care Victoria undertook reviews into two serious clinical incidents involving detainees in hotel quarantine in Victoria. The first incident involved the apparent suicide death of REDACTED (Hotel Quarantine Incident 1), and the second incident involved the care of REDACTED year old REDACTED who developed COVID-19 symptoms and deteriorated rapidly, requiring intensive care unit admission at the Alfred Hospital (Hotel Quarantine Incident 2).

Two teams of reviewers with relevant incident review and subject matter expertise were convened to undertake the reviews. The purpose of the reviews was to identify contributing factors relevant to the specific incidents, as well as provide insights into issues affecting the operation of hotel quarantine in Victoria, with the view to facilitating timely system improvements. To this end, the final output will be two separate reports, each detailing the contributing factors relevant to the incident, along with a summary of key high-level themes identified in both reviews which are relevant to the overall operation of hotel quarantine. These will be shared with the Secretary as well as the Operation Soteria Working Group, which includes representatives from Public Health, Emergency Operation Centre, Accommodation Commander, Welfare Cell, Office of Chief Psychiatrist and Safer Care Victoria. The Operation Soteria Working Group will be responsible for monitoring the implementation of the recommendations.

Herewith please find a draft report detailing the contributing factors for Hotel Quarantine Incident 1, along with a summary of key themes relevant to the overall operation of hotel quarantine in Victoria that have so far been identified across both reviews (see Appendix 2). The draft report for Hotel Quarantine Incident 2 will follow shortly.

The findings and recommendations provided are based on evidence and information available to the review teams at the time of writing and relate to issues and circumstances at the times and places the incidents took place (i.e. 3 to 13 April 2020). It is also noted that certain information sought by the review teams was not able to be provided or obtained, or was conflicting, and some individuals with potentially relevant information declined to be interviewed. It is further acknowledged that a number of recommendations and key themes may have since been addressed.

Yours sincerely,

REDACTED

Director, Patient Safety and Experience
Safer Care Victoria

Date: 25 / 05 /2020

VICTORIA State Government

Incident review report: Hotel Quarantine Incident One

ENDORSEMENT

Review lead

Signature: REDACTED **Date:** 25/05/2020

Executive sponsor

Signature:  **Date:** 25/05/2020

REVIEW TEAM

Executive sponsor	Director, Centre for Patient Safety and Experience, Safer Care Victoria
Review project manager	Senior Project Officer, Centre for Patient Safety and Experience, Safer Care Victoria
Review lead	Academy Member, Safer Care Victoria
Human factors / methodology lead	Manager, Patient Safety Review, Centre for Patient Safety and Experience, Safer Care Victoria
Review coordinator	Senior Project Officer, Centre for Patient Safety and Experience, Safer Care Victoria
Team member	Academy Member, Safer Care Victoria
Team member	Chair, Mental Health Clinical Network, Safer Care Victoria
Review team support	Senior Project Officer, Safer Care Victoria
Administrative support	Project Officer, Centre for Patient Safety and Experience, Safer Care Victoria

Contents

Safer Care Victoria

CONFIDENTIAL

ABOUT THE REVIEW

Background

On 11 April 2020, REDACTED was found deceased in his room at the Pan Pacific Hotel, Docklands, while in mandatory detention as part of the initiative that would later become known as Operation Soteria. As part of the response to REDACT death, the Secretary of the Department of Health and Human Services requested that Safer Care Victoria undertake an independent review into the incident. This report pertains to that review. We acknowledge that REDACT death will be examined by the Coroner, who is the authority on his official cause of death. However, for the purposes of this review, the review team considered his death as though it were a suicide.

Unless otherwise specified or indicated by grammatical tense, the information in this review describes and relates to the period of the incident, being 3 April 2020 to 11 April 2020. The team acknowledges, based on evidence provided during the review, that some systems and processes have changed since that time. This may mean that certain recommendations have since been addressed, or some findings do not reflect the current state. However, the methodology requires that the review address the events and circumstances as they were at the time.

Method

The ongoing detention of people in hotel quarantine, and need to identify and address any ongoing risks to these individuals in real time, necessitated a rapid review methodology. This methodology has certain limitations regarding data collection and scope. These limitations were weighed against the need for a rapid review process in making final determinations about the methodological approach and scope of the review. The review used a version of the AcciMap method, customised to use the London Protocol – both widely-recognised and validated approaches to rigorous incident review.

The review team acknowledges that REDACT death was unexpected for all involved. We note that in cases of suspected suicide, the purpose of a review is not to determine the 'cause' of the person's death, as this requires speculation about the state-of-mind and complex circumstances of the person who has died. Therefore, the review team cannot determine for certain whether changes to the events and factors surrounding REDACT death would have ultimately contributed to a different outcome. For this reason, the review focuses on addressing whether the management of REDACT quarantine corresponded to an adequate standard of care, based on the information available about him to those involved at the time. Therefore, in producing this report, the team do not purport to make any conclusions about fault or blame, nor whether any changes to the circumstances outlined would have prevented REDACT death.

Evidence

The team has collected and considered a variety of evidence, including (but not limited to):

- Interviews with staff from the following categories: DHHS/Operation Soteria management, welfare check team members, hotel team leaders, nursing staff, Authorised Officers and REDACT family.
- Templates, forms and questionnaires pertaining to detainee health and wellbeing including the 'Welfare Check – Initial long form survey', 'Confidential Hotel Questionnaire', 'DHHS Hotel Isolation Medical Screening Form' and 'COVID-19 Assessment Form'.
- Copies of the above containing REDACT information. Except for the 'Confidential Hotel Questionnaire', for which only a blank template was provided, despite the completed version being requested.

- Other ad hoc records including an incident report, Victoria Police witness statement, handwritten on-site nurse notes, Post-it notes, Pan Pacific Room Request records (provided for 5-7 April 2020).
- Plans, policies and procedures including 'Operation Soteria – Operations Plan', 'COVID-19 – Interim Healthcare and Welfare Mandatory Quarantine Plan (Draft)', 'Team Leader Pack – Hotels' and 'Referral Pathways for people issued COVID-19 quarantine orders'.
- Information for detainees including 'Mental Health and coronavirus (COVID-19) – Information for those in isolation' and 'Mental Health and Wellbeing'.

We acknowledge the cooperation and openness of the Operation Soteria staff who shared their experiences with us, and their willingness to do so despite the significant emotional impact the event had on some of them. We are especially grateful to REDACTED and REDA for providing information about REDAC who he was to those who loved him, his life, and the events surrounding his death, during their time of grief.

The information in this report is based on evidence and information available to the team at the time of review. It is noted that certain information sought by the team was not able to be provided or obtained, and some individuals with potentially relevant information declined to be interviewed. Therefore, the review team acknowledges that there may be unintended gaps or inaccuracies in the report that the team's reasonable efforts to seek required information were unable to rectify. The information presented was accurate - to the best of the team's knowledge – at the time of writing, given the information available to us, and with an eye to the potential limitations identified above.

Safer Care Victoria

INCIDENT REVIEW

Description of the incident

On 03/04/2020 REDACTED was issued a detention notice after arriving from REDACTED where he normally resided. The detention notice required him to remain in hotel quarantine for 14 days.

REDACTED was detained as part of the Victorian government's response to the COVID-19 pandemic (later known as Operation Soteria), in line with a national agreement to require mandatory quarantine of any international arrivals after midnight 28/03/2020. REDACTED was detained alone in REDACTED at the Pan Pacific Hotel in Docklands, Melbourne.

REDACTED

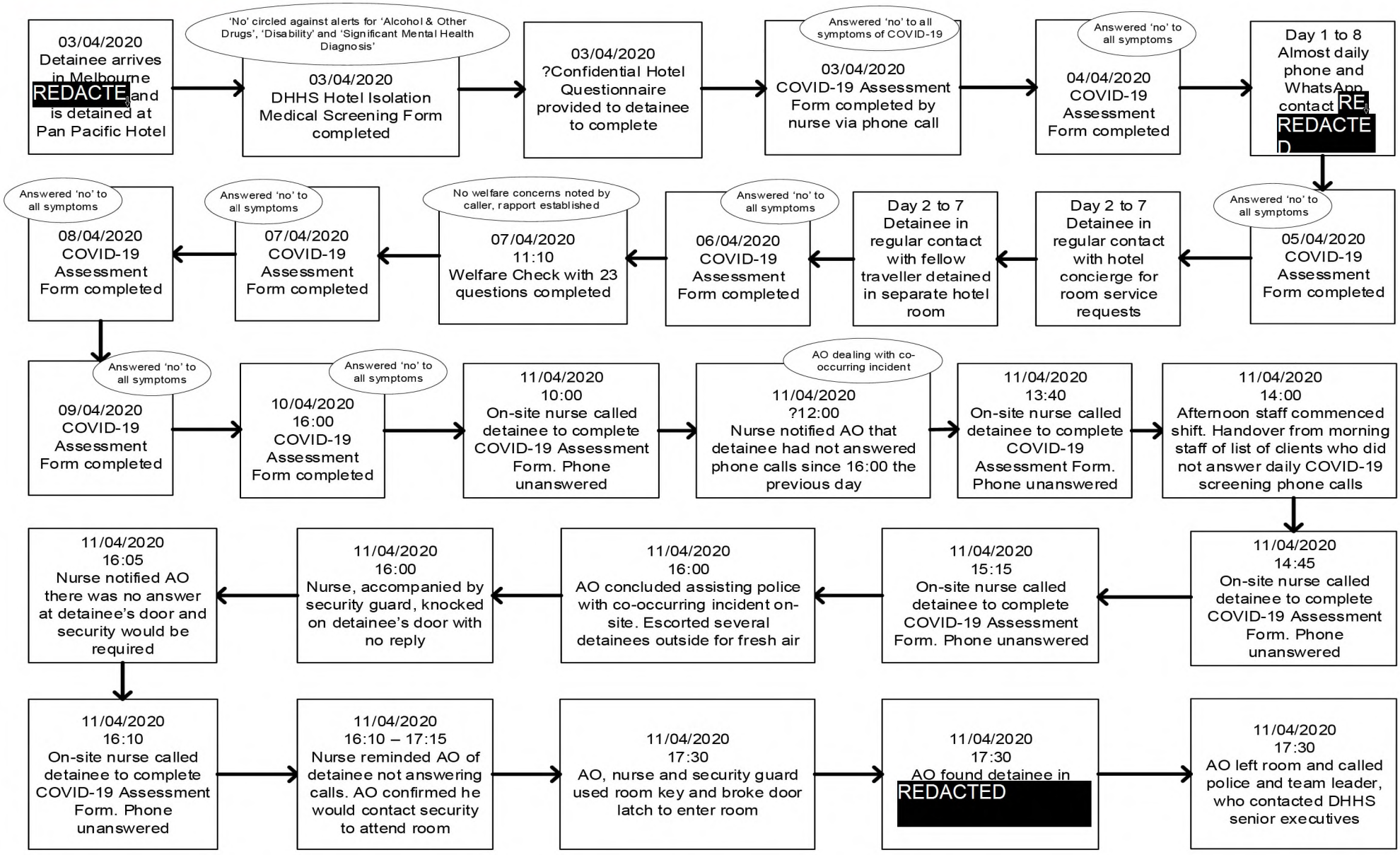
REDACTED, on-site nurses phoned him daily to complete the COVID-19 Assessment form (to screen for COVID-19 symptoms). He completed this assessment daily, and did not report COVID-19 symptoms during his detainment. The 'Welfare Check – Initial long form survey' was completed on day five of REDACTED REDACTED No concerns were identified. REDACTED

REDACTED

On 10/04/2020, there was a serious incident involving another detainee barricading themselves in their room. The incident resulted in significant police attendance and activity at the hotel. That incident continued into 11/04/2020 – the day REDACTED was found deceased REDACTED

Throughout day nine of his detainment (11/04/20), REDACTED did not answer repeated calls to his room from nursing staff attempting to complete the COVID-19 Assessment form. Nursing staff escalated the issue of REDACTED to the Authorised Officer. The Authorised Officer attended to some other matters, including the barricading incident and other detainees with identified significant mental health concerns, before turning his attention to the concerns raised about REDACTED. On the basis of the repeated unanswered calls, at approximately 17:30 on 11/04/2020, the Authorised Officer, a security guard and on-site nurse attended REDACTED room, and obtained entry. They found REDACTED deceased. It appeared he had died by suicide, REDACTED

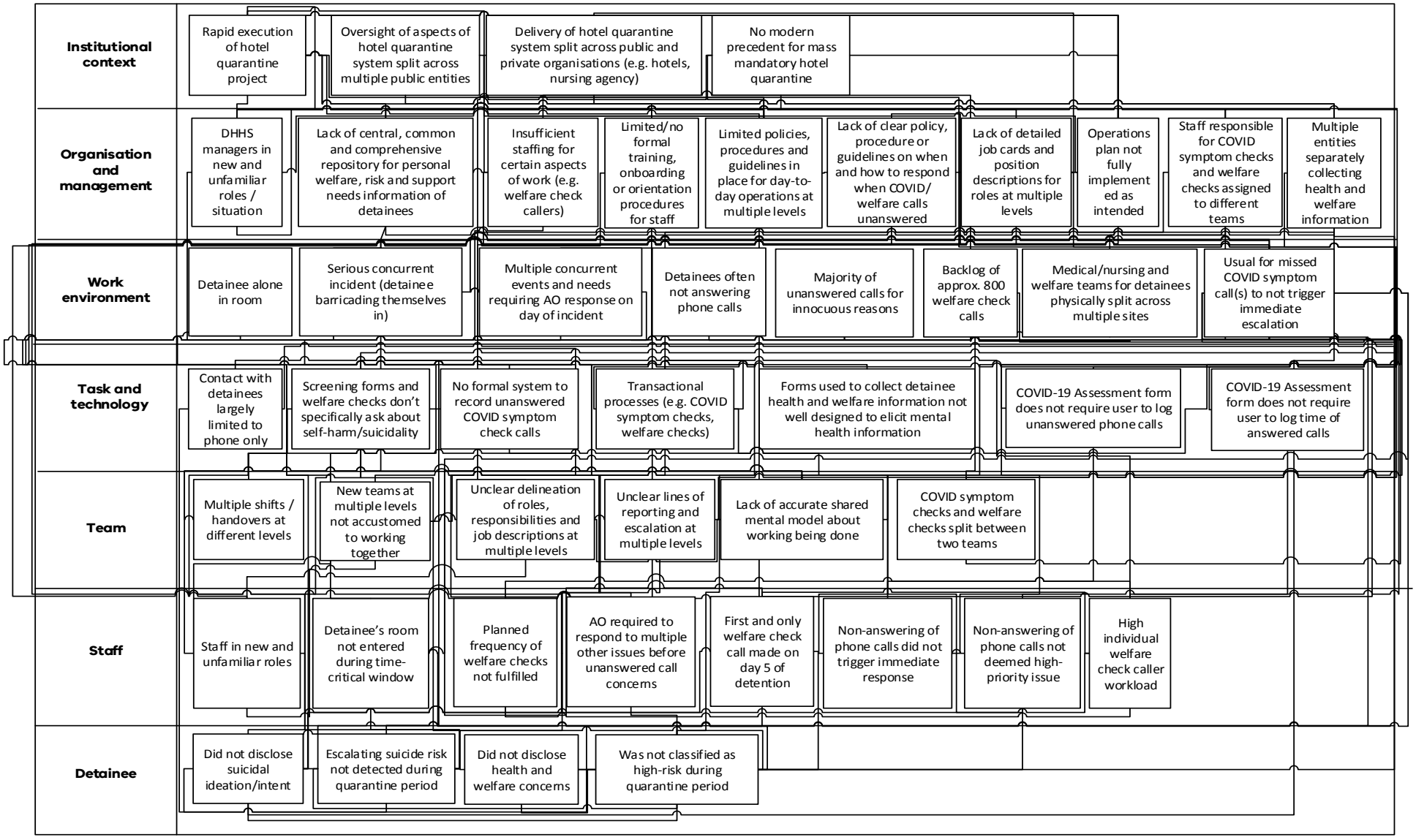
TIMELINE OF EVENTS



ACTOR MAP

Institutional context	Victorian Government	Department of Health and Human Services	Department of Jobs, Precincts and Regions			
Organisation and management	DHHS management					
Work environment	Hotel public areas	Hotel room	Hotel work areas	DHHS offices		
Team	DHHS Authorised Officer Team Leader					
Task and technology	DHHS Hotel Isolation Medical Screening Form	Welfare check - initial long form survey	COVID-19 Assessment Form	Confidential Hotel Questionnaire		
Staff	Welfare check caller	DHHS Authorised Officer	Nurse 1	Nurse 2	Nurse 3	Team Leader
Detainee	Detainee	REDACTED	REDACTED	Fellow detainee involved in major incident		

ACCIMAP



Safer Care Victoria

ANALYSIS OUTCOMES

The review team has identified system and process improvement opportunities. Some are directly related to the event. These are described in 'Findings'. Others were identified in the course of reviewing the event, but the review team did not establish that they played a direct role in the events surrounding REDACTED death. These are described in 'Learnings'.

FINDINGS

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

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

Reasoning

While not completed prior to the incident, the Operation Soteria 'Operations Plan' is indicative of the intentions for running the hotel quarantine system at the time. It notes that DHHS would be responsible for the "provision of regular welfare calls to all quarantined passengers". The meaning of "regular" is not further specified. Interviewees advised the review team that the original intention was that welfare check calls would be made daily. Staff from outside the welfare check team indicated they believed or assumed that welfare check calls were and had always been made daily to all detainees.

Staff reported that at the time of the first and only welfare check call to REDACTED the welfare check team had a backlog of approximately 800 calls to work through. In interview, staff also noted that the script/form provided to welfare check staff for making initial calls to detainees included a paragraph – to be read to the detainee – telling the detainee to expect welfare calls "regularly". This script has been sighted by the review team. They told the review team that staff were instructed not to convey this information, as it was no longer accurate. In interview, staff indicated that due to the backlog, the revised aim was for two welfare calls to be made to detainees throughout their detainment.

Due to the backlog, the first welfare check call (to administer the 'Welfare Check – Initial long form survey') was not made to REDACTED until day five of his detainment. It was the only welfare check call made during the nine days of detainment before his death. Evidence obtained in interview indicated that it was not unusual for detainees who were not already identified as high risk to receive their first welfare check call around detainment day 5-7.

Detainee safety implications

The delayed and infrequent welfare check calls resulted in missed opportunities to monitor detainee welfare and meet duty-of-care obligations in a timely and consistent manner. It also resulted in missed opportunities for detainees to request support or disclose health and welfare concerns.

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

Reasoning

Welfare check team members reported that they had access to minimal information about detainees prior to calling them for the first time (by then, often day 5-7 of the detainee's detention). Information available to staff making these calls was typically only the detainee's name, date of birth, and expected detention period. Therefore, any information already collected about the detainee's health, welfare and support needs through other channels (including information in the 'welfare questionnaire' referenced in the 'Team Leader Pack – Hotels and Confidential Hotel Questionnaire'), was not accessible to welfare check callers.

The review team has sighted a template of the 'Confidential Hotel Questionnaire' provided to detainees. The template advises detainees that "the information [they] provide will be used to help support [them] during [their] quarantine period". However, the information gathered was not systematically shared with key teams responsible for detainee health and welfare, including welfare check callers and medical staff. The review team requested a copy of the completed 'Confidential Hotel Questionnaire' for REDAC However, it was not provided. Therefore, it is unclear if REDAC received and/or completed this questionnaire, or what answers and information he provided on it.

Similarly, staff reported generating and having access to health and welfare information about detainees that was not systematically made readily available to other teams and individual staff members. For example, information about detainee responses to daily COVID-19 Assessment Form calls was available to nurses, but not the welfare check team. In addition, some detainee health and welfare information was written on a whiteboard (visible only to some on-site staff), in staff member's personal notebooks (not visible to others), and on 'Post-it' notes.

Detainee safety implications

The lack of central, comprehensive and accessible repository for detainee health and welfare information resulted in inadequate communication about detainee health and welfare concerns and needs within and between teams. It also resulted in staff being unable to have holistic and global oversight to adequately identify, assess and manage health and welfare risks for individual detainees.

3. **Detainee health and welfare information was collected in a fragmented manner, involving multiple entities and teams and multiple formats.**

Reasoning

The review team has sighted multiple templates/forms/questionnaires/surveys, some of which have been completed about, for or by REDAC. Examples include the 'COVID-19 Assessment Form', 'Hotel Isolation Medical Screening Form', 'Welfare Check – Initial long form survey' and 'Confidential Hotel Questionnaire'. The content of these forms is not complementary – with evidence of both duplication and, in the view of the review team, notable omissions (see Finding 7).

For example, both the 'DHHS Hotel Isolation Medical Screening Form' and 'Welfare Check - Initial long form survey' ask detainees to answer questions about allergies and "immediate" health/medical conditions. And both the 'Welfare Check - Initial long form survey' and the 'Confidential Hotel Questionnaire' ask the detainee how

children/others travelling with them are “coping”. And the ‘COVID-19 Assessment Form’ and ‘Welfare Check - Initial long form survey’ both ask detainees about symptoms of COVID-19. By contrast, none of the forms sighted by the review team directly and clearly ask the detainee if they have mental health concerns aside from those attached to a formal medical diagnosis, if they are a smoker (there is a question about requiring nicotine patches, but the two are not synonymous), or if they would like to speak with someone about any issues of concern regarding their health and welfare.

The review team requested a copy of REDACTED ‘Confidential Hotel Questionnaire’, but this was not provided. It is therefore unclear if REDACTED received and/or completed this questionnaire, or what answers and information he provided on it.

The review team noted that day-to-day operations were marked by a lack of communication and coordination regarding detainee information collected through these fragmented channels. The review team also noted that the content of each form is focused on issues which match the specific functions of each of the entities and teams administering them. In interview, staff indicated that detainee health and welfare information was collected on separate forms because individual entities and teams were separately collecting only information required to fulfil their designated function. For example, the nursing team received the ‘Hotel Isolation Medical Screening Form’, the hotel received the ‘Confidential Hotel Questionnaire’, and the welfare check team conducted their own 23-question survey in the first call (therefore not receiving substantive information about individual detainees beforehand).

The review team’s view is that, most detainees were most likely unaware of the nuances of the complex structure of the hotel quarantine system and its many teams and entities. Therefore, it would have been unclear that information they provided in the varying forms was not shared among all those who had responsibility for their health and welfare. It would also have been unclear which form or team was most appropriate for raising concerns that were not explicitly addressed by the pre-formulated questions.

Detainee safety implications

The lack of a coordinated and consistent method for collecting detainee health and welfare information, and collating and sharing it, compromised staff members’ ability to adequately identify and manage health and welfare risks for individual detainees. It also compromised detainee’s ability to direct their health and welfare questions, support needs and concerns to the individuals and teams best suited to address them.

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

Reasoning

In interview, on-site staff tasked with completing daily COVID-19 Assessment symptom screening calls articulated a shared mental model that unanswered calls to detainees were almost never a cause for health and welfare concerns. They noted that most unanswered calls were the result of detainees being engaged in innocuous activities such as sleeping (they specifically sighted the effects of jet lag), bathing, talking on the phone or online, or using headphones. Staff reported that the daily transactional nature of the COVID-19 Assessment symptom screening calls became predictable to detainees, contributing to some who were asymptomatic not answering the calls, or taking the in-room landline phone off the hook.

The review team heard that on average, by the end of a typical day, between 5-15 detainees had not answered repeated COVID-19 Assessment symptom screening calls, and a nurse was required to knock on their door to elicit a response. Between them, staff reported that in their personal experiences of such follow-up 'door knocks', only one had uncovered a serious reason for the unanswered calls. Nursing staff and AOs reported that as a result, they did not routinely prioritise or escalate unanswered calls (beyond follow-up calls) until the end of the day, or even later.

In REDACT case, there were at least five unanswered calls throughout 11/04/2020. Due to a lack of formal system for documenting these unanswered calls (see Finding 5), the review team could not be certain if there were more unanswered calls. There was a delay of more than 24 hours from the time REDAC last answered a COVID-19 Assessment symptom screening call (approximately 16:00 on 10/04/2020 - as per police witness statement) to when the AO, nurse and security guard forced entry to his room at approximately 17:30 on 11/04/2020.

It is the view of the review team that the frequency of unanswered calls, and the pattern of these unanswered calls not indicating serious issues, resulted in less priority being placed on following up unanswered calls compared with other tasks. In REDACT case, the AO noted the issue of REDACT unanswered calls was escalated to him, but he was required to deal with multiple competing issues that he deemed to be of higher priority, before attending REDACT room for follow-up. The other matters deemed to be of higher priority included the concurrent serious barricading incident, and providing assistance to several detainees with anxiety who has previously been identified as high risk.

Detainee safety implications

The shared mental model that unanswered COVID-19 Assessment symptom screening calls mostly did not indicate significant concerns increased the risk that a definitive response may be delayed. This posed a risk to safety in instances where the main indicator of a detainee's need for urgent assistance was unanswered calls.

5. **There was a lack of specific formal policy about the threshold for escalating concerns about repeated unanswered COVID-19 Assessment calls, and a lack of formal procedure for tracking these.**

Reasoning

In interview, staff stated there was no formal policy about when to escalate instances of repeated unanswered COVID-19 Assessment symptom screening calls for more definitive action (e.g. knocking on or opening the detainee's door), and no formal procedure for tracking unanswered calls. This lack of formal policy was corroborated by an email (sighted by the review team) from the Director, Emergency Management to DHHS senior executive on 12/04/2020 (the day after REDACT was found deceased). In that email, the Director cited the lack of such a policy, and the need for one to be developed.

The lack of clarity about the threshold for escalating unanswered calls was evident when the review team asked staff to describe the escalation process for unanswered calls. They gave variable answers as to when escalation should occur (e.g. after two calls, after four hours), but were clear that the AO was the appropriate line of escalation. They noted that when to act was a matter of judgement (in the absence of a formal policy), and their decisions took into account perceptions that AOs sometimes had high workloads and competing priorities.

In the absence of a formal policy or procedure, nursing staff described having developed a work-around to track and follow-up unanswered calls. If a call was not answered the first time, nursing staff would place the detainee's COVID-19 Assessment Form in a designated box. Nurses would later revisit that box "if [they] had time" and make the follow-up calls. The forms of detainees who answered follow-up calls were removed from the box. The forms of those who did not answer were returned to the box, and were revisited again when a nurse had time available. Post-it notes/whiteboard notes were also used to record the names of detainees with repeated unanswered calls. This cycle continued until the end of the day, when staff would attend the rooms of any detainees whose forms remained in the box, to knock on their doors.

The lack of policy and process for tracking unanswered calls was also evident in the COVID-19 Assessment Form, which does not require (or provide specific space for) the caller to log unanswered calls. It also does not provide space for callers to log the times of answered calls (only the dates). This issue was evident in RE REDA case, where the date of his last answered COVID-19 Assessment was recorded on his form, but not the time. Therefore, the extended time since his last answered call was not readily evident to all relevant staff.

Detainee safety implications

A lack of formal policies and processes around tracking and responding to unanswered COVID-19 Assessment calls increased the risk that a definitive response may be delayed. This posed a risk to safety in instances where the main indicator of a detainee's need for urgent assistance was unanswered calls.

6. **Due to workload and delegation challenges, Authorised Officers (AOs) were sometimes required to prioritise multiple competing demands, resulting in delays in attending to potential detainee health and welfare concerns.**

Reasoning

Due to the strict legal requirements around detention procedures, and the AOs specific legal role, they had limited ability to delegate tasks required of them under the Health and Wellbeing Act 2008. In addition, the ability to accurately predict any AO's workload from day-to-day was limited. This was due to multiple factors including a reported lack of prior information about the needs of the detainee cohort (and individual detainees) before arrival, and uncertainty about how these needs may arise and change over time. In interview, on-site staff reported that AOs were frequently very busy, juggling multiple competing demands for their time and attention.

This was seen in REDACT case, as evident in interviews, as well as the AO's statement to police. On the day nurses escalated their concerns about REDACT unanswered calls to the AO, he was required to deal with a serious concurrent multi-day incident involving a detainee who had barricaded himself in his room, requiring significant police presence. Concurrently, the AO was required to attend at the rooms of multiple people identified as high risk due to anxiety-related issues. He attended to these issues before attending REDACT room to follow-up the unanswered calls.

Detainee safety implications

Because AOs sometimes face complex competing demands and priorities with limited opportunities to delegate to non-AO staff, this may limit their ability to respond to detainee health and welfare needs or incidents in a timely manner.

7. **The forms for collecting detainee information were not well designed to readily elicit specific and detailed information regarding past or current mental health concerns, self-harm or suicidal ideation.**

Reasoning

The review team has sighted multiple templates, forms and questionnaires used to gather information from and about individual detainees. None of those sighted by the review team directly and specifically asked about past or current self-harm or suicidal ideation. Welfare check staff also reported they did not routinely ask such questions of detainees.

Overall, the forms sighted contained limited questions that addressed mental health. In the view of the review team, questions that did allude to mental health generally were not direct, in plain language, or written in a manner that was relatable and understandable to the general public. Where mental health was mentioned, this was typically done using a 'medical model' approach, focused on identifying diagnoses, but not more general issues about mental distress, risk factors or concerns that may not specifically correlate to a 'diagnosis'. For example, the questions may not have captured the concerns and risks associated with people worried about managing grief in quarantine. For example, the one direct mental health question in the 'DHHS Hotel Isolation Medical Screening Form' read "Significant mental health diagnosis Y/N". This question only clearly applied to those with a formal diagnosis, used the subjective word 'significant', and only provided for a binary yes/no answer (without encouraging further elaboration or disclosure). In another example, the 'Confidential Hotel Questionnaire's' possible allusions to mental health are vague and indirect (e.g. "are you feeling well at the moment?" and "do you or anyone in your group have any immediate health or safety concerns?"). It also contained questions about how children/people accompanying the detainee were "coping", but did not ask the same about the detainee themselves.

In the forms sighted, questions about their support needs place a significant onus on detainees to anticipate their psychological response to, and needs in an unfamiliar, uncertain and potentially stressful situation. And did so prior to detainees having spent any significant time in that situation. Of note is that the forms do not include a list of common support needs to select from (alongside free text space for other needs), which may otherwise assist detainees in identifying their likely support needs.

Detainee safety implications

Not routinely asking a specific question(s) about past or current mental health concerns, self-harm or suicidal ideation represented a missed opportunity for detainees to disclose this information, and thus the opportunity for their welfare and safety to be adequately supported. Forms designed in a way that did not readily elicit information about mental health information and associated risk factors compromised staff members' ability to adequately identify and manage health and welfare risks for individual detainees. It also resulted in missed opportunities for detainees to request support or disclose health and welfare concerns.

Safer Care Victoria

LEARNINGS

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

	Learnings
1	Separate welfare check calls and COVID-19 Assessment symptom screening calls were made to the same detainees by separate teams located at different sites (welfare check team and nursing team respectively). These teams had ostensibly different remits (general welfare checks vs COVID symptom screening), although the distinction was blurred in practice. This duplication of effort decreased the opportunity for holistic oversight of detainee health and wellbeing. It may also have increased the probability a detainee would mention concerns or issues during a call from one team, where those issues were within the remit of the other team, and the information would not be definitively acted upon.
2	Staff sometimes had to use (or felt they had to use) indirect means to request escalation and assistance regarding issues and concerns (such as use of general email addresses or helpline-like phone numbers). This lead to a delayed response or definitive action, or none at all. This was exacerbated by escalated issues being 'lost' in generic email inboxes which received copious numbers of emails, or because staff answering calls to generic helpline numbers were unable to provide definitive answers or actions.
3	Welfare check callers had been working remotely (the team understands this began after the incident), reducing the ability for their work interacting with detainees to be supervised and monitored for quality control and training purposes.
4	Staff putting themselves forward to take up temporary new roles in the hotel quarantine system did not have an adequate opportunity to nominate at the outset the types of roles for which they would or would not be suitable. In selecting and assigning the above staff to new roles, there were limited checks regarding their relevant skills, experience, education or professional background to assess their suitability. Therefore, some staff were placed in roles for which they were not suitably knowledgeable, skilled or experienced, or for which they were otherwise ill-suited.
5	For many new roles created for the hotel quarantine system, there was a lack of clear and detailed job descriptions and/or job cards at the outset, resulting in a lack of clarity about roles and responsibilities.
6	There was limited to no standardised formal training, orientation or shadowing for staff starting new roles in the hotel quarantine system.

Safer Care Victoria

RECOMMENDATIONS

Recommendations describe actions that could be taken to address the findings and/or learnings identified in the review, and achieve system improvement.

The strength of recommendations (weak, moderate or strong) describes the overall likelihood that their implementation is likely to succeed in establishing sustained changes in risk and/or behaviour, and achieve the desired outcomes. This likelihood is determined based on general evidence about human factors, systems improvement and change management.

	Recommendation	Associated findings / learnings	Strength
A	Develop and implement a detainee arrival pack that consolidates the current suite of 'onboarding' forms into a single onboarding form (for data entry into the central repository in Recommendation H), alongside printed information for detainees.	Findings 2, 3 and 7	Moderate
B	Design the new onboarding form to: include a specific question(s) about past or current self-harm and suicidal ideation; be clear, direct and use plain language; not use relative, subjective words such as 'significant' to delineate what information is important; encourage disclosure beyond binary answers; address mental wellbeing from both medicalised and non-medicalised perspectives; and provide specific examples of common support needs.	Findings 3 and 7	Moderate
C	Establish a formal process to ensure each (newly consolidated) detainee onboarding form is reviewed by a single staff member within 48 hours, adopting a holistic approach, to identify and act upon any immediate or ongoing support needs or health and welfare risks factors, identify detainees requiring further risk and assign an initial risk level (see Recommendation D).	Findings 2, 3 and 7 Learnings 1 and 5	Weak
D	Establish a formal process for nursing staff (with additional clinical advice if required) to assign and monitor a health and welfare risk level (low, medium or high) for each detainee, based on all information available (e.g. onboarding form, 'initial screening call', staff observations).This level should be dynamic and changeable at any time in the face of new information or circumstances, with a schedule for regular review of each detainee's risk level.	Findings 3 and 7 Learning 1	Weak
E	Replace current daily COVID-19 Assessment symptom screening calls with daily 'health and welfare screening calls', delivered by nursing staff for detainees of **all risk levels**. Include in these calls the COVID-19 Assessment symptoms screening questions, and other basic health and welfare questions to screen for unmet support needs or elevated safety and welfare risks.	Findings 1, 3, 4 and 7 Learnings 1, 2 and 5	Moderate
F	For detainees classified as **medium or high risk** only, extend the purpose of the new daily 'health and welfare screening calls' (see Recommendation E) to specifically discuss, monitor and provide support around their specific health and welfare issues.	Findings 1, 3, 4 and 7 Learnings 1, 2 and 5	Moderate
G	For detainees classified as **low risk**, make the provision of regular 'check-in calls' from the welfare team an optional, opt in addition to receiving the mandatory 'health and welfare screenings calls' (to provide social contact and practical needs-check) (see Recommendation E). Implement processes for welfare team members with concerns to escalate these for potential re-classification of a detainee as higher risk.	Findings 1 and 4 Learning 1	Weak
H	Implement a comprehensive central repository for detainee's personal information (including health and welfare information) accessible to all staff with a role in providing services, care, support and oversight for detainees. Include functionality to provide an 'alerts list' for each shift to identify detainees with a medium or high risk level, and the reasons for those ratings.	Findings 2 and 3 Learning 1	Strong
I	In the central repository of detainee personal information, design the section for logging health and welfare calls (from the nursing and welfare teams) to include a specific field(s) for users to record the dates *and times* of both answered and	Findings 2, 3 4 and 5	Moderate

	unanswered calls to detainees (with the list of unanswered calls automatically visible to users).		
J	Offer detainees the option (at onboarding and throughout their detainment, for example via text message or email) to nominate a time slot each day in which they prefer to take calls from welfare and/or nursing staff, and call detainees during the nominated time slot.	Findings 1 and 4 Learning 1	Weak
K	Implement a formal policy about when to escalate situations in which detainees are not answering calls from nursing or welfare teams – using a decision-tree approach that accounts for factors such as number and frequency of unanswered calls, detainee's existing health and welfare risk factors, and previous behaviour in answering/not answering calls.	Findings 4 and 5 Learning 5	Weak
L	Increase and/or more strategically roster the number of AOs on duty at one time to ensure adequate baseline capacity, and rapid response surge capacity that AOs can directly and immediately request if they are task- or demand-overloaded.	Finding 6 Learning 2	Moderate
M	Establish a formal selection process for staff taking up new roles that accounts for their skills, preferences and attributes. Require that welfare team members have relevant background or experience (e.g. mental health, counselling, social work, peer support etc). Complement this with targeted initial and ongoing training and supervision (including for remote working staff) for all new and current staff.	Learnings 3, 4, 5 and 6	Moderate

APPENDIX 1: RECOMMENDATION ACTION PLAN TEMPLATE

Please outline the plan for how recommendations will be enacted.

If a recommendation has been wholly enacted when the report is received, indicate 'wholly' in column two of Table 1. Write N/A in subsequent columns of Table 1. Then complete Table 2 for that recommendation.

If a recommendation has been partly enacted when the report is received, indicate 'partly' in column two of Table 1. Complete the remaining columns in Table 1 for aspects of the recommendation that have not yet been enacted. Then provide details in Table 2 for aspects of the recommendation that have been enacted.

If no part of a recommendation has yet been enacted when the report is received, indicate 'no' in column two of Table 1. Complete the remaining columns in Table 1. Do not use Table 2 for that recommendation.

Table 1.

Recommendation	Already enacted (Write: 'wholly', 'partly' or 'no')	Actions still required to enact recommendation	Outcome measure(s)	Executive position sponsor	Position responsible/ accountable	Due date for completion
A						
B						
C						
D						
E						
F						

G						
H						
I						
J						
K						
L						
M						

RECOMMENDATIONS ALREADY IMPLEMENTED

If any recommendations have been wholly or partly implemented when the report is received, use Table 2 to provide details of what has been done, how implementation has been monitored (e.g. monitoring on-the-ground uptake and impacts – intended and unintended), and outcomes (using appropriate outcome measures).

Table 2.

Recommendation	Actions already completed	Monitoring undertaken	Outcomes

APPENDIX 2: KEY THEMES FROM HOTEL QUARANTINE INCIDENTS 1 AND 2

Operation Soteria Hotel Quarantine – Common themes arising from two incident reviews as of 15 May 2020.

Below is a summary of key quality and safety issues, and associated contributing factors, identified by Safer Care Victoria during their review of two incidents involving returned travellers in hotel quarantine in Victoria.

Based on evidence and information available to Safer Care Victoria at the time of writing, these issues were evident at the time of the two incidents (3 to 13 April 2020). It is noted that certain information sought by the team was unable to be provided or obtained during the data collection period. In addition, some individuals invited for interview in relation to these incidents declined to be interviewed during the data collection period.

Due to the ongoing detention of returned travellers in hotel quarantine as a result of the COVID-19 pandemic, a rapid review methodology was employed. This methodology has some limitations regarding data collection and scope. These limitations were considered against the need for a rapid review process to inform system improvement in real time. With that approach and goal in mind, the review teams share a summary of issues identified below.

Issue	Comments
Selection of staff	Victorian public sector staff putting themselves forward to take up temporary new roles in the hotel quarantine system did not have an adequate opportunity to pre-emptively nominate the types of roles for which they would or would not be suitable. In selecting and assigning staff to new roles, there were limited checks regarding their relevant skills, experience, education or professional background, in order to assess their suitability for particular roles. As a result of the above (and possibly other factors) some staff were assigned to roles for which they did not have the appropriate knowledge base, skill set or relevant experience.
Onboarding and training of staff	For many of the new roles created for the hotel quarantine system, there was a lack of clear and detailed job descriptions and/or job cards available to staff when they commenced in their roles. This resulted in a lack of clarity about individual roles and responsibilities. There was limited to no formal and standardised training, orientation or opportunities for mentoring available to staff commencing new roles within the hotel quarantine system. Some individuals reported taking the initiative to develop and provide training for their teams. However, these efforts were individually driven by frontline staff and were therefore not consistently adopted across the system. On the day of their first shift in their new role, some staff did not experience adequate handover from their counterpart who had worked the previous shift.
Continuity of staffing	Continuity of staff rostered at hotel locations was limited. This resulted in staff reporting challenges relating to their roles. These included issues relating to hotel familiarity, teamwork, clarity regarding roles and responsibilities, and continuity of support provided to returned travellers. Some staff reported requesting to be rostered at the same location and/or team. However these efforts were individually-driven by frontline staff, and therefore were not consistently adopted across the system.
Collection, storage and access to personal information about returned travellers	There were reports of inadequate and inconsistent systems and resources (paper or electronic) available for the recording information about returned travellers. As a result, such information (e.g. health and welfare notes, returned traveller requests and concerns) was commonly recorded in ad hoc ways (e.g. staff member's personal note books, post-it notes, whiteboards etc). During a returned traveller's period of detention, they were required to complete (either on paper or via phone) a variety of forms, questionnaires and assessments. These were administered by multiple entities and teams (i.e. nursing staff, welfare check team, hotel staff and the Department of Jobs, Precincts and Regions). The information gathered through the multitude of channels was not centrally coordinated and stored, and thus was not available to all staff who required it. As a result, staff often did not have the information needed to perform their roles optimally and provide adequate support and care to returned travellers. For example, welfare check callers did not have access to nursing notes or the hotel questionnaire when making calls to returned travellers.
Policies and procedures	A number of policies and procedures considered necessary to ensure safe operation of the hotel quarantine system were reported to be either under development or not readily accessible by frontline staff at the time these incidents occurred. For example, policies regarding appropriate use of personal protective equipment,

	escalation of concerns about returned travellers not answering calls, how to conduct handovers, record-keeping and issues tracking, or managing ambulance attendance. Some policies or procedures reflected plans and intentions that were not operationalised or achieved in practice (e.g. differences between planned frequency of welfare checks and actual frequency of these).
Escalation and leadership responsibilities	There was a reported lack of clarity among frontline staff about escalation processes and pathways, and the circumstances under which they should be utilised. Where formal policies or processes had been formulated, frontline staff reported being either unaware of these, or these were not operationalised fully. There was a reported lack of understanding amongst frontline staff in relation to decision-making hierachies in complex and unprecedented situations. For example, deciding on the appropriate level of clinical care, or when to escalate concerns about a returned traveller not responding to phone calls and door knocks. There was no dedicated role on-site with specific responsibility for decision-making regarding returned traveller health and wellbeing. This role was often either shared between nurses, or an informal 'lead' nurse was appointed for the shift by the nursing team, with access to consultation with a doctor (most often off-site) if required. Some team leaders, authorised officers and nurses reported not receiving adequate information about to whom they should escalate concerns (e.g. specific names, roles and direct phone numbers). Staff sometimes had to use indirect means to request escalation and assistance about issues and concerns (such as use of general email or 'helpline' phone numbers), leading to reported delayed or no response or definitive action.

APPENDIX 3: REPORT VERSION TRACKING

Date	Action
21/05/2020	Draft report shared with Merrin Bamert, Commander, Operation Soteria, requesting fact check. Response received 22/5/20.
25/05/2020	Final report shared with Merrin Bamert (Commander, Operation Soteria) and Operation Soteria Working Group.

OFFICIAL - Sensitive: initial review/ fact check

From: REDACTED (DHHS)" <REDACTED>
To: "Merrin Bamert (DHHS)" <merrin.bamert@dhhs.vic.gov.au>
Cc: REDACTED (DHHS)" REDACTED @safercare.vic.gov.au>
Date: Tue, 02 Jun 2020 18:09:43 +1000
Attachments: HQI2 Report with cover letter_V1.5_ 20200602_Draft to M.Bammert for fact checking.docx (823.73 kB)

Dear Merrin

Please find attached the final draft for your review please.

Once you have responded with nay points of clarity / factual corrections we will progress to the committee.

It would be good to turn this around as soon as is practicable. Would you have capacity to do by the end of this week or is beginning of next week more achievable please?

Once you have submitted your questions/ proposed track changes we will then finalise for Euan and progress from there. I will hold off signing this off until then. I have read the report just as an FYI.

Obviously the intent is to inform any further improvements that need to be made.

With thanks

REDACTED
Director- Centre for Patient Safety and Experience

REDACTED @safercare.vic.gov.au
S @SaferCareVic
REDACTED

Safer Care Victoria

RE: OFFICIAL - Sensitive: initial review/ fact check

From: "Merrin Bamert (DHHS)" <"/o=exchangelabs/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=638a479568194a798229202add0cc910-mbam1802">
To: REDACTED (DHHS)" REDACTED @safercare.vic.gov.au>
Cc: REDACTED (DHHS)"REDACTED @safercare.vic.gov.au>, "Andrea Spiteri (DHHS)" <REDACTED>, "Jason Helps (DHHS)" <REDACTED>
Date: Sun, 07 Jun 2020 11:49:11 +1000
Attachments: HQI2 Report with cover letter_V1.5_ 20200602_Draft to M.Bammert for fact checking MB review.docx (831.76 kB)

Hi REDACTED

I have provided comments within the document.

Can you please advise whether SEMC we part of your review and interviewees?

As much of this information will need to be confirmed with them given that's where command and health coordination was being managed out of.

Kind regards

Merrin

Merrin Bamert
Commander, Operation Soteria, Covid - 19
Director, Emergency Management, Population Health and Health Protection
South Division
Department of Health and Human Services
Level 5 / 165-169 Thomas Street, Dandenong, 3175
REDACTED

From: REDACTED (DHHS) REDACTED @safercare.vic.gov.au>
Sent: Tuesday, 2 June 2020 6:10 PM
To: Merrin Bamert (DHHS) <Merrin.Bamert@dhhs.vic.gov.au>
Cc: REDACTED (DHHS) REDACTED @safercare.vic.gov.au>
Subject: OFFICIAL - Sensitive: initial review/ fact check
Importance: High

Dear Merrin

Please find attached the final draft for your review please.

Once you have responded with nay points of clarity / factual corrections we will progress to the committee.

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Once you have submitted your questions/ proposed track changes we will then finalise for Euan and progress from there. I will hold off signing this off until then. I have read the report just as an FYI.

Obviously the intent is to inform any further improvements that need to be made.

With thanks

REDACTED
Director - Centre for Patient Safety and Experience
REDACTED
@safercare.vic.gov.au
S @SaferCareVic
REDACTED

Safer Care Victoria

Safer Care Victoria report on clinical incidents occurring in hotel quarantine in Victoria

At the request of the Secretary of the Department of Health and Human Services, Safer Care Victoria undertook reviews into two serious clinical incidents involving returned travellers in hotel quarantine in Victoria. The first incident involved the apparent suicide death of REDACTED (Hotel Quarantine Incident 1), and the second incident involved the care of [redacted]-year-old REDACT who developed COVID-19 symptoms and deteriorated rapidly, requiring intensive care unit admission at the Alfred Hospital (Hotel Quarantine Incident 2).

Two teams of reviewers with relevant incident review and subject matter expertise were convened to undertake the reviews. The purpose of the reviews was to identify contributing factors relevant to the specific incidents, as well as provide insights into issues affecting the operation of hotel quarantine in Victoria, with the view to facilitating timely system improvements. To this end, the final output has been two separate reports, each detailing the contributing factors relevant to one incident, along with a summary of key high-level themes identified in both reviews which are relevant to the overall operation of hotel quarantine. These will be shared with the Secretary as well as the Operation Soteria Working Group, which includes representatives from Public Health, Emergency Operation Centre, Accommodation Commander, Welfare Cell, Office of Chief Psychiatrist and Safer Care Victoria. The Operation Soteria Working Group will be responsible for monitoring the implementation of the recommendations.

Please find a draft report detailing the contributing factors for Hotel Quarantine Incident 2. The findings and recommendations provided are based on evidence and information available to the review team at the time of writing and relate to issues and circumstances at the times and places the incident took place (7 to 13 April 2020). It is also noted that certain information sought by the review team was not able to be provided or obtained, or was conflicting, and some individuals with potentially relevant information declined to be interviewed. It is further acknowledged that a number of recommendations and key themes may have since been addressed.

Yours sincerely,

REDACTED

Director, Patient Safety and Experience

Safer Care Victoria

Date: / /2020

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Safer Care Victoria

Incident review report: Hotel Quarantine Incident Two

ENDORSEMENT

Review lead

Signature: REDACTED **Date:** 28 May 2020

Executive sponsor

Signature: **Date:**

REVIEW TEAM

Executive sponsor	Director, Centre for Patient Safety and Experience, Safer Care Victoria
Review lead	Senior Project Officer, Patient Safety Review Team, Centre for Patient Safety and Experience, Safer Care Victoria
Human factors / review method advisor	Manager, Patient Safety Review Team, Centre for Patient Safety and Experience, Safer Care Victoria
Review coordinator	Project Officer, Centre for Patient Safety and Experience, Safer Care Victoria
Team member	Safer Care Victoria Academy Member
Team member	Safer Care Victoria Academy Member
Team member	Senior Project Officer, Centre for Patient Safety and Experience, Safer Care Victoria
Administrative support	Project Officer, Centre for Patient Safety and Experience, Safer Care Victoria

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ABOUT THE REVIEW

Background

On 13 April 2020, R year-old REDACTED was transferred by ambulance to the Alfred Hospital from the Four Points Hotel, Southbank, Melbourne, where R had been in mandatory quarantine since returning from overseas. At the time of R transfer REDACT had returned a positive COVID-19 swab result on day seven, and had experienced rapid deterioration in R condition, having shown symptoms for several days. As part of the response to REDACT transfer to hospital, the Secretary of the Department of Health and Human Services (DHHS) requested that Safer Care Victoria undertake an independent review into the incident.

Unless otherwise specified or indicated, the information in this review refers to the period of the incident 7 April 2020 to 13 April 2020. The team acknowledges, based on evidence provided during the review, that some systems and processes detailed have changed since that time. This may mean that certain recommendations have since been addressed, or certain findings may not reflect the current state.

Method

The ongoing detention of people in hotel quarantine and need to identify and address any ongoing risks to these individuals in real time, necessitated a systems review method that could be undertaken rapidly. The time limited nature of rapid reviews means that their data collection and scope are also limited. These limitations were weighed against the need for a systems review process in determining the review method and scope. The review used the AcciMap method, customised with elements of the London Protocol – both widely-recognised and validated approaches to rigorous incident review.

In cases of clinical deterioration, the review team cannot determine for certain whether changes to the contributing factors would have ultimately contributed to a different outcome. Therefore, the review team has focused on addressing whether the care REDACT received, and management of R quarantine, corresponded to an adequate standard of care. The team has done so without making conclusions about whether any changes to the contributing factors would or would not have prevented R present situation. At the time of writing this report, REDACT remains intubated and ventilated in the Intensive Care Unit at the Alfred Hospital, Melbourne.

Evidence

The review team has collected and considered evidence from a variety of sources, including (but not limited to):

- Interviews with seventeen people, drawn from the following groups: DHHS/Operation Soteria leadership, hotel team leaders, nursing staff, medical staff, authorised officers and REDACT family and general practitioner.
- A letter to DHHS written by REDACTED outlining R concerns in relation to the incident.
- Clinical notes and documentation relating to REDACT
- Audio recordings of telephone calls with Ambulance Victoria related to the incident.
- Plans, policies and procedures including 'Operation Soteria – Operations Plan', 'COVID-19 – Interim Healthcare and Welfare Mandatory Quarantine Plan (Draft)', 'Team Leader Pack – Hotels' and 'Referral Pathways for people issued COVID-19 quarantine orders.

The review team would like to acknowledge the cooperation and openness of the Operation Soteria staff who shared their experiences with us, and their willingness to do so. We are especially grateful to REDACT family for providing information relating REDACT and the events surrounding this incident during this difficult and challenging time.

Commented [MB(1]: In addition we should not be using days its should be dates and they are not consistent with how we count days

Commented [MB(2]: I think the back ground should include a short paragraph about the order when it was made that we developed the policy in 12 hours prior to the first passengers arriving that it commenced on the 28 March

Australian National Cabinet directed that all passengers returning from international destinations who arrive in Australia after midnight on Saturday 28 March 2020 are to undergo 14 days enforced quarantine in hotels to curb the spread of COVID-19. Passengers are to be quarantined in the city in which they land, irrespective of where they live. That REDA arrived 10 days into the operation

Commented [MB(3]: Can you advise who was interviewed from the SEMC as they were the overarching group and health coordination and logistics being run out of the SEMC roster.

Need to ensure it was not just me interviewed as the EOC was not established at this time.

The information in this report is based on evidence and information available to the team at the time of writing. Certain information sought by the team was not provided or obtained within the review timeframe, and some individuals declined an invitation to be interviewed. Therefore, the review team acknowledges there may be unintended gaps or inaccuracies in the report that the team's reasonable efforts to seek required information were unable to rectify. The information presented was accurate – to the best of the team's knowledge – at the time of writing, given the information available, and with consideration of the potential limitations identified above.

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DESCRIPTION OF THE INCIDENT

On 7 April 2020, REDACTED and RED were placed into mandatory hotel quarantine in adjoining rooms REDACTE at the Four Points Hotel, Southbank, Melbourne. This followed disembarking from the REDACTE cruise ship, where they had been quarantined at sea for four weeks. REDACT and R relatives were detained in accordance with section 200(1)(a) of the Public Health and Wellbeing Act (2008) (Vic) as part of the Victorian government's response to the COVID-19 pandemic (Operation Soteria). This was in line with a National Cabinet agreement for international arrivals, after midnight 28 March 2020, to complete mandatory hotel quarantine for 14 days.

On days two and four of R quarantine, REDACT reported physical symptoms to nursing staff (shaking and coughing). Nursing staff provided R with paracetamol. On day five, having been in contact with REDAC REDACTED based general practitioner (GP) contacted nursing staff (via telephone) expressing concerns about REDACT clinical presentation and symptoms. The GP relayed concerns that R REDACT a history of REDACTED as R was and queried whether R may have urosepsis (sepsis causes by an infection of the urinary tract). In response, nursing staff attended to REDACT in R room, obtaining a self-administered swab for COVID-19 testing, and noting R had a high blood pressure reading, a rapid heart rate and fever. After consulting with a doctor, nursing staff gave paracetamol. Later that day, a follow-up visit by nurses was conducted and it was noted by them that R symptoms had improved.

Overnight from day five into day six, there were several contacts between REDACTED and nursing staff, with handover provided to the on-call doctor by nursing staff. During routine COVID-19 symptom screening on day six, REDACT reported R did not feel feverish or shaky. In the subsequent hours, RE REDA told REDACTED based REDA (by telephone) that REDACT condition had worsened, but RE had been unable to contact on-site nursing staff for several hours, citing issues with the intercom system (in-room telephone). RE also told REDACTED had repeatedly requested help from a security guard to secure nursing assistance, without success. REDACTED advised REDAC to call an ambulance.

REDACTE called 000 and was transferred to a secondary triage clinician (AV clinician). REDACTE relayed REDACT history and symptoms, and RE concerns, particularly about accessing help if R condition was to deteriorate overnight. The AV clinician contacted hotel nursing staff directly to discuss how to proceed. After discussions between the on-site doctor and nursing staff, the AV clinician and nursing staff then later agreed for nursing staff to visit REDACTED room and call the AV clinician back with their assessment.

In a subsequent call, nursing staff and the AV clinician discussed the importance of providing reassurance to REDACTED noting the benefits of not dispatching an ambulance in the 'community interest'. After a series of failed attempts to contact REDACT on the telephone, the AV clinician finally contacted RE REDA via hotel reception while nursing staff were attending their room. The AV clinician repeated that it was not in REDACT best interest to go to hospital, to which REDACT responded with R disagreement and concern. The AV clinician then spoke directly with REDACT at which point the nurse present in the room, subsequently took over the call. After relaying the features of REDACT clinical presentation to the AV clinician, the AV clinician and nurse present in the room agreed that an ambulance was not needed and would not be dispatched. This was done despite protests from REDACTED and without their explicit agreement.

On returning downstairs to the staff area of the hotel, the nurse advised the on-site doctor of the ambulance cancellation. After expressing concern the on-site doctor had a phone consultation with REDACT in which R reported having fever, chills and fatigue. In two subsequent phone calls, REDACTED and staff discussed the ambulance cancellation and the most appropriate course of action for R care.

On day seven, REDACT condition deteriorated rapidly, marked by shortness of breath, dizziness, lethargy, chest pain, high blood pressure, a rapid heart rate, fever and low oxygen saturations. By then REDACT positive COVID-19 swab result had been notified. Hotel nursing staff called an ambulance, which transferred R REDA to the Alfred Hospital shortly after. R was intubated and ventilated two days later (16 April 2020).

Commented [MB(4]: REDACTED REDACTED

Commented [MB(5]: We should not use days we should use dates for clarity as your days do not align with how we count days.

Your arrival date is day 0, day one is the next day and so on

Commented [MB(6]: Should use dates

Commented [MB(7]: should have date and time

Commented [MB(8]: should have date and time

Commented [MB(9]: should have date and time

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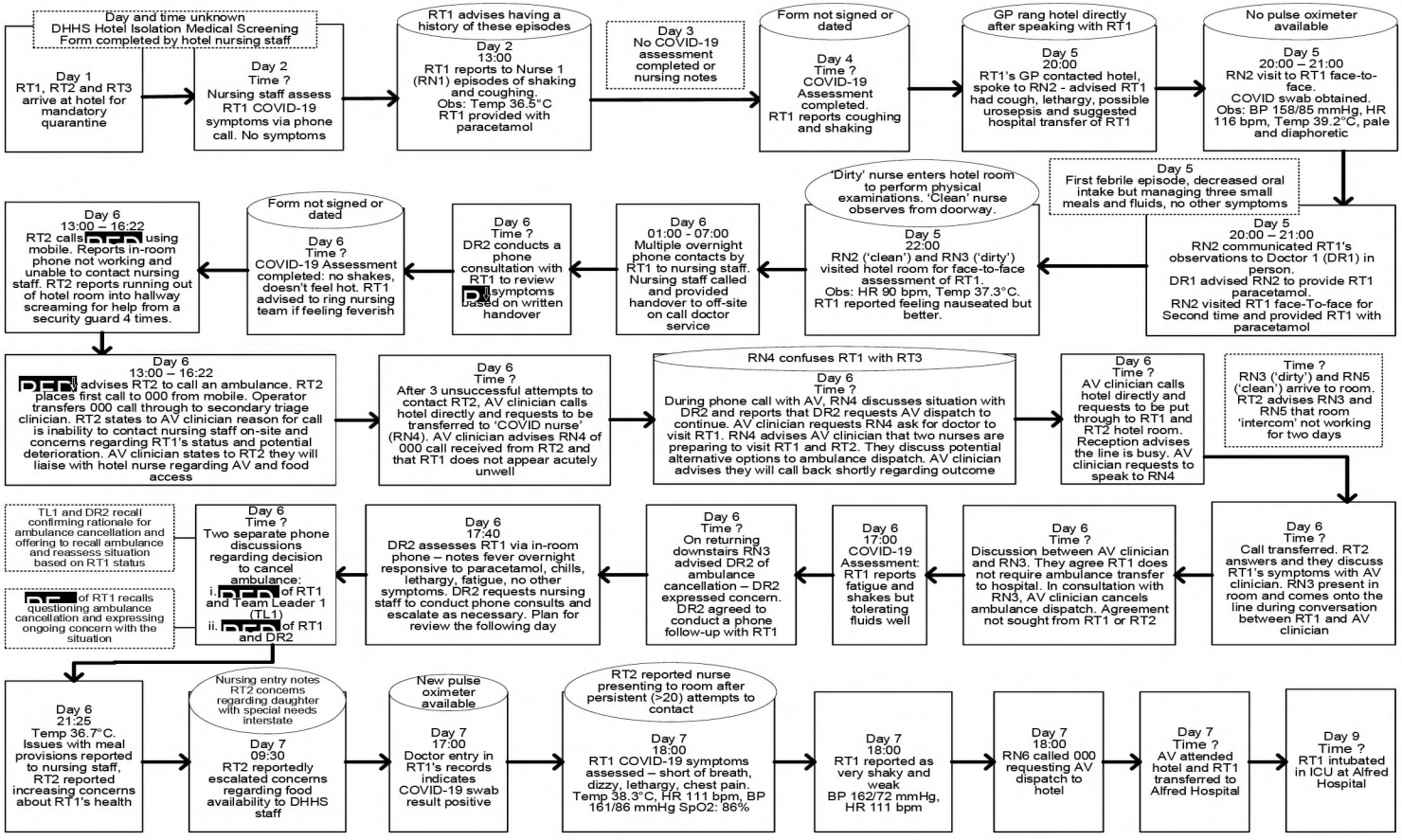
TIMELINE OF EVENTS

- [redacted] (RT1), [redacted] (RT2) and [redacted] (RT3) detained at hotel after 4 weeks quarantined on a cruise ship.
- Accommodated in adjoining rooms.
- RT1 [redacted], history of cardiac disease and ulcerative colitis.



Commented [MB(10]: need to fix dates and time day as per previous comments

Glossary of terms

DHHS	Department of Health and Human Services
AV	Ambulance Victoria
RT1	Returned traveller 1
RT2	Returned traveller 2
RT3	Returned traveller 3
DR	Doctor
RN	Nurse
TL	Team Leader
HR	Heart rate
bpm	Beats per minute
BP	Blood pressure
mmHg	Millimetres of mercury
SpO2	Oxygen saturation
Temp	Temperature

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ACTORMAP

		Parties with no direct involvement
Institutional context	Victorian Government; Department of Health and Human Services (DHHS); Department of Jobs, Precincts and Regions; Chief Health Officer (Public Health Victoria); Public Health and Wellbeing Act 2008; Australian Border Force	
Organisation and management	State Emergency Management Centre (SEMC); Ambulance Victoria (AV); External nursing agency; External medical agency; Hotel groups	
Work environment	Hotels; Hotel rooms (adjoining); Staff office (Green room); DHHS offices; Remote working; Call centres (AV)	
Team	Nursing team; Medical team; Team Leaders; DHHS hotline (Emergency Operation Centre); DHHS Logistics team	Authorised Officers
Task and technology	Clinical consultation (Telehealth); Personal Protective Equipment; In-room communication system; Documentation system; Handover within and between frontline teams; Transfer procedures (hospital); Clinical equipment and sanitisation	
Staff	Team Leader 1; Nurse 1; Nurse 2; Nurse 3; Nurse 4; Nurse 5; Nurse 6; Doctor 1; Doctor 2; Security guard; AV clinician	
Returned traveller	Returned traveller 1 (Patient); Returned traveller 2 RE; Returned traveller 3 REDACTED; RED of returned travellers 1 and 2; General Practitioner	

Commented [MB(11)]: this must include SEMC and EOC was not established at this time

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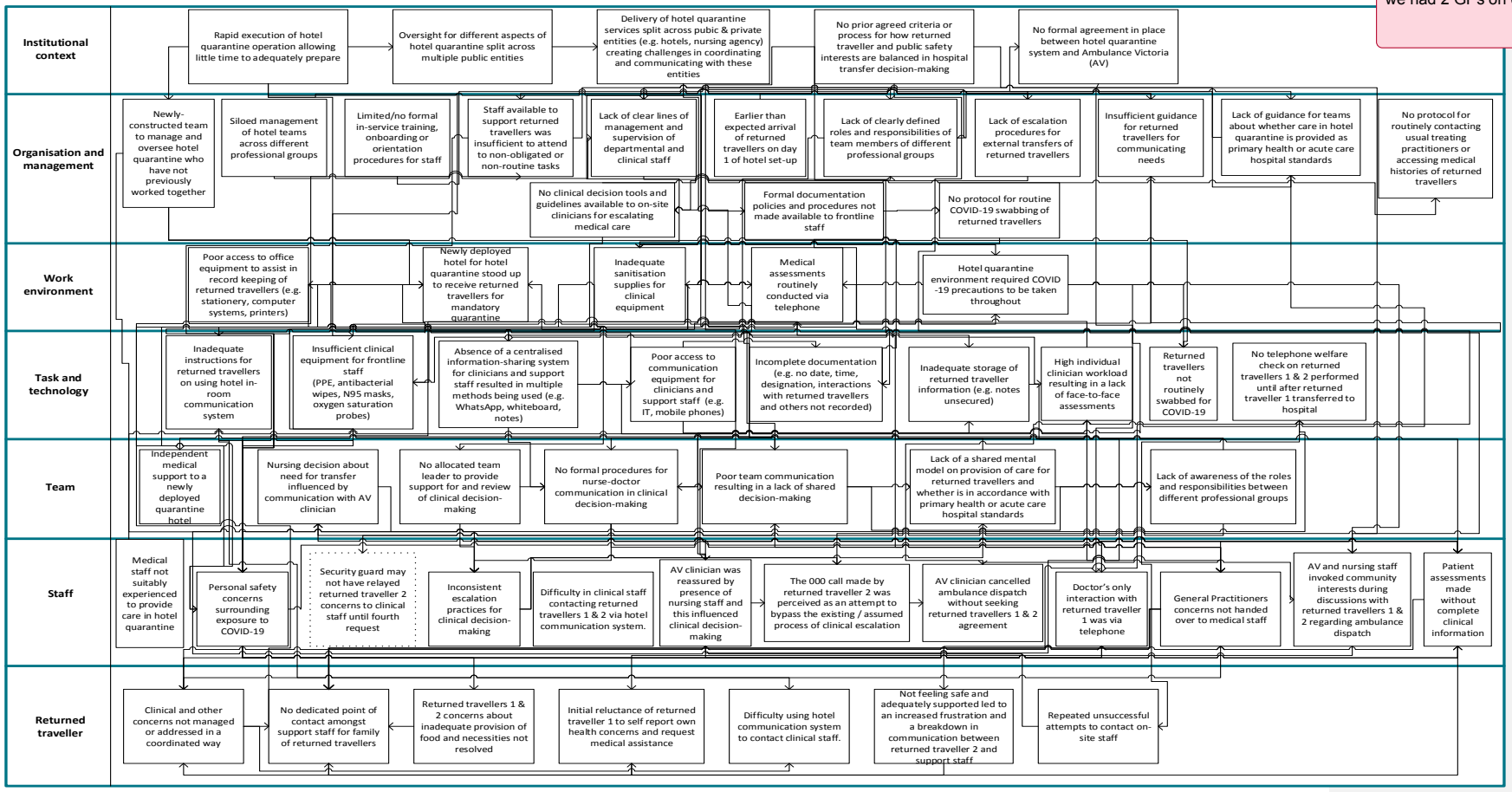
ACCIMAP

This AcciMap analysis reflects the system at the time this incident occurred. It does not consider any subsequent changes to conditions, processes or systems made after th

Commented [MB(12]: I have multiple issues with the this map however unable to comment on individual boxes mostly around the assumptions of GPs not qualified to care for guests we had 2 GPs on each day form the 4th April



SYSTEMS ANALYSIS OUTCOMES

The review team has identified system and process improvement opportunities. Some are directly related to the event. These are described in 'Findings'. Others were identified in the course of reviewing the event, but the review team did not establish that they played a direct role in the events surrounding REDACT deterioration and transfer to hospital. These are described in 'Learnings'.

FINDINGS

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

1. **On-site clinicians were constrained in their ability to conduct face-to-face clinical assessments when indicated due to an insufficient supply of readily accessible and reliable personal protective equipment (PPE). Medical consultation with returned travellers was routinely undertaken by telephone only, limiting the ability of medical staff to perform a complete and independent assessment.**

Reasoning

Staff took the risk of exposure to COVID-19, and transmitting it to others, very seriously. In interviews staff expressed concerns about these risks, and the resources available in the hotels to assist in mitigating them. In particular, they described a lack of sufficient, readily accessible, reliable and fit-for-purpose PPE for use while undertaking their roles. They also reported a need to prioritise and reserve use of available PPE supplies to allow certain staff groups to undertake their routine duties.

Consistent with safe work practices, staff would not enter the rooms of returned travellers for the purposes of providing clinical care without donning what they described as 'full' PPE, consisting of a gown, disposable gloves, mask and goggles. In interview, staff noted that they routinely lacked some components of full PPE, a situation which was confirmed in interviews with those in management roles. As a result, staff purposefully endeavored to provide clinical care, including clinical assessments, in a 'contactless' manner (specifically, by telephone), avoiding visiting or entering the rooms of returned travellers wherever possible.

The routine use of telephone-only consultation by both medical and nursing staff with returned travellers resulted in clinicians not being able to use visual cues or conduct a comprehensive physical examination during their clinical assessments and monitoring of returned travellers. These limitations in clinical assessment capability were compounded by a lack of clinical equipment and sanitation capacity (see Finding 2). Together, these limitations resulted in clinicians having to make clinical assessments and decisions based on incomplete clinical information.

Staff reported that on the occasions when returned travellers were physically examined, this was most often (although not always) done by nursing staff. Therefore, doctors (onsite and on-call) most often provided assessments and clinical decisions about returned travellers based on verbal information only, either from direct conversation with the returned traveller or their family member, or via information relayed by nursing staff.

These factors were observed in REDACTE case whereby staff expressed an initial (and ongoing) hesitancy to attend to RE face-to-face. In R case, despite having experienced many days of symptoms, R was not directly sighted or physically attended to by a doctor until day seven, when the second ambulance was called by nursing staff. Therefore, assessments about the seriousness of and

Commented [MB(13]: This is not the only reason for limited face to face, in the community it was recommended to keep to a minimum for all DRs there had been approved telehealth mbs so it was often made on a risk assessment. This may be a factor but is poorly written as the only reason.

Commented [MB(14]: This was often due to a risk approach. In addition the fear of interacting with this group of guests is not acknowledged anywhere in the report. Given this group of guest came off a cruise ship.

Commented [MB(15]: We had two doctors available for telehealth and this was a clinical decision for them about risk to self.

deterioration in REDACT condition, and related decision-making, were based on incomplete, and likely inadequate, information.

Returned traveller safety implications

The delays in and reduced intervals of face-to-face clinical assessments resulted in missed opportunities to monitor and trend clinical parameters in a timely and consistent manner. It also resulted in a missed opportunity for comprehensive physical assessment and for returned travellers to directly express any health and welfare concerns to medical staff.

2. **Unavailable or unreliable access to clinical equipment for physical examination and clinical monitoring of returned travellers, resulted in clinical decision-making being based on incomplete clinical information and assessment.**

Reasoning

Staff reported that they did not have access to the clinical equipment they required to fully examine, assess and monitor the clinical status of returned travellers. Clinical equipment not always readily available included pulse oximeters (to measure blood oxygen saturation levels) and COVID-19 swabs. They also noted that a lack of adequate sanitisation supplies and equipment (e.g. sanitising agents and wipes) limited their ability to use the items they did have (e.g. stethoscopes and blood pressure cuffs), especially as re-use for multiple returned travelers is necessary. In the absence of access to adequate clinical equipment and ability to sanitise equipment, staff were unable to perform complete clinical assessments of returned travellers. This limitation of being unable to conduct thorough clinical assessments was compounded by the practice of routinely providing care to returned travellers without physically seeing or attending to them (see Finding 1).

Commented [MB(16]: Have we confirmed with logistics and health coordination from SEMC that they did not have a sat probe available?

These factors were observed in the case of REDACT in that several assessments of R physical condition were conducted by telephone only, and during interviews staff suggested that inadequate pulse oximeter access may have contributed to a delay in clinical staff being aware REDACT had low oxygen (O_2) saturation levels. An earlier awareness of this clinical sign, had low O_2 saturation been present, may have influenced the decision to cancel the ambulance called on day six.

Returned travellers safety implications

Clinical staff not having access to the equipment necessary required to perform complete assessments resulted in clinical decision making based on incomplete information, specifically in the absence of key markers of COVID- 19 prognosis and deterioration. This may have contributed to missed opportunities for clinical staff to adequately assess REDACT

3. **Staff involved in clinical assessments and decision-making often did not have timely, direct access to returned traveller clinical and welfare information to perform their roles effectively.**

Reasoning

In requesting information and evidence to undertake the review, the challenges experienced by staff were evident. These mainly related to difficulty readily locating and accessing information from records about specific returned travellers. This was partially due to the fragmented nature of how this information was collected, stored and accessed. There was also a need to navigate the multiple entities, sources and necessary permissions associated with accessing the information.

Similarly, staff reported being unable to readily access required health and welfare information about returned travellers due to the absence of an accessible, comprehensive, central repository for this information. Staff reported that this made it difficult to identify returned travellers with high and/or escalating health and welfare risks, especially monitoring this across different shifts, over time, and between different teams (e.g. nursing and medical staff). This impaired their ability to have good visibility of the full clinical picture of unwell returned travelers in a timely manner. It also affected attempts by staff to provide a holistic and coordinated response to distress or frustration among returned travellers who felt that their support needs were not being met. These limitations in accessing information meant that staff did not have the complete information required to make fully informed clinical and non-clinical decisions about the care and support of returned travellers.

In REDACT case, these limitations meant that staff did not have ready access to all available information regarding RE medical history; risk factors for COVID-19 complications; the length and deteriorating nature of R condition; and the context, events and issues that contributed to RED REDACTE concerns about accessing help when needed.

Returned travellers safety implications

The absence of a coordinated and consistent system for the management of returned traveller health and welfare information, including its collection, recording and sharing, compromised the ability of staff members to adequately identify and manage health and welfare risks for individuals. It also reduced returned travellers' ability to direct their health and welfare questions, support needs and concerns to those best placed to efficiently and effectively address them.

4. **The number and skill set of staff rostered on shifts in the hotel quarantine system did not always match workload demands and the health care needs of returned travellers. This resulted in delays or tasks not being completed when needed to address returned traveller health and welfare.**

Reasoning

Staff reported consistently having high workloads and managing multiple competing demands – to the extent that they were often unable to attend adequately to the needs of returned travellers, or systematically address concerns raised by returned travellers in a timely manner. Routine tasks that nursing staff were required to undertake included completing initial medical screening forms; conducting COVID-19 assessment symptom checks; obtaining medication lists from returned travellers to arrange prescription and dispensing of necessary medications; and undertaking COVID-19 testing (swabs) in symptomatic returned travellers. In addition to these tasks, nursing staff were responsible for assessing returned travellers in their rooms, if deemed necessary and the needs of returned travellers could not be adequately addressed over the telephone. This required one nurse to

stay outside (referred to as the 'clean' nurse), while the other nurse would don PPE and enter the room (referred to as the 'dirty' nurse). In the context of many other competing tasks, this meant that direct nursing assessment of returned travellers was time and resource intensive.

Staff reported problems with both baseline levels of staffing, as well as the adequacy of staffing in response to surges in workload demand. At any given time, there were generally three nurses rostered onto a shift, attending to the health needs of all the returned travellers, (approximately 200 to 350). On the day REDACTED arrived at the hotel, there were only three nurses on-site to receive the new cohort of approximately 200 returned travellers, who had arrived earlier than had been expected (see Finding 10). Staff described the experience as 'chaotic' and highlighted the challenges of attending to a cohort of mostly older returned travellers with multiple health needs.

Medical staffing was provided by one on-site doctor during the day, and an on-call doctor overnight (who was responsible for the provision of services to several hotel quarantine sites concurrently). In addition to addressing the routine and ad hoc health needs of returned travellers, nursing and medical staff were also involved in sourcing the equipment they needed to perform their duties (e.g. pulse oximeters, blood pressure cuffs, cleaning equipment, stationery). They were also called upon by returned travellers to assist in procuring items such as books, toys, and games. The diverse nature of the tasks that frontline staff were required to address added to the cognitive and physical demands of their work.

Commented [MB(17]: Two doctors were available during the day on onsite and one purely doing telehealth

The skillset and level of experience of the nursing staff was variable and included those with backgrounds in general medical, oncology, surgical and emergency nursing. The pool of medical staff working in the hotel quarantine system was equally variable and included hospital medical officers with less than two years of experience, working as independent medical practitioners. Most of the frontline staff had not previously worked in a similar detention setting and had not been provided with any formal guidance on the tasks they were undertaking (see Findings 8 & 9).

Commented [MB(18]: Is this true??? Our doctors were all being provided by Medi & at this point? We were not aware of HMOs on their roster – this should be check with health coordination and the MEDI7 contractor

The high workload and limited number of staff generated a backlog of work that resulted in routine tasks not always being completed. This was reflected in documentation relating to REDACTED case. R daily COVID-19 symptom screening checks were not always recorded as having been conducted, and R did not receive a welfare check telephone call for the entire duration of R time in hotel quarantine. REDACTED received R initial welfare check call on day nine.

Returned travellers safety implications

Staff facing high workloads and multiple competing demands led to routine tasks including health and welfare checks not being completed in a timely manner. This limited the ability for staff to identify and promptly act on returned traveller needs and concerns.

5. Outside of routine targeted COVID-19 symptom screening checks, some returned travellers did not receive timely welfare screening checks, which reduced the opportunity to identify and address their needs and concerns in a suitable and systematic way.

Reasoning

Clinical staff were required to conduct daily COVID-19 symptom screening using the 'COVID-19 Assessment' form. The purpose of the form was to identify if the returned traveller was potentially symptomatic with COVID-19. Returned travelers were asked if they had any of five symptoms of COVID-19, (fever, cough, shortness of breath, sore throat and/or fatigue) each day via telephone. The form did not specifically prompt staff to inquire about any broader health and welfare issues.

Screening for such broader health and welfare matters was the responsibility of the DHHS welfare team, who were remotely located and were tasked with conducting welfare checks with returned travellers by telephone.

During interviews, staff reported that the welfare team experienced a significant backlog in overdue calls to be made. This meant some returned travellers did not receive their first welfare check call (to complete the 'Welfare check – initial long form survey') in a timely manner. This resulted in missed opportunities to identify and address returned travellers' concerns early, establish rapport and clear channels of communication, and provide returned travellers with information about how to access support, if needed.

Neither R nor REDACTE received a welfare telephone call to complete the 'Welfare check – initial long form survey' before REDACT transfer to hospital on day seven. A copy of RE REDAC form (completed on day nine, after REDACTE hospital transfer) was sighted by the review team. This form included responses to questions which, had they been flagged and appropriately referred earlier, may have assisted staff to appropriately identify and act upon RE REDAC escalating concerns. Responses indicated REDACTE expressing RE was very unhappy with the responsiveness of nursing and medical staff in the hotel. Having an awareness of this may have allowed staff to ameliorate REDACTE frustration that R needs were not being adequately met. In turn, this may have assisted the returned travellers to feel safer and more supported. It may have improved the relationship and collaboration between the returned travellers and staff. A welfare check may have provided an opportunity to provide REDACTE with information about how to successfully contact staff to ask for help, and how to escalate any additional unaddressed concerns.

Returned travellers safety implications

The delay in conducting initial welfare check calls resulted in missed opportunities to monitor returned traveller welfare in a timely and consistent manner. It also resulted in significant health and welfare concerns not being disclosed, identified and missed opportunities to attempt to resolve these by direct escalation to the most appropriate person/agency.

6. Frontline staff working in the hotel quarantine system did not have access to adequate resources, training support and polices relating to documentation and record keeping of health and welfare information for returned travellers. This resulted in the information often being incomplete, inconsistently recorded, not fit-for-purpose, and not readily accessible by relevant staff.

Reasoning

Staff reported an overall lack of resources for record-keeping, such as stationery, forms/templates, access to printers, (including permission to use printers being granted at the discretion of individual members of hotel management), IT equipment and systems. Staff reported that they had to develop ad hoc workarounds, including sourcing their own supplies of stationery from office supply retailers, and using personal notebooks to keep clinical records, which did not always remain onsite or securely stored. They also reported that there was a lack of formal policies, systems and training to guide them in documenting returned traveller information and events that occurred during each shift.

This was reflected in the clinical notes and records sighted by the review team. Records were often created in ad hoc formats, using resources that were not specifically fit-for-purpose (e.g. handwritten records in notebooks, on loose and nondescript pieces of paper). In addition, information about returned travellers (including their health and welfare), was often not systematically filed or was inter-

dispersed with information about other returned travellers. Documentation was frequently missing key information such as dates, times and staff identifiers (names, signatures and designations).

Limitations in the quality of record-keeping impaired staff members' ability to proactively identify returned travellers with high and/or escalating health and welfare risks, especially across different shifts, over time, and between different teams (e.g. nursing and medical). It also impaired their ability to see the full clinical picture, and better understand the reasons for returned travellers' reactions and behaviour.

The lack of a centralised, coordinated system for logging and monitoring issues raised by returned travellers resulted in concerns and needs raised by REDACTED either being incompletely addressed, addressed after considerable delay, or not addressed at all. These returned travellers had a range of health and welfare needs that, during interview, were described by staff as unanticipated. As also described in Finding 10, the limited set-up time, and staff onboarding and training meant that the manner in which health and welfare concerns were identified and addressed was often inadequate and inconsistent.

The experience of not having R[redacted] concerns appropriately tracked and actioned meant that RE[redacted] REDAC[redacted] sought support through alternative means, namely by seeking help from a security guard in the hotel, telephoning REDACTED usual GP and ultimately 000 to request an ambulance.

Unavailable, incomplete and conflicting records contributed to staff members making clinical decisions with incomplete and/or inconsistent information. Some staff may not have been sufficiently aware of events and issues that contributed to REDACTED feeling unsafe and unsupported.

Returned travellers safety implications

Unavailable or inconsistently documented records relating to returned travellers resulted in increased frustration experienced and/or expressed by some, who often needed to raise their concerns repeatedly with multiple staff members for appropriate action to be initiated. Staff receiving this information, either through routine or ad hoc contact with returned travellers, may not have been privy to earlier concerns raised and may have borne the brunt of cumulative frustrations they expressed.

7. Many clinical staff were unclear on the processes for escalating health concerns raised by returned travellers, which resulted in independent ad hoc decision-making by staff.

Reasoning

Staff reported not being suitably aware or understanding policies and processes about escalating concerns, including about returned traveller health and welfare issues. This included who to escalate to, how to escalate, and circumstances that necessitate escalation. Clinical staff reported feeling unsure, and lacking formal guidance, about who had authority to make certain decisions (e.g. ambulance cancellation), and who was 'ultimately responsible' for making final decisions in certain clinical situations.

Staff reported that, on some occasions, certain issues could only be escalated through indirect channels. These channels included generic email addresses that were overwhelmed with incoming emails or general 'hotline' phone numbers, where call-takers were unable to offer definitive assistance. Staff reported that these indirect methods often resulted in slowed or no responses to their questions or concerns. In such instances, staff reported that they sometimes took steps to seek advice from others (e.g. by telephoning or emailing their counterparts at other hotels or identifying

contact details for relevant individuals). At times, this resulted in inconsistent advice that led to more confusion.

Staff noted that there was no clear, designated clinical care lead on-site, each shift (i.e. a line manager for the clinicians). This meant that it was unclear to whom they should escalate clinical concerns or complex cases requiring leadership input or guidance on how to proceed. Some staff reported developing informal workarounds for this issue, such as appointing a 'head' nurse for the shift through consensus agreement, based on who had worked at the specific hotel for more than one shift only. However, these workarounds remained informal and person dependent.

Returned travellers safety implications

Limited understanding of the processes to escalate clinical concerns were evident, e.g. the challenges in resolving different views among doctors and nurses regarding ambulance dispatch/cancellation and the best course of clinical care.

8. **Team-based care and care continuity for returned travellers was compromised by inadequate handover, issues tracking and communication processes within and between teams, and with external health practitioners.**

Reasoning

As described in Findings 3 ,6 and 8, information and communication systems and processes in the hotel quarantine system were fragmented and ad hoc. Staff noted a lack of formal handover policies and processes between shifts, as well as for inter-team communication during shifts. Some described developing ad hoc workarounds to address these limitations, but these efforts were individually driven, and thus not always consistently applied.

No central repository for returned traveller health and welfare information combined with ad hoc record-keeping, meant that returned traveller concerns, health needs and welfare issues were not well tracked. This included a lack of formal systems for collecting and acting upon concerns raised by returned travellers' usual treating clinicians in the community. Therefore, there was no systematic way to track that issues were acknowledged, responded to, actioned, and then finalised, and to assign accountability for these steps. Staff noted that responses to these issues or concerns were often delayed, incomplete or unaddressed.

These limitations in communication, issues-tracking and handover contributed to staff needing to make both clinical and non-clinical decisions without a proper overview of all the relevant information. It also contributed to inconsistent advice and information being provided to returned travellers.

Returned travellers safety implications

The information and concerns raised by REDACTED usual general practitioner (in the community) were not adequately conveyed or available to those making clinical decisions at that point in time or later. Similarly, there were minimal records kept of the multiple contacts between REDACTED and staff; of REDACTED difficulties with making contacting with staff by telephone and of the lack of a welfare check call, as well as of the concerns REDACTED had raised. This resulted in staff having an incomplete view of REDACTED experiences. This may have contributed to staff not appreciating the extent to which REDACTED felt unsafe and unsupported whilst in quarantine.

9. **Some staff were unclear on the scope of their role, as well as the delineation of roles and responsibilities within and between teams, which affected team care delivery and completion of tasks to address returned traveller health and welfare needs.**

Reasoning

During interviews, staff reported that they had not felt suitably briefed on the purpose and scope of their role, and the broader context in which they were operating within the hotel quarantine system. This included being uncertain about the boundaries and delineations between different teams within the hotel quarantine system, including in supporting the health and welfare of returned travellers. They described not receiving job descriptions or job cards pertaining to their roles, and limited or no formal training, orientation or supervision. Some reported that the extent of their 'onboarding' was an informal and brief 'handover' on their first day, from the person who worked their role in the previous shift, who was themselves often new.

The lack of a formally designated clinical lead role on-site (see Finding 7) contributed to uncertainty about lines of escalation and hierarchies of responsibility. In addition, some medical staff were in roles that exceeded the level of independent decision-making responsibility and accountability, and involved lower levels of supervision, than they had in their usual substantive roles, (this relates to both clinical and non-clinical roles).

Together, the lack of clarity about roles and responsibilities led to some tasks not being completed, and others being completed inconsistently, or in a delayed manner. It also put clinicians in situations where they had to make clinical decisions without being certain about their authority to do so, or the correct escalation processes to follow.

Returned travellers safety implications

In REDACT case, interviews and recordings relating to interactions between staff working in the hotel and Ambulance Victoria show that there was mutual uncertainty about processes around ambulance dispatch or cancellation, and who should perform what role in decision-making regarding this. During interviews, staff also described a lack of agreement between nursing staff and medical staff about who (if anybody) had the authority to agree to the cancellation of an ambulance called by returned travellers.

10. **The earlier than expected arrival of returned travellers during the hotel's designated set-up period for mandatory quarantine use, limited the ability of frontline staff to orient returned travellers and effectively implement processes to address their health and welfare needs.**

Reasoning

Staff reported that the first cohort of travellers (which included REDACTED arrived unexpectedly during the period designated to set the hotel up as a mandatory quarantine site. They described how this led to a disrupted and truncated time to set up the hotel, become familiar with and implement systems, policies and procedures, before receiving returned travellers. This affected the 'onboarding' of staff and may have contributed to staff not being fully aware of policies and procedures that existed at the time. The earlier than expected arrival therefore affected the 'onboarding' of staff (see Finding 6) as well as the orientation of returned travellers to their quarantine environment. A potential repercussion of this may have been that inexperienced staff onboarded subsequent staff. Staff mentioned that the earlier than expected arrival of the returned travellers may also have contributed to lack of access to adequate resources of various types (e.g. stationery, IT resources, record-keeping resources, clinical equipment, sanitisation supplies and PPE). These

played a role in the clinical care provided to REDACT (see Findings 1 and 2). In turn, this reduced staff capacity to identify returned travellers who had health, welfare and/ or other concerns and required extra support. This was evident in REDACT not receiving a welfare check call prior to R transfer to hospital.

The quality of orientation of returned travellers to their new environment was also negatively impacted. For example, returned travellers received little or no instructions on how to access help and support. This meant that REDACTE was not adequately supported in learning how to use the hotel's in-room communication system and was not provided with alternative options for seeking help.

Returned travellers safety implications

Insufficient staff preparation time has immediate and latent negative effects on the systems and processes needed to address the health and welfare needs of returned travellers.

11. There was no clear agreement between the hotel quarantine system and Ambulance Victoria (AV) about managing the hospital transfer needs of returned travellers. This contributed to improvised clinical decision-making by frontline staff.

Reasoning

If a returned traveller became unwell and required transfer to hospital under quarantine conditions, there was no evidence of any formal policies or guidelines to support clinical staff in their decision-making. The review team confirmed that there was no formal agreement between the hotel quarantine system and Ambulance Victoria to address the hospital transfer needs of returned travellers.

After the initial 000 call was placed by REDACTE requesting an ambulance, there were several calls between AV and the hotel to identify the appropriate people to communicate with and determine the best course of action. There was discussion regarding whether to contact the returned travellers directly, or whether hotel staff or nurses should act as conduits. The ambulance requested by RE REDAC was not dispatched, instead the AV clinician sought further information from others at the hotel.

The decision to not dispatch an ambulance was reached during a conversation between the AV clinician and a nurse attending to REDACT in R room. REDACT was considered at high risk of being COVID-19 positive. Considering R age and comorbidities, the shared decision not to dispatch an ambulance appeared to be based in part on the nurse's observations that R was 'standing', 'not dehydrated' and on incomplete clinical assessment outlined in Findings 1 and 2. It was also influenced by consideration of the risk of community and occupational risk of COVID-19 transmission. The AV clinician and nurse purported the importance of 'community interests' as a factor in deciding whether to dispatch an ambulance – a formal agreement would perhaps have provided guidance on whether factors outside of clinical need should be considered in making dispatch decisions.

The initial conversation between the AV clinician and REDACTED was interrupted by the nurse who had entered their room which meant their concerns may not have been fully heard, they disagreed with cancelling the ambulance and protested the decision.

Returned travellers safety implications

In the absence of a formal agreement, balancing the acute health needs of deteriorating returned travellers with broader community safety risks relies solely upon the individuals working at the time to determine the most appropriate response. The concerns of returned travellers, which reflects their understanding of their own health, is an important consideration in any hospital transfer decision.

LEARNINGS

Learnings describe system issues for which there was insufficient evidence that they contributed to the incident, but nonetheless provide important opportunities to improve.

	Learnings
1	There was limited to no standard process for routine early screening for COVID-19 of returned travellers in hotel quarantine. For returned travellers both with and without demonstrated or reported COVID-19 symptoms, testing was performed on an ad hoc basis, at the discretion of clinical staff. As a result, it was common for asymptomatic returned travellers to not undergo testing for the duration of their hotel quarantine period.
2	Staff working in the hotel quarantine setting were not aware of the process for managing instances in which a COVID-19 positive result was obtained for a traveller accommodated in the same hotel room as another returned traveller(s). Staff were unclear on the process of separating returned travellers in these instances, and relocation to a different room for the remainder of their quarantine period was at the discretion of the returned travellers involved.
3	The in-room communication system (i.e. hotel room telephone) was not able to be used by some returned travellers in order to make calls external to the hotel. As a result, it was necessary for some returned travellers to use their own personal mobile telephones to communicate. However, some returned travellers did not have suitable access to a functioning mobile telephone (e.g. if they had been overseas for an extended period or did not have adequate reception or access to suitable telephone charger or credit to make calls).
4	There was inconsistent language used to describe returned travellers in hotel quarantine (e.g. passengers, guests, detainees). Some of the terms have connotations that could bring unconscious bias to the way they are cared for by the staff working in the hotel quarantine environment.
5	Inconsistent rostering practices exacerbated the perception by staff working in the hotel quarantine environment that their work was temporary in nature. Some staff were rostered to work a single shift across different hotels, which prevented them from gaining familiarity with the operations of the specific hotel, the other staff members, or the returned travellers in their care, and may have contributed to a lack of shared understanding, team development and accountability.
6	A lack of systems and capacity existed in the hotel quarantine system to ensure concerns and needs raised by returned travellers were managed and resolved in a timely, systematic, responsive and reliable manner. This led to returned travellers expressing their frustration with various aspects of their hotel detention. In some instances, deteriorating health concerns expressed by returned travellers may have been misinterpreted as expressions of frustration with the lack of systems and resources to resolve a broad range of hotel detention issues in a timely way.

Commented [MB(19]: Not sure of value of this statement across community now asymptomatics were being tested!

Commented [MB(20]: This is a hotel issue about their equipment

Commented [MB(21]: Relevance regardless of these three terms provided as examples needs to be clear it was a community type setting!

RECOMMENDATIONS

Recommendations describe actions that should be taken to address the findings and/or learnings identified in the review and achieve system improvement.

The strength of recommendations (weak, moderate or strong) describes the overall likelihood that their implementation is likely to succeed in establishing sustained system changes to achieve the desired risk mitigation and safety outcomes. This likelihood is determined based on general evidence about human factors, systems improvement and change management.

	Recommendation	Associated findings / learnings	Strength
A	As a matter of priority, implement measures to ensure an adequate and reliable on-site supply of Personal Protective Equipment (PPE) that is readily accessible to staff working in the hotel quarantine system.	Finding 1	Strong
B	Develop and implement robust, fit-for-purpose, readily accessible policies and procedures relating to the appropriate use of PPE for staff working in hotel quarantine.	Finding 1	Weak
C	Develop and implement processes to enable clinical staff working in the hotel quarantine system to conduct visual telehealth (i.e. video calls) consultations for returned travellers who are willing and able to use these methods, particularly those identified as higher risk. This would enhance initial 'contactless' clinical assessments for returned travellers. These processes should be co-designed. The visual telehealth platform should be capable of including external family members, community caregivers in telehealth consultations, at the discretion of the returned traveller, particularly in circumstances requiring a case management approach. The visual telehealth platform should also enable participation of language interpreters, consider the specific needs of returned travellers with visual or hearing impairment and other physical and/or mental disabilities, as needed.	Finding 1 Learning 2	Strong
D	As a matter of priority and in consultation with clinical leads, implement measures to ensure an adequate and readily accessible on-site clinical equipment and the resources required to effectively sanitise this equipment. This would ensure timely assessment, monitoring and first line treatment of returned travellers.	Findings 1 & 2 Learning 1	Strong
E	Develop and implement a policy with clear guidance and specific criteria for when medical staff are required to assess to returned travellers via visual telehealth or face-to-face whilst in mandatory hotel quarantine.	Findings 3 & 7 Learning 1	Weak
F	Implement an off-the-shelf, fit-for-purpose (or easily customised), single, centralised and real-time information sharing and tracking system containing all individual returned traveller information (including their health and welfare), accessible by all staff with a role in providing services, care, support and oversight for returned travellers. This should include functionality to provide 'alerts' to identify to staff working on each shift, returned travellers with significant health and/or welfare risks requiring monitoring or follow-up.	Finding 3 Learning 2	Strong
G	Undertake ongoing needs analyses to strategically match the number and designation of staff rostered on shifts to ensure there are adequate staff available to be able to provide a rapid response surge capacity to meet the dynamic needs of specific cohorts of returned travellers. This should include a mechanism by which if necessary additional resources can be mobilised to respond to evolving situations.	Findings 4 & 5 Learnings 1 & 5	Moderate
H	Expand the daily COVID-19 assessment symptom screening calls to include other basic health and welfare questions to screen for unmet support needs or issues. For returned travellers with medium to high risk health conditions, this presents an opportunity to discuss their specific issues. Ensure adequate, dedicated and appropriately qualified staff are available to conduct these calls daily for the duration of returned travellers' period of mandatory quarantine.	Findings 5 Learnings 2 & 6	Moderate
I	Implement formal, standardised processes for the recording and tracking of issues raised by returned travellers with hotel quarantine staff (via all means – including screening calls). This should include assignment of these issues for follow up, tracking progress to completion, and alerting relevant staff when issues have not been actioned and closed.	Findings 5 Learnings 2 & 6	Weak

Commented [MB(22]: This was available on the DHHS website for all health professionals and community health so not sure why this would need to be different

Commented [MB(23]: This is available is it not to all medical practitioners providing telehealth so as practitioners this would be the same as for any community setting, starting point of limit interaction.

Commented [MB(24]: At what point in time are these being made as the GPS were using an off the shelf medical director software. So needs to be delineated.

	Recommendation	Associated findings / learnings	Strength
J	Co-design with frontline staff and implement the use of specific fit-for-purpose materials, methods and systems suitable for recording returned traveller health and welfare information in a consistent, comprehensive and systematic way. This includes record keeping templates and information systems. Ensure the availability of resources so these systems are readily accessible to all relevant staff, and feedback mechanisms ensure continuous evaluation and improvement relating to the suitability of related current policies and processes.	Finding 6 Learnings 5 & 6	Weak
K	Develop and implement formal policies and procedures for recording information provided by external health providers about returned travellers in quarantine, and ensure that relevant information be reviewed, actioned as needed and evaluated by an appropriate clinician on-site.	Findings 3, 6 & 8 Learning 6	Weak
L	Implement formal processes for conducting handover and communication within and between teams working in the hotels in the quarantine system.	Finding 8 Learning 4	Weak
M	Co-develop with staff detailed descriptions for all roles in the hotel quarantine system, and a visual and simple written guide to how these roles work together. Provide this to all existing and future staff and include this information in staff orientation and in-service training.	Findings 6, 8 & 9 Learning 5 & 6	Weak
N	Based on experience to date and staff input, revise methods for determining the staffing level and mix needed around the time of large returned traveller influxes and implement revised models of staffing and rostering based on these. Ensure readily available increased staffing capacity for surges in workload associated with arriving cohorts of returned travellers.	Findings 4 Learning 4, 5 & 6	Moderate
O	Co-develop agreed formal processes with relevant entities (e.g. Australian Border Force, the Department of Foreign Affairs and Trade) to improve the accuracy, detail and optimise timeliness of information received about incoming returned traveller cohorts to facilitate planning and preparedness.	Findings 3, 8, 10 Learning 4 & 6	Weak
P	Co-develop and implement a formal agreement between all relevant parties in the hotel quarantine system and Ambulance Victoria regarding the ambulance service requirements of returned travellers. This agreement must provide specific guidance to support decision-making by frontline staff; reflect the rights and role of consumers (returned travellers or their significant others) in participating in these decisions; and provide clear guidance on ambulance dispatch and cancellation.	Findings 7 &11 Learning 1	Weak
Q	On arrival, all returned travellers and their external family members should be routinely provided with clear information about how to escalate unaddressed or inadequately addressed concerns. This information should be easily accessible for those from culturally and linguistically diverse backgrounds, the elderly, the visually impaired, and be suitable for varying levels of health literacy.	Findings 10 Learnings 2, 3, 4 & 6	Weak
R	On arrival, all returned travellers should have suitable access to a functioning mobile telephone for the duration of their mandatory detention, (e.g. telephone handsets, chargers, Australian SIM cards and access to credit and top-up methods to be able to make calls).	Learnings 3 & 6	Moderate

Commented [MB(25]: Why they have phones the issue unfortunately was the hotel phone was not working in this case – which should have been fixed not us provided phone or Australian sim cards to everyone. Also she was able to call REDA so had a working phone.

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APPENDIX 1: RECOMMENDATION ACTION PLAN TEMPLATE

Please outline the plan for how recommendations will be enacted.

If a recommendation has been wholly enacted when the report is received, indicate 'wholly' in column two of Table 1. Write N/A in subsequent columns of Table 1. Then complete Table 2 for that recommendation.

If a recommendation has been partly enacted when the report is received, indicate 'partly' in column two of Table 1. Complete the remaining columns in Table 1 for aspects of the recommendation that have not yet been enacted. Then provide details in Table 2 for aspects of the recommendation that have been enacted.

If no part of a recommendation has yet been enacted when the report is received, indicate 'no' in column two of Table 1. Complete the remaining columns in Table 1. Do not use Table 2 for that recommendation.

Table 1.

Recommendation	Already enacted (Write: 'wholly', 'partly' or 'no')	Actions still required to enact recommendation	Outcome measure(s)	Executive position sponsor
A				
B				
C				
D				
E				
F				
G				
H				
I				
J				
K				

RECOMMENDATIONS ALREADY IMPLEMENTED

If any recommendations have been wholly or partly implemented when the report is received, use Table 2 to provide details of what has been done, how implementation has been monitored (e.g. monitoring on-the-ground uptake and impacts – intended and unintended), and outcomes (using appropriate outcome measures).

Table 2.

Recommendation	Actions already completed	Monitoring undertaken

PROTECTED

APPENDIX 2: KEY THEMES FROM HOTEL QUARANTINE INCIDENTS 1 AND 2

Operation Soteria Hotel Quarantine – Common themes arising from two incident reviews as of 15 May 2020.

Below is a summary of key quality and safety issues, and associated contributing factors, identified by Safer Care Victoria during their review of two separate incidents involving returned travellers in hotel quarantine in Victoria.

Based on evidence and information available to Safer Care Victoria at the time of writing, these issues were evident at the time of the two incidents (3 to 13 April 2020). It is noted that certain information sought by the team was unable to be provided or obtained during the data collection period. In addition, some individuals invited for interview in relation to these incidents declined to be interviewed during the data collection period.

Due to the ongoing detention of returned travellers in hotel quarantine as a result of the COVID-19 pandemic, a rapid review method was employed. This review approach has some limitations regarding data collection and scope. These limitations were considered against the need for a rapid review process to inform system improvement in real time. With that approach and goal in mind, the review teams share a summary of issues identified below.

Issue	Comments
Selection of staff	Victorian public sector staff putting themselves forward to take up temporary new roles in the hotel quarantine system did not have an adequate opportunity to pre-emptively nominate the types of roles for which they would or would not be suitable. In selecting and assigning staff to new roles, there were limited checks regarding their relevant skills, experience, education or professional background, in order to assess their suitability for particular roles. As a result of the above (and possibly other situational factors arising from the state of emergency declared in Victoria) some staff were assigned to roles for which they did not have the appropriate knowledge base, skill set or relevant experience.
Onboarding and training of staff	For many of the new roles created for the hotel quarantine system, there was a lack of clear and detailed job descriptions and/or job cards available to staff when they commenced in their roles. This resulted in a lack of clarity about individual roles and responsibilities. There was limited to no formal and standardised training, orientation or opportunities for mentoring available to staff commencing new roles within the hotel quarantine system. Some individuals reported taking the initiative to develop and provide training for their teams. However, these efforts were individually driven by frontline staff and were therefore not consistently adopted across the system. On the day of their first shift in their new role, some staff did not experience adequate handover from their counterpart who had worked the previous shift.
Continuity of staffing	Continuity of staff rostered at hotel locations was limited. This resulted in staff reporting challenges relating to their roles. These included issues relating to hotel familiarity, teamwork, clarity regarding roles and responsibilities, and continuity of support provided to returned travellers. Some staff reported requesting to be rostered at the same location and/or team. However these efforts were individually-driven by frontline staff, and therefore were not consistently adopted across the system.
Collection, storage and access to personal information about returned travellers	There were reports of inadequate and inconsistent systems and resources (paper or electronic) available for the recording information about returned travellers. As a result, such information (e.g. health and welfare notes, returned traveller requests and concerns) was commonly recorded in ad hoc ways (e.g. staff member's personal note books, post-it notes, whiteboards etc). During a returned traveller's period of detention, they were required to complete (either on paper or via phone) a variety of forms, questionnaires and assessments. These were administered by multiple entities and teams (i.e. nursing staff, welfare check team, hotel staff and the Department of Jobs, Precincts and Regions).

Issue	Comments
	The information gathered through the multitude of channels was not centrally coordinated and stored, and thus was not available to all staff who required it. As a result, staff often did not have the information needed to perform their roles optimally and provide adequate support and care to returned travellers. For example, welfare check callers did not have access to nursing notes or the hotel questionnaire when making calls to returned travellers.
Policies and procedures	Several policies and procedures considered necessary to ensure safe operation of the hotel quarantine system were reported to be either under development or not readily accessible by frontline staff at the time these incidents occurred. For example, policies regarding appropriate use of personal protective equipment, escalation of concerns about returned travellers not answering calls, how to conduct handovers, record-keeping and issues tracking, or managing ambulance attendance. Some policies or procedures reflected plans and intentions that were not operationalised or achieved in practice (e.g. differences between planned frequency of welfare checks and actual frequency of these).
Escalation and leadership responsibilities	There was a reported lack of clarity among frontline staff about escalation processes and pathways, and the circumstances under which they should be utilised. Where formal policies or processes had been formulated, frontline staff reported being either unaware of these, or these were not operationalised fully. There was a reported lack of understanding amongst frontline staff in relation to decision-making hierachies in complex and unprecedented situations. For example, deciding on the appropriate level of clinical care, or when to escalate concerns about a returned traveller not responding to phone calls and door knocks. There was no dedicated role on-site with specific responsibility for decision-making regarding returned traveller health and wellbeing. This role was often either shared between nurses, or an informal 'lead' nurse was appointed for the shift by the nursing team, with access to consultation with a doctor (most often off-site) if required. Some team leaders, authorised officers and nurses reported not receiving adequate information about to whom they should escalate concerns (e.g. specific names, roles and direct phone numbers). Staff sometimes had to use indirect means to request escalation and assistance about issues and concerns (such as use of general email or 'helpline' phone numbers), leading to reported delayed or no response or definitive action.

APPENDIX 3: REPORT VERSION TRACKING

Date	Action
2 June 2020	Draft report (V1.5) approved by Euan Wallace, CEO, Safer Care Victoria. Sent to REDACT Director, Centre of Patient Safety and Experience.
2 June 2020	Draft report shared with Merrin Bamert, Commander, Operation Soteria, requesting fact checking.

OFFICIAL - Sensitive: initial review/ fact check

From: REDACTED (DHHS)" REDACTED @safercare.vic.gov.au>
To: "Pam Williams (DHHS)" <REDACTED>
Date: Tue, 02 Jun 2020 18:13:52 +1000
Attachments: HQI2 Report with cover letter_V1.5_ 20200602_Draft to M.Bammert for fact checking.docx (823.73 kB)

Dear Pam I note Merrin is on leave

Please find attached the final draft. Would you have the ability to review please?

Once you have responded with nay points of clarity / factual corrections we will progress to the committee.

It would be good to turn this around as soon as is practicable. Would you have capacity to do by the end of this week or is beginning of next week more achievable please?

Once you have submitted your questions/ proposed track changes we will then finalise for Euan and progress from there. I will hold off signing this off until then. I have read the report just as an FYI.

Obviously the intent is to inform any further improvements that need to be made.

Let me know if you foresee any issues

Kind Regards

REDACTED
Director- Centre for Patient Safety and Experience
REDACTED
S @SaferCareVic
Executive Assistant: REDACTED

Safer Care Victoria

PROTECTED: update HQ12

From: [redacted] (DHHS)" [redacted]@safercare.vic.gov.au>
To: "Merrin Bamert (DHHS)" <[redacted]
Date: Tue, 16 Jun 2020 18:42:29 +1000
Attachments: HQI2 Report with cover letter_V2_ 20200612 .docx (825.17 kB)

Dear Merrin

How's things? You are certainly very busy!

Thank you for reviewing the draft report for Hotel Incident Two and providing your feedback on it. The report is now finalised and ready to be progressed to the committee. I have attached the latest version for you.

The review team have systematically gone through your feedback and the queries you raised. Although it would not substantively change the content of the report, as you suggested they have sought clarity regarding the rostering arrangements for the medical staff during that period.

Fact checking was undertaken by re-requesting copies of the applicable rosters from Operation Soteria and also confirming the specific arrangements with Jenny Owen. Based on the evidence provided, the review team is satisfied that this final version of report is an accurate reflection of this.

We acknowledge your feedback in relation to the Accimap in the report and appreciate it can be challenging for a reader to read/follow. The Accimap is only there to act as a tool to assist the review team with the review process and reflects their thought processes. It is not intended to be for standalone interpretation and really only included for transparency.

Obviously the intent of these reviews is to inform any further system improvements that need to be made for the hotel quarantine system.

Thanks to you and your team for their assistance with and for helping to facilitate this review process.

With thanks

[redacted]
Director- Centre for Patient Safety and Experience
[redacted]
S @SaferCareVic
[redacted]

Safer Care Victoria

PROTECTED

Incident Review Report - Hotel Quarantine Incident Two

From: REDACTED (DHHS) REDACTED @safercare.vic.gov.au>

To: Euan Wallace (DHHS) <euan.wallace@safercare.vic.gov.au>, Andrea Spiteri (DHHS) REDACTED, Pam Williams (DHHS) <REDACTED, Merrin Bamert (DHHS) <REDACTED, Colleen Clark (DHHS) <REDACTED>, Anita Morris (DHHS) <REDACTED, Nicole Brady (DHHS) <REDACTED, Melissa Skilbeck (DHHS) <REDACTED, Jacinda de Witts (DHHS) <REDACTED Leanne Hughson (DHHS) <REDACTED>, Murray Smith (DHHS) REDACTED, Vanessa Brotto (DHHS) <REDACTED

Date: Fri, 19 Jun 2020 16:19:45 +1000

Attachments: HQI2 Report with cover letter_V2_ 20200612_.pdf (780.49 kB)

Hi All,

Please find attached the second incident review report undertaken by SCV's Incident Review Team.

Euan or myself are happy to facilitate any questions or comments with the Incident Review Team, based on discussions from the first incident review report I understand that Pam Williams is convening a governance group to review and oversee the response to the recommendations.

Kind Regards

REDACTED

REDACTED
Principal Advisor, Office of the CEO

REDACTED
W safercare.vic.gov.au

Please note I work part-time hours over 5 days, usually leaving at 2:30pm.

Safer Care Victoria

Operation Soteria Incident Review Escalation Points April 29 2020

Teleconference with review leads last night in escalation of what were seen to be present and current risks and safety issues requiring immediate response.

Summary:

Issue	Comments
Daily checks	Some confusion as to who was doing these. Team thought nurses on site were doing daily checks vs nurses via phone. Nurses doing daily COVID symptom checking. Some concerns that this was not always occurring
Welfare checks	Team concerned these are not sufficient (only 2 required across 14 days) they are completed by non-clinical people- either at 50 Lonsdale or via Hello World (travel agency). Often not occurring. They are conducted via phoning the room directly (assume to check they are in their rooms?) which means they go via hotel switch as you can't call room directly. Often switch is overwhelmed and therefore welfare check not done at all.
PPE	Limited access to PPE resulting in conflict locally between staff (security and nursing staff had a stand-up verbal fight over masks yesterday). Nurse now hiding PPE. Also has led to avoidance of contact with passengers. Clinical contacts have also been avoided as a result. Another instance a hotel member went into a room with a positive resident without PPE and now in quarantine themselves. Cause of much stress and anxiety.
Escalation processes	No clear escalation processes with any of the checks- be that daily or welfare. On the same day as the suicide at Park Royal a male passenger barricaded themselves in their room requiring a police fly by the window in a helicopter.
Family and friends communication	Cases of families not being informed that their family member is I quarantine. Families and friends have no avenue to escalate any concerns. Hotels will not take calls or 'fob' them off. No number to call DHHS. DHHS do collate NOK on the medical screening form.
Information sharing re key passenger information	Recent meeting with police revealed that there are a number of offenders in passenger group. Prior to this DHHS had no knowledge of this. Some are alleged or confirmed sex offenders. "You've a number of dodgy people in these hotels". No risk assessment or safeguards in place.
Unaccompanied minors	No clear process for managing unaccompanied minors. Hotel unaware of the presence of a minor until they land on the doorstep so can't prepare. Child protection know about them, but we are not sure in what capacity and what they do exactly. Also indications for welfare checking process- especially frequency and nature of the person doing the check.
Family violence	Hotel staff have alleged that they have had instances of hearing family violence in rooms. One case REDACTED Hotel's response was to offer a bigger room/ suite to give more space as RED said the challenge was the RE was used to being outdoors and was playing up. Staff feel they can't do anything. Seems no screening for family violence. Also causes other passengers concern as they hear things.

Smoking	No smoking screening in place which means passengers who smoke are in rooms with no open-air space / appropriate ventilation so resulting to smoke in the shower and bloke smoke in the fan. There is a Facebook page some passengers have set up – how to smoke without getting caught. There are now some processes in place for patches and Quitline support. Some hotels have blanket rules no parcels for passengers from outside so passengers can't get more cigarettes resulting in 'cold turkey'. ? is this also a potential fire risk
Management of post quarantine contacts who subsequently receive positive COVID result	One known case of passenger who was exposed to a positive passenger REDACTED and refused to stay in quarantine and now back in REDACT and COVID positive. 13-day test commenced pre 'discharge'. I believe CHO is doing contact tracing with QLD.
Staff wellbeing	Many staff report working under duress and very stressed – both DHHS staff and hotel staff.
Incident management	No process for incident management – i.e. identification, response, documentation/ notification and review

Overall to date they uncovered large inconsistencies and lack of processes. REDACT did make comment that lots of good people working hard to manage this centrally at 50 Lonsdale, but sheer lack of coordination means it is falling down or happening in silos. RE is concerned about these staff burning out. There may be posters for EAP around, but it isn't meeting the needs and people seem reluctant to take it up/ are not accessing it.

RE: URGENT: Fact-checking of draft report for hotel quarantine incident 1.

From: "Merrin Bamert (DHHS)" <REDACTED
To: REDACTED (DHHS)" <REDACTE @safercare.vic.gov.au>
Cc: REDACTED (DHHS)" <REDACTED @safercare.vic.gov.au>, REDACTED (DHHS)" <REDACTED @safercare.vic.gov.au>
Date: Thu, 21 May 2020 21:28:06 +1000

REDACTED

Regards

merrin
Merrin Bamert
Commander, Operation Soteria, Covid - 19
Director, Emergency Management, Population Health and Health Protection
South Division
Department of Health and Human Services
Level 5 / 165-169 Thomas Street, Dandenong, 3175
p. 03 REDACTED REDACTED
e. REDACTED

From: Merrin Bamert (DHHS)
Sent: Thursday, 21 May 2020 9:21 PM
To: REDACTE (DHHS) <REDACTE @safercare.vic.gov.au>
Cc: REDACTED (DHHS) <REDACTED @safercare.vic.gov.au>; REDACTED (DHHS) REDACTED @safercare.vic.gov.au>
Subject: RE: URGENT: Fact-checking of draft report for hotel quarantine incident 1.

Hi
I am not sure how to review the facts of this report as I am only aware of my involvement which was the call at 6pm so not sure how to do what you are asking. I can only confirm that what you have been told about the day is the same as I what I observed in his notes.
I can say however though that the roles listed on page 7 are incorrect – line two under organisation and management.
We did not have the EOC set up and therefore did not have a commander or dep commander at that time.
This operation was being managed out of a range of sites with no clear operational structure (which is why I worked on the Saturday morning) the same day REDACTED to start drafting one.
I am not sure who you would say was in charge at that point however email traffic was going to the SEMT.
I was certainly not the commander (and had no official role on any structure) at the time so the timelines on page 6 need to change I was called by Jason Helps (SCC) to go in on the night and assist as they wanted an exec to help out and I had been assisting the hotels from the commencement of the policy.
The EOC structure did not officially commence till the following week. Its first official day was the following Friday 17 April
Regards
Merrin
Merrin Bamert
Commander, Operation Soteria, Covid - 19
Director, Emergency Management, Population Health and Health Protection
South Division
Department of Health and Human Services

Level 5 / 165-169 Thomas Street, Dandenong, 3175
p.REDACTED
e.REDACTED

From: REDACTED (DHHS) <REDACTED@safercare.vic.gov.au>
Sent: Thursday, 21 May 2020 10:09 AM
To: Merrin Bamert (DHHS) <REDACTED
Cc: REDACTED (DHHS) <REDACTED@safercare.vic.gov.au>; REDACTED (DHHS) <REDACTED@safercare.vic.gov.au>
Subject: URGENT: Fact-checking of draft report for hotel quarantine incident 1.

Good morning Merrin,

Thanks once again for your assistance while we have been undertaking two reviews relating to incidents in hotel quarantine. We appreciate your time and your efforts in assisting us to access the evidence and information required for the review.

Attached is a draft report in relation to what we refer to as incident one (involving the person CP), which we are providing first. The report relating to the other incident (involving the person EC) will follow shortly. We are providing this draft to you for the purposes of fact-checking, prior to the draft being finalised. Please do not distribute the draft any further.

We ask that you provide feedback specifically about any factual inaccuracies in the report's content. Should you highlight any inaccuracies, please note that we may require further information to assist us in contextualising and verifying the new information.

Please keep in mind that, as per standard incident review methodology, the information in the report describes – based on the evidence examined by the review team – events and circumstances as they relate to what happened 'on-the-ground' on the specific days in question, involving the specific individuals and the specific hotel. The information may be accurate, while also differing from your own high-level understanding of how the system operated more generally at the time (e.g. as you would have expected, or at different hotels, or in other circumstances).

Please also keep in mind that, as per standard incident review methodology, the information in the report refers to the state of the hotel quarantine at the time of the incident, and intentionally does not describe any changes that may have occurred since that time. Once the report is finalised and provided to the agreed receivers, Appendix 1 provides the opportunity for any changes in the system since the incident to be recorded and explained, including noting any recommendations already actioned.

To facilitate us providing the report to the Operation Soteria Working Group by early next week, please provide any feedback by COB Friday 22 May 2020.

Regards,

REDACTED
Safer Care Victoria Academy

T REDACTED
E REDACTED@safercare.vic.gov.au
W safercare.vic.gov.au

Safer Care Victoria

Safer Care Victoria report on clinical incidents occurring in hotel quarantine in Victoria

At the request of the Secretary of the Department of Health and Human Services, Safer Care Victoria undertook reviews into two serious clinical incidents involving returned travellers in hotel quarantine in Victoria. The first incident involved the apparent suicide death of REDACTED (Hotel Quarantine Incident 1), and the second incident involved the care of [redacted]-year-old REDACTED who developed COVID-19 symptoms and deteriorated rapidly, requiring intensive care unit admission at the Alfred Hospital (Hotel Quarantine Incident 2).

Two teams of reviewers with relevant incident review and subject matter expertise were convened to undertake the reviews. The purpose of the reviews was to identify contributing factors relevant to the specific incidents, as well as provide insights into issues affecting the operation of hotel quarantine in Victoria, with the view to facilitating timely system improvements. To this end, the final output has been two separate reports, each detailing the contributing factors relevant to one incident, along with a summary of key high-level themes identified in both reviews which are relevant to the overall operation of hotel quarantine. These will be shared with the Secretary as well as the Operation Soteria Working Group, which includes representatives from Public Health, Emergency Operation Centre, Accommodation Commander, Welfare Cell, Office of Chief Psychiatrist and Safer Care Victoria. The Operation Soteria Working Group will be responsible for monitoring the implementation of the recommendations.

Please find a draft report detailing the contributing factors for Hotel Quarantine Incident 2. The findings and recommendations provided are based on evidence and information available to the review team at the time of writing and relate to issues and circumstances at the times and places the incident took place (7 to 13 April 2020). It is also noted that certain information sought by the review team was not able to be provided or obtained, or was conflicting, and some individuals with potentially relevant information declined to be interviewed. It is further acknowledged that a number of recommendations and key themes may have since been addressed.

Yours sincerely,

REDACTED

Director, Patient Safety and Experience

Safer Care Victoria

Date: / /2020

VICTORIA State Government

Safer Care Victoria

Incident review report: Quarantine Incident Two Hotel

ENDORSEMENT

Review lead

Signature: REDACTED

Date: 12 June 2020

Executive sponsor

Signature:

Date:

REVIEW TEAM

Executive sponsor	Director, Centre for Patient Safety and Experience, Safer Care Victoria
Review lead	Senior Project Officer, Patient Safety Review Team, Centre for Patient Safety and Experience, Safer Care Victoria
Human factors / review method advisor	Manager, Patient Safety Review Team, Centre for Patient Safety and Experience, Safer Care Victoria
Review coordinator	Project Officer, Centre for Patient Safety and Experience, Safer Care Victoria
Team member	Safer Care Victoria Academy Member
Team member	Safer Care Victoria Academy Member
Team member	Senior Project Officer, Centre for Patient Safety and Experience, Safer Care Victoria
Administrative support	Project Officer, Centre for Patient Safety and Experience, Safer Care Victoria

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ABOUT THE REVIEW

Background

On 13 April 2020, RE[redacted]-year-old [redacted] was transferred by ambulance to the REDA[redacted] Hospital from the Four Points Hotel, Southbank, Melbourne, where RE[redacted] had been in mandatory quarantine since returning from overseas. At the time of RE[redacted] transfer, [redacted] had returned a positive COVID-19 swab result on day seven, and had experienced rapid deterioration in RE[redacted] condition, having shown symptoms for several days. As part of the response to [redacted] transfer to hospital, the Secretary of the Department of Health and Human Services (DHHS) requested that Safer Care Victoria undertake an independent review into the incident.

Unless otherwise specified or indicated, the information in this review refers to the period of the incident 7 April 2020 to 13 April 2020. The team acknowledges, based on evidence provided during the review, that some systems and processes detailed have changed since that time. This may mean that certain recommendations have since been addressed, or certain findings may not reflect the current state.

Method

The ongoing detention of people in hotel quarantine and need to identify and address any ongoing risks to these individuals in real time, necessitated a systems review method that could be undertaken rapidly. The time limited nature of rapid reviews means that their data collection and scope are also limited. These limitations were weighed against the need for a systems review process in determining the review method and scope. The review used the AcciMap method, customised with elements of the London Protocol – both widely-recognised and validated approaches to rigorous incident review.

In cases of clinical deterioration, the review team cannot determine for certain whether changes to the contributing factors would have ultimately contributed to a different outcome. Therefore, the review team has focused on addressing whether the care [redacted] received, and management of RE[redacted] quarantine, corresponded to an adequate standard of care. The team has done so without making conclusions about whether any changes to the contributing factors would or would not have prevented RE[redacted] present situation. At the time of writing this report, [redacted] remains intubated and ventilated in the Intensive Care Unit at the Alfred Hospital, Melbourne.

Evidence

The review team has collected and considered evidence from a variety of sources, including (but not limited to):

- Interviews with seventeen people, drawn from the following groups: DHHS/Operation Soteria leadership, hotel team leaders, nursing staff, medical staff, authorised officers and [redacted] family and general practitioner.
- A letter to DHHS written by [redacted] outlining RE[redacted] concerns in relation to the incident.
- Clinical notes and documentation relating to [redacted]
- Audio recordings of telephone calls with Ambulance Victoria related to the incident.
- Plans, policies and procedures including 'Operation Soteria – Operations Plan', 'COVID-19 – Interim Healthcare and Welfare Mandatory Quarantine Plan (Draft)', 'Team Leader Pack – Hotels' and 'Referral Pathways for people issued COVID-19 quarantine orders.

The review team would like to acknowledge the cooperation and openness of the Operation Soteria staff who shared their experiences with us, and their willingness to do so. We are especially grateful to [redacted] family for providing information [redacted], and the events surrounding this incident during this difficult and challenging time.

The information in this report is based on evidence and information available to the team at the time of writing. Certain information sought by the team was not provided or obtained within the review timeframe, and some individuals declined an invitation to be interviewed. Therefore, the review team acknowledges there may be unintended gaps or inaccuracies in the report that the team's reasonable efforts to seek required information were unable to rectify. The information presented was accurate – to the best of the team's knowledge – at the time of writing, given the information available, and with consideration of the potential limitations identified above.

Safer Care Victoria

DESCRIPTION OF THE INCIDENT

REDACTED and REDA were placed into mandatory hotel quarantine in adjoining rooms REDACTED at the Four Points Hotel, Southbank, Melbourne. This followed their arrival in Melbourne on a flight from REDACTED after disembarking from the REDACTED cruise ship, where they had been quarantined at sea for four weeks. REDACTED and RE relatives were detained in accordance with section 200(1)(a) of the Public Health and Wellbeing Act (2008) (Vic) as part of the Victorian government's response to the COVID-19 pandemic (Operation Soteria). This was in line with a National Cabinet agreement for international arrivals, after midnight 28 March 2020, to complete mandatory hotel quarantine for 14 days.

On days two and four of his quarantine, REDACTED reported physical symptoms to nursing staff (shaking and coughing). Nursing staff provided RE with paracetamol. On day five, having been in contact with REDACTED REDACTED -based general practitioner (GP) contacted nursing staff (via telephone) expressing concerns about REDACTED clinical presentation and symptoms. The GP relayed concerns that RE REDACTED a history of not appearing as unwell as RE was and queried whether RE may have REDACT REDACTED In response, nursing staff attended to REDACTED in RE room, obtaining a self-administered swab for COVID-19 testing, and noting R had a high blood pressure reading, a rapid heart rate and fever. After consulting with a doctor, nursing staff gave paracetamol. Later that day, a follow-up visit by nurses was conducted and it was noted by them that RE symptoms had improved.

Overnight from day five into day six, there were several contacts between REDACTED and nursing staff, with handover provided to the on-call doctor by nursing staff. During routine COVID-19 symptom screening on day six, REDACTED reported RE did not feel feverish or shaky. In the subsequent hours, RE REDACT told REDACTED -based REDACT (by telephone) that REDACTED condition had worsened, but RE had been unable to contact on-site nursing staff for several hours, citing issues with the intercom system (in-room telephone). RE also told REDACTED had repeatedly requested help from a security guard to secure nursing assistance, without success. REDACTED advised RE parents to call an ambulance.

REDACTED called 000 and was transferred to a secondary triage clinician (AV clinician). REDACTED relayed REDACTED history and symptoms, and RE concerns, particularly about accessing help if RE condition was to deteriorate overnight. The AV clinician contacted hotel nursing staff directly to discuss how to proceed. After discussions between the on-site doctor and nursing staff, the AV clinician and nursing staff then later agreed for nursing staff to visit REDACTED room and call the AV clinician back with their assessment.

In a subsequent call, nursing staff and the AV clinician discussed the importance of providing reassurance to REDACTED noting the benefits of not dispatching an ambulance in the 'community interest'. After a series of failed attempts to contact REDACTED on the telephone, the AV clinician finally contacted RE REDACT via hotel reception while nursing staff were attending their room. The AV clinician repeated that it was not in REDACTED best interest to go to hospital, to which REDACTED responded with her disagreement and concern. The AV clinician then spoke directly with REDACTED at which point the nurse present in the room, subsequently took over the call. After relaying the features of REDACTED clinical presentation to the AV clinician, the AV clinician and nurse present in the room agreed that an ambulance was not needed and would not be dispatched. This was done despite protests from REDACTED and without their explicit agreement.

On returning downstairs to the staff area of the hotel, the nurse advised the on-site doctor of the ambulance cancellation. After expressing concern the on-site doctor had a phone consultation with REDACTED in which R reported having fever, chills and fatigue. In two subsequent phone calls, REDACTED and staff discussed the ambulance cancellation and the most appropriate course of action for RE care.

On day seven, REDACTED condition deteriorated rapidly, marked by shortness of breath, dizziness, lethargy, chest pain, high blood pressure, a rapid heart rate, fever and low oxygen saturations. By then REDACTED positive COVID-19 swab result had been notified. Hotel nursing staff called an ambulance, which transferred RE REDACT to the Alfred Hospital shortly after. He was intubated and ventilated two days later (16 April 2020).

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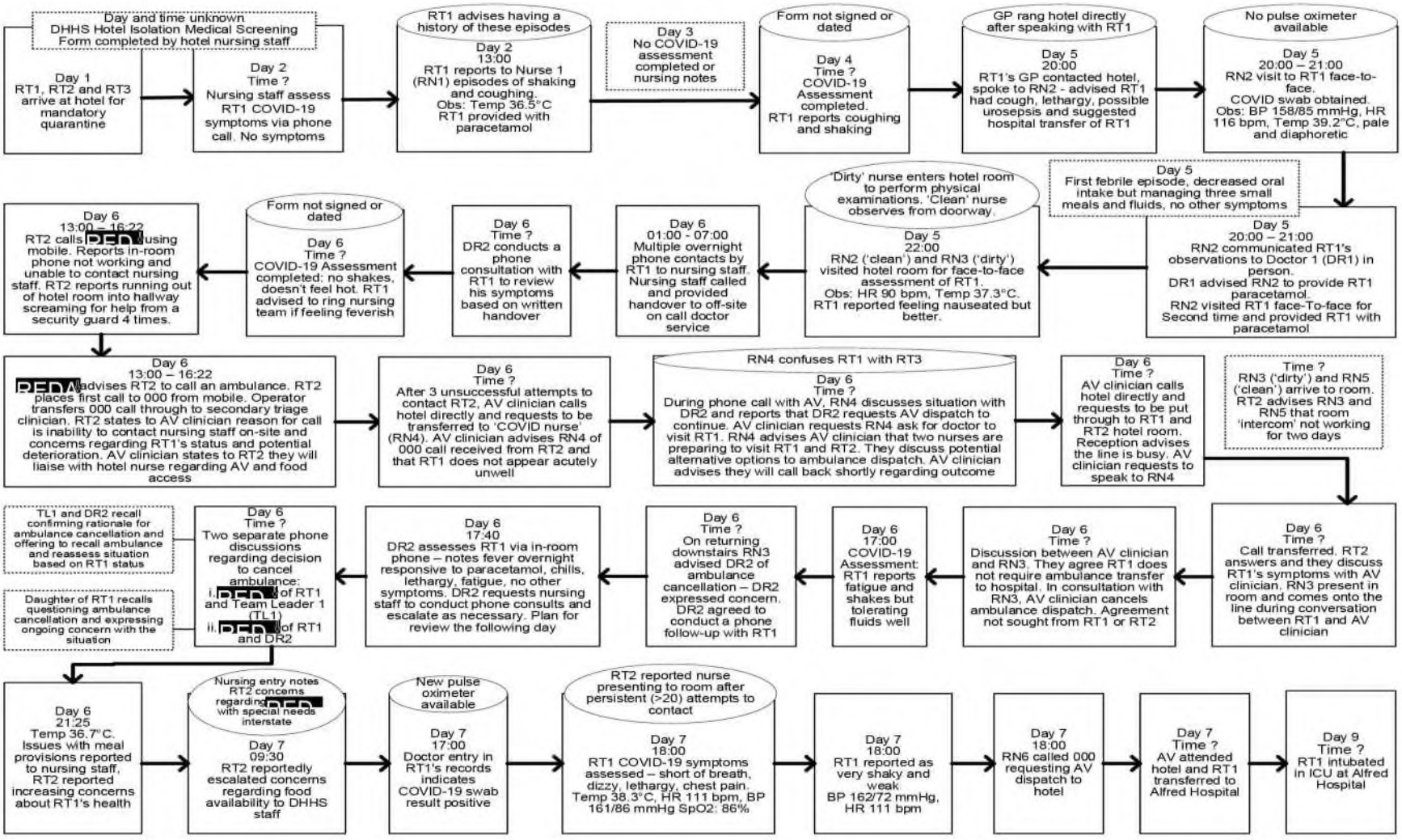
TIMELINE OF EVENTS

- On 7 April 2020 (Day 1), REDACTED (RT1), RED (RT2) and REDAC (RT3) detained at hotel after 4 weeks quarantined on a cruise ship.
- Accommodated in adjoining rooms.
- RT1: REDAC history of cardiac disease and ulcerative colitis.



Glossary of terms

DHHS	Department of Health and Human Services
AV	Ambulance Victoria
RT1	Returned traveller 1
RT2	Returned traveller 2
RT3	Returned traveller 3
DR	Doctor
RN	Nurse
TL	Team Leader
HR	Heart rate
bpm	Beats per minute
BP	Blood pressure
mmHg	Millimetres of mercury
SpO2	Oxygen saturation
Temp	Temperature

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ACTORMAP

		Parties with no direct involvement
Institutional context	Victorian Government; Department of Health and Human Services (DHHS); Department of Jobs, Precincts and Regions; Chief Health Officer (Public Health Victoria); Public Health and Wellbeing Act 2008; Australian Border Force	
Organisation and management	State Emergency Management Centre (SEMC); Ambulance Victoria (AV); External nursing agency; External medical agency; Hotel groups	
Work environment	Hotels; Hotel rooms (adjoining); Staff office (Green room); DHHS offices; Remote working; Call centres (AV)	
Team	Nursing team; Medical team; Team Leaders; DHHS hotline (Emergency Operation Centre); DHHS Logistics team	Authorised Officers
Task and technology	Clinical consultation (Telehealth); Personal Protective Equipment; In-room communication system; Documentation system; Handover within and between frontline teams; Transfer procedures (hospital); Clinical equipment and sanitisation	
Staff	Team Leader 1; Nurse 1; Nurse 2; Nurse 3; Nurse 4; Nurse 5; Nurse 6; Doctor 1; Doctor 2; Security guard; AV clinician	
Returned traveller	Returned traveller 1 (Patient); Returned traveller 2 [redacted]; Returned traveller 3 [redacted]; [redacted] of returned travellers 1 and 2; General Practitioner	

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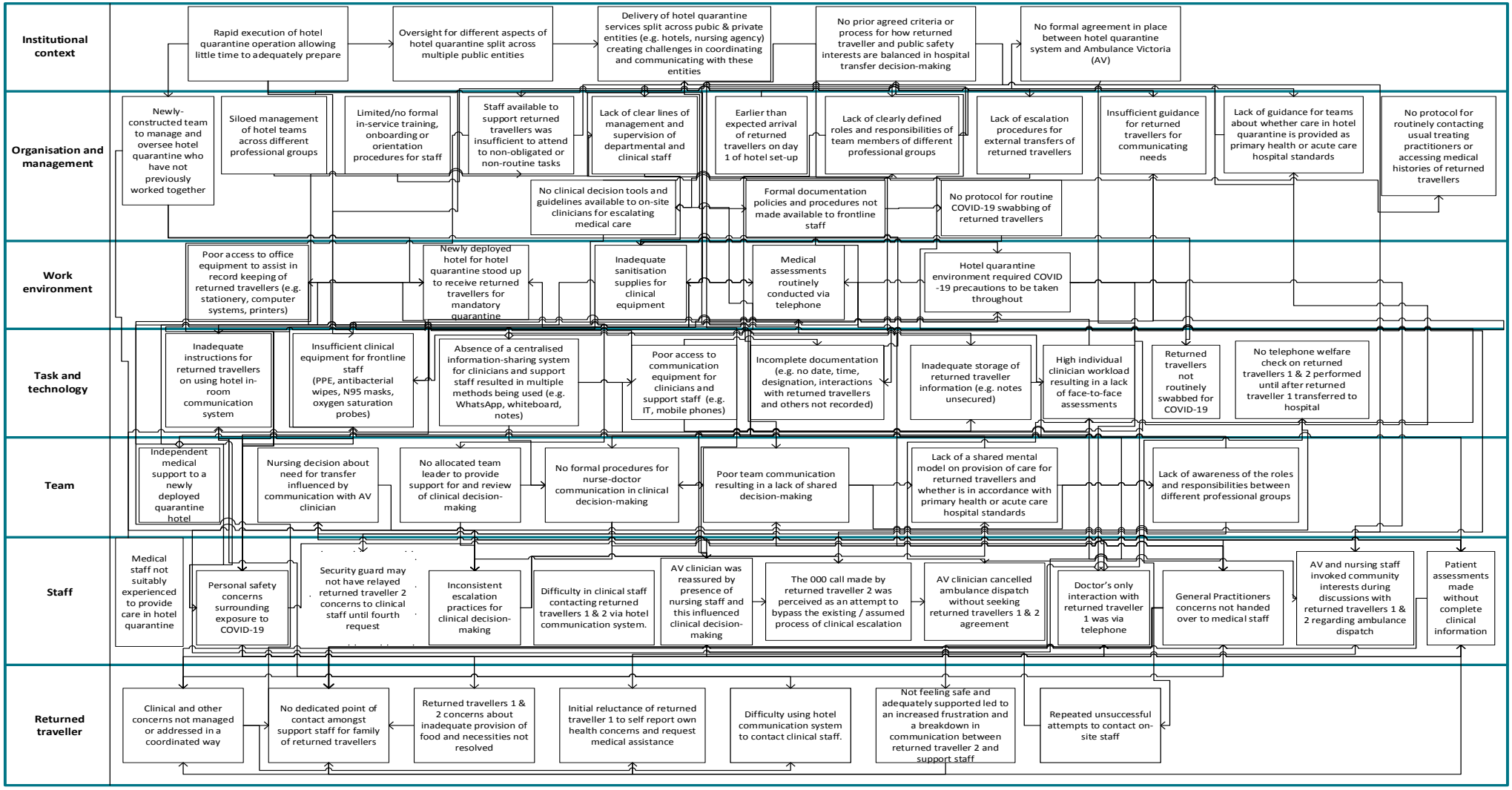
ACCIMAP

This AcciMap analysis reflects the system at the time this incident occurred. It does not consider any subsequent changes to conditions, processes or systems made after the incident.



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SYSTEMS ANALYSIS OUTCOMES

The review team has identified system and process improvement opportunities. Some are directly related to the event. These are described in 'Findings'. Others were identified in the course of reviewing the event, but the review team did not establish that they played a direct role in the events surrounding REDACTED deterioration and transfer to hospital. These are described in 'Learnings'.

FINDINGS

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

1. **On-site clinicians were constrained in their ability to conduct face-to-face clinical assessments when indicated due in part to an insufficient supply of readily accessible and reliable personal protective equipment (PPE). Medical consultation with returned travellers was routinely undertaken by telephone only, limiting the ability of medical staff to perform a complete and independent assessment.**

Reasoning

Staff took the risk of exposure to COVID-19, and transmitting it to others, very seriously. In interviews staff expressed concerns about these risks, and the resources available in the hotels to assist in mitigating them. In particular, they described a lack of sufficient, readily accessible, reliable and fit-for-purpose PPE for use while undertaking their roles. They also reported a need to prioritise and reserve use of available PPE supplies to allow certain staff groups to undertake their routine duties.

Consistent with safe work practices, staff would not enter the rooms of returned travellers for the purposes of providing clinical care without donning what they described as 'full' PPE, consisting of a gown, disposable gloves, mask and goggles. In interview, staff noted that they routinely lacked some components of full PPE, a situation which was confirmed in interviews with those in management roles. As a result, staff purposefully endeavored to provide clinical care, including clinical assessments, in a 'contactless' manner (specifically, by telephone), avoiding visiting or entering the rooms of returned travellers wherever possible.

The routine use of telephone-only consultation by both medical and nursing staff with returned travellers resulted in clinicians not being able to use visual cues or conduct a comprehensive physical examination during their clinical assessments and monitoring of returned travellers. These limitations in clinical assessment capability were compounded by a lack of clinical equipment and sanitation capacity (see Finding 2). Together, these limitations resulted in clinicians having to make clinical assessments and decisions based on incomplete clinical information.

Staff reported that on the occasions when returned travellers were physically examined, this was most often (although not always) done by nursing staff. Therefore, doctors (onsite and on-call) most often provided assessments and clinical decisions about returned travellers based on verbal information only, either from direct conversation with the returned traveller or their family member, or via information relayed by nursing staff.

These factors were observed in REDACTED case whereby staff expressed an initial (and ongoing) hesitancy to attend to RED face-to-face. In RE case, despite having experienced many days of symptoms, RE was not directly sighted or physically attended to by a doctor until day seven, when the second ambulance was called by nursing staff. Therefore, assessments about the seriousness of and

deterioration in RE condition, and related decision-making, were based on incomplete, and likely inadequate, information.

Returned traveller safety implications

The delays in and reduced intervals of face-to-face clinical assessments resulted in missed opportunities to monitor and trend clinical parameters in a timely and consistent manner. It also resulted in a missed opportunity for comprehensive physical assessment and for returned travellers to directly express any health and welfare concerns to medical staff.

2. **Unavailable or unreliable access to clinical equipment for physical examination and clinical monitoring of returned travellers, resulted in clinical decision-making being based on incomplete clinical information and assessment.**

Reasoning

Staff reported that they did not have access to the clinical equipment they required to fully examine, assess and monitor the clinical status of returned travellers. Clinical equipment not always readily available included pulse oximeters (to measure blood oxygen saturation levels) and COVID-19 swabs. They also noted that a lack of adequate sanitisation supplies and equipment (e.g. sanitising agents and wipes) limited their ability to use the items they did have (e.g. stethoscopes and blood pressure cuffs), especially as re-use for multiple returned travelers is necessary. In the absence of access to adequate clinical equipment and ability to sanitise equipment, staff were unable to perform complete clinical assessments of returned travellers. This limitation of being unable to conduct thorough clinical assessments was compounded by the practice of routinely providing care to returned travellers without physically seeing or attending to them (see Finding 1).

These factors were observed in the case of REDACTED in that several assessments of RE physical condition were conducted by telephone only, and during interviews staff suggested that inadequate pulse oximeter access may have contributed to a delay in clinical staff being aware REDACTED had low oxygen (O_2) saturation levels. An earlier awareness of this clinical sign, had low O_2 saturation been present, may have influenced the decision to cancel the ambulance called on day six.

Returned travellers safety implications

Clinical staff not having access to the equipment necessary required to perform complete assessments resulted in clinical decision making based on incomplete information, specifically in the absence of key markers of COVID- 19 prognosis and deterioration. This may have contributed to missed opportunities for clinical staff to adequately assess REDACTED

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3. **Staff involved in clinical assessments and decision-making often did not have timely, direct access to returned traveller clinical and welfare information to perform their roles effectively.**

Reasoning

In requesting information and evidence to undertake the review, the challenges experienced by staff were evident. These mainly related to difficulty readily locating and accessing information from records about specific returned travellers. This was partially due to the fragmented nature of how this information was collected, stored and accessed. There was also a need to navigate the multiple entities, sources and necessary permissions associated with accessing the information.

Similarly, staff reported being unable to readily access required health and welfare information about returned travellers due to the absence of an accessible, comprehensive, central repository for this information. Staff reported that this made it difficult to identify returned travellers with high and/or escalating health and welfare risks, especially monitoring this across different shifts, over time, and between different teams (e.g. nursing and medical staff). This impaired their ability to have good visibility of the full clinical picture of unwell returned travelers in a timely manner. It also affected attempts by staff to provide a holistic and coordinated response to distress or frustration among returned travellers who felt that their support needs were not being met. These limitations in accessing information meant that staff did not have the complete information required to make fully informed clinical and non-clinical decisions about the care and support of returned travellers.

In REDACTED case, these limitations meant that staff did not have ready access to all available information regarding RE medical history; risk factors for COVID-19 complications; the length and deteriorating nature of RE condition; and the context, events and issues that contributed to REDAC REDACTED concerns about accessing help when needed.

Returned travellers safety implications

The absence of a coordinated and consistent system for the management of returned traveller health and welfare information, including its collection, recording and sharing, compromised the ability of staff members to adequately identify and manage health and welfare risks for individuals. It also reduced returned travellers' ability to direct their health and welfare questions, support needs and concerns to those best placed to efficiently and effectively address them.

4. **The number and skill set of staff rostered on shifts in the hotel quarantine system did not always match workload demands and the health care needs of returned travellers. This resulted in delays or tasks not being completed when needed to address returned traveller health and welfare.**

Reasoning

Staff reported consistently having high workloads and managing multiple competing demands – to the extent that they were often unable to attend adequately to the needs of returned travellers, or systematically address concerns raised by returned travellers in a timely manner. Routine tasks that nursing staff were required to undertake included completing initial medical screening forms; conducting COVID-19 assessment symptom checks; obtaining medication lists from returned travellers to arrange prescription and dispensing of necessary medications; and undertaking COVID-19 testing (swabs) in symptomatic returned travellers. In addition to these tasks, nursing staff were responsible for assessing returned travellers in their rooms, if deemed necessary and the needs of returned travellers could not be adequately addressed over the telephone. This required one nurse to

stay outside (referred to as the 'clean' nurse), while the other nurse would don PPE and enter the room (referred to as the 'dirty' nurse). In the context of many other competing tasks, this meant that direct nursing assessment of returned travellers was time and resource intensive.

Staff reported problems with both baseline levels of staffing, as well as the adequacy of staffing in response to surges in workload demand. At any given time, there were generally three nurses rostered onto a shift, attending to the health needs of all the returned travellers, (approximately 200 to 350). On the day REDACTED arrived at the hotel, there were only three nurses on-site to receive the new cohort of approximately 200 returned travellers, who had arrived earlier than had been expected (see Finding 10). Staff described the experience as 'chaotic' and highlighted the challenges of attending to a cohort of mostly older returned travellers with multiple health needs.

On day six of REDACTED stay, medical staffing was provided by one on-site doctor during the day, and an on-call doctor overnight (who was responsible for the provision of services to several hotel quarantine sites concurrently). In addition to addressing the routine and ad hoc health needs of returned travellers, nursing and medical staff were also involved in sourcing the equipment they needed to perform their duties (e.g. pulse oximeters, blood pressure cuffs, cleaning equipment, stationery). They were also called upon by returned travellers to assist in procuring items such as books, toys, and games. The diverse nature of the tasks that frontline staff were required to address added to the cognitive and physical demands of their work.

The skillset and level of experience of the nursing staff was variable and included those with backgrounds in general medical, oncology, surgical and emergency nursing. The pool of medical staff working in the hotel quarantine system was equally variable and included hospital medical officers with less than two years of experience, working as independent medical practitioners. Most of the frontline staff had not previously worked in a similar detention setting and had not been provided with any formal guidance on the tasks they were undertaking (see Findings 8 & 9).

The high workload and limited number of staff generated a backlog of work that resulted in routine tasks not always being completed. This was reflected in documentation relating to REDACTED case. RE daily COVID-19 symptom screening checks were not always recorded as having been conducted, and RE did not receive a welfare check telephone call for the entire duration of RE time in hotel quarantine. REDACTED received RE initial welfare check call on day nine.

Returned travellers safety implications

Staff facing high workloads and multiple competing demands led to routine tasks including health and welfare checks not being completed in a timely manner. This limited the ability for staff to identify and promptly act on returned traveller needs and concerns.

5. Outside of routine targeted COVID-19 symptom screening checks, some returned travellers did not receive timely welfare screening checks, which reduced the opportunity to identify and address their needs and concerns in a suitable and systematic way.

Reasoning

Clinical staff were required to conduct daily COVID-19 symptom screening using the 'COVID-19 Assessment' form. The purpose of the form was to identify if the returned traveller was potentially symptomatic with COVID-19. Returned travelers were asked if they had any of five symptoms of COVID-19, (fever, cough, shortness of breath, sore throat and/or fatigue) each day via telephone. The form did not specifically prompt staff to inquire about any broader health and welfare issues.

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Screening for such broader health and welfare matters was the responsibility of the DHHS welfare team, who were remotely located and were tasked with conducting welfare checks with returned travellers by telephone.

During interviews, staff reported that the welfare team experienced a significant backlog in overdue calls to be made. This meant some returned travellers did not receive their first welfare check call (to complete the 'Welfare check – initial long form survey') in a timely manner. This resulted in missed opportunities to identify and address returned travellers' concerns early, establish rapport and clear channels of communication, and provide returned travellers with information about how to access support, if needed.

Neither REDACTED received a welfare telephone call to complete the 'Welfare check – initial long form survey' before REDACTED transfer to hospital on day seven. A copy of RE REDACTE form (completed on day nine, after REDACTED hospital transfer) was sighted by the review team. This form included responses to questions which, had they been flagged and appropriately referred earlier, may have assisted staff to appropriately identify and act upon RED REDACTE escalating concerns. Responses indicated REDACTED expressing RE was very unhappy with the responsiveness of nursing and medical staff in the hotel. Having an awareness of this may have allowed staff to ameliorate REDACTED frustration that RE needs were not being adequately met. In turn, this may have assisted the returned travellers to feel safer and more supported. It may have improved the relationship and collaboration between the returned travellers and staff. A welfare check may have provided an opportunity to provide REDACTED with information about how to successfully contact staff to ask for help, and how to escalate any additional unaddressed concerns.

Returned travellers safety implications

The delay in conducting initial welfare check calls resulted in missed opportunities to monitor returned traveller welfare in a timely and consistent manner. It also resulted in significant health and welfare concerns not being disclosed, identified and missed opportunities to attempt to resolve these by direct escalation to the most appropriate person/agency.

6. Frontline staff working in the hotel quarantine system did not have access to adequate resources, training support and polices relating to documentation and record keeping of health and welfare information for returned travellers. This resulted in the information often being incomplete, inconsistently recorded, not fit-for-purpose, and not readily accessible by relevant staff.

Reasoning

Staff reported an overall lack of resources for record-keeping, such as stationery, forms/templates, access to printers, (including permission to use printers being granted at the discretion of individual members of hotel management), IT equipment and systems. Staff reported that they had to develop ad hoc workarounds, including sourcing their own supplies of stationery from office supply retailers, and using personal notebooks to keep clinical records, which did not always remain onsite or securely stored. They also reported that there was a lack of formal policies, systems and training to guide them in documenting returned traveller information and events that occurred during each shift.

This was reflected in the clinical notes and records sighted by the review team. Records were often created in ad hoc formats, using resources that were not specifically fit-for-purpose (e.g. handwritten records in notebooks, on loose and nondescript pieces of paper). In addition, information about returned travellers (including their health and welfare), was often not systematically filed or was inter-

dispersed with information about other returned travellers. Documentation was frequently missing key information such as dates, times and staff identifiers (names, signatures and designations).

Limitations in the quality of record-keeping impaired staff members' ability to proactively identify returned travellers with high and/or escalating health and welfare risks, especially across different shifts, over time, and between different teams (e.g. nursing and medical). It also impaired their ability to see the full clinical picture, and better understand the reasons for returned travellers' reactions and behaviour.

The lack of a centralised, coordinated system for logging and monitoring issues raised by returned travellers resulted in concerns and needs raised by REDACTED either being incompletely addressed, addressed after considerable delay, or not addressed at all. These returned travellers had a range of health and welfare needs that, during interview, were described by staff as unanticipated. As also described in Finding 10, the limited set-up time, and staff onboarding and training meant that the manner in which health and welfare concerns were identified and addressed was often inadequate and inconsistent.

The experience of not having RE concerns appropriately tracked and actioned meant that RED REDACTE sought support through alternative means, namely by seeking help from a security guard in the hotel, REDACTED usual GP and ultimately 000 to request an ambulance.

Unavailable, incomplete and conflicting records contributed to staff members making clinical decisions with incomplete and/or inconsistent information. Some staff may not have been sufficiently aware of events and issues that contributed to REDACTED feeling unsafe and unsupported.

Returned travellers safety implications

Unavailable or inconsistently documented records relating to returned travellers resulted in increased frustration experienced and/or expressed by some, who often needed to raise their concerns repeatedly with multiple staff members for appropriate action to be initiated. Staff receiving this information, either through routine or ad hoc contact with returned travellers, may not have been privy to earlier concerns raised and may have borne the brunt of cumulative frustrations they expressed.

7. Many clinical staff were unclear on the processes for escalating health concerns raised by returned travellers, which resulted in independent ad hoc decision-making by staff.

Reasoning

Staff reported not being suitably aware or understanding policies and processes about escalating concerns, including about returned traveller health and welfare issues. This included who to escalate to, how to escalate, and circumstances that necessitate escalation. Clinical staff reported feeling unsure, and lacking formal guidance, about who had authority to make certain decisions (e.g. ambulance cancellation), and who was 'ultimately responsible' for making final decisions in certain clinical situations.

Staff reported that, on some occasions, certain issues could only be escalated through indirect channels. These channels included generic email addresses that were overwhelmed with incoming emails or general 'hotline' phone numbers, where call-takers were unable to offer definitive assistance. Staff reported that these indirect methods often resulted in slowed or no responses to their questions or concerns. In such instances, staff reported that they sometimes took steps to seek advice from others (e.g. by telephoning or emailing their counterparts at other hotels or identifying

contact details for relevant individuals). At times, this resulted in inconsistent advice that led to more confusion.

Staff noted that there was no clear, designated clinical care lead on-site, each shift (i.e. a line manager for the clinicians). This meant that it was unclear to whom they should escalate clinical concerns or complex cases requiring leadership input or guidance on how to proceed. Some staff reported developing informal workarounds for this issue, such as appointing a 'head' nurse for the shift through consensus agreement, based on who had worked at the specific hotel for more than one shift only. However, these workarounds remained informal and person dependent.

Returned travellers safety implications

Limited understanding of the processes to escalate clinical concerns were evident, e.g. the challenges in resolving different views among doctors and nurses regarding ambulance dispatch/cancellation and the best course of clinical care.

8. Team-based care and care continuity for returned travellers was compromised by inadequate handover, issues tracking and communication processes within and between teams, and with external health practitioners.

Reasoning

As described in Findings 3 ,6 and 8, information and communication systems and processes in the hotel quarantine system were fragmented and ad hoc. Staff noted a lack of formal handover policies and processes between shifts, as well as for inter-team communication during shifts. Some described developing ad hoc workarounds to address these limitations, but these efforts were individually driven, and thus not always consistently applied.

No central repository for returned traveller health and welfare information combined with ad hoc record-keeping, meant that returned traveller concerns, health needs and welfare issues were not well tracked. This included a lack of formal systems for collecting and acting upon concerns raised by returned travellers' usual treating clinicians in the community. Therefore, there was no systematic way to track that issues were acknowledged, responded to, actioned, and then finalised, and to assign accountability for these steps. Staff noted that responses to these issues or concerns were often delayed, incomplete or unaddressed.

These limitations in communication, issues-tracking and handover contributed to staff needing to make both clinical and non-clinical decisions without a proper overview of all the relevant information. It also contributed to inconsistent advice and information being provided to returned travellers.

Returned travellers safety implications

The information and concerns raised by REDACTED usual general practitioner (in the community) were not adequately conveyed or available to those making clinical decisions at that point in time or later. Similarly, there were minimal records kept of the multiple contacts between REDACTED and staff; of REDACTED difficulties with making contacting with staff by telephone and of the lack of a welfare check call, as well as of the concerns RE had raised. This resulted in staff having an incomplete view of RE experiences. This may have contributed to staff not appreciating the extent to which REDACTED felt unsafe and unsupported whilst in quarantine.

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9. Some staff were unclear on the scope of their role, as well as the delineation of roles and responsibilities within and between teams, which affected team care delivery and completion of tasks to address returned traveller health and welfare needs.

Reasoning

During interviews, staff reported that they had not felt suitably briefed on the purpose and scope of their role, and the broader context in which they were operating within the hotel quarantine system. This included being uncertain about the boundaries and delineations between different teams within the hotel quarantine system, including in supporting the health and welfare of returned travellers. They described not receiving job descriptions or job cards pertaining to their roles, and limited or no formal training, orientation or supervision. Some reported that the extent of their 'onboarding' was an informal and brief 'handover' on their first day, from the person who worked their role in the previous shift, who was themselves often new.

The lack of a formally designated clinical lead role on-site (see Finding 7) contributed to uncertainty about lines of escalation and hierarchies of responsibility. In addition, some medical staff were in roles that exceeded the level of independent decision-making responsibility and accountability, and involved lower levels of supervision, than they had in their usual substantive roles, (this relates to both clinical and non-clinical roles).

Together, the lack of clarity about roles and responsibilities led to some tasks not being completed, and others being completed inconsistently, or in a delayed manner. It also put clinicians in situations where they had to make clinical decisions without being certain about their authority to do so, or the correct escalation processes to follow.

Returned travellers safety implications

In REDACTED case, interviews and recordings relating to interactions between staff working in the hotel and Ambulance Victoria show that there was mutual uncertainty about processes around ambulance dispatch or cancellation, and who should perform what role in decision-making regarding this. During interviews, staff also described a lack of agreement between nursing staff and medical staff about who (if anybody) had the authority to agree to the cancellation of an ambulance called by returned travellers.

10. The earlier than expected arrival of returned travellers during the hotel's designated set-up period for mandatory quarantine use, limited the ability of frontline staff to orient returned travellers and effectively implement processes to address their health and welfare needs.

Reasoning

Staff reported that the first cohort of travellers (which included REDACTED arrived unexpectedly during the period designated to set the hotel up as a mandatory quarantine site. They described how this led to a disrupted and truncated time to set up the hotel, become familiar with and implement systems, policies and procedures, before receiving returned travellers. This affected the 'onboarding' of staff and may have contributed to staff not being fully aware of policies and procedures that existed at the time. The earlier than expected arrival therefore affected the 'onboarding' of staff (see Finding 6) as well as the orientation of returned travellers to their quarantine environment. A potential repercussion of this may have been that inexperienced staff onboarded subsequent staff. Staff mentioned that the earlier than expected arrival of the returned travellers may also have contributed to lack of access to adequate resources of various types (e.g. stationery, IT resources, record-keeping resources, clinical equipment, sanitisation supplies and PPE). These

played a role in the clinical care provided to REDACTED (see Findings 1 and 2). In turn, this reduced staff capacity to identify returned travellers who had health, welfare and/ or other concerns and required extra support. This was evident in REDACTED not receiving a welfare check call prior to RE transfer to hospital.

The quality of orientation of returned travellers to their new environment was also negatively impacted. For example, returned travellers received little or no instructions on how to access help and support. This meant that REDACTED was not adequately supported in learning how to use the hotel's in-room communication system and was not provided with alternative options for seeking help.

Returned travellers safety implications

Insufficient staff preparation time has immediate and latent negative effects on the systems and processes needed to address the health and welfare needs of returned travellers.

11. There was no clear agreement between the hotel quarantine system and Ambulance Victoria (AV) about managing the hospital transfer needs of returned travellers. This contributed to improvised clinical decision-making by frontline staff.

Reasoning

If a returned traveller became unwell and required transfer to hospital under quarantine conditions, there was no evidence of any formal policies or guidelines to support clinical staff in their decision-making. The review team confirmed that there was no formal agreement between the hotel quarantine system and Ambulance Victoria to address the hospital transfer needs of returned travellers.

After the initial 000 call was placed by REDACTED requesting an ambulance, there were several calls between AV and the hotel to identify the appropriate people to communicate with and determine the best course of action. There was discussion regarding whether to contact the returned travellers directly, or whether hotel staff or nurses should act as conduits. The ambulance requested by RED REDACTE was not dispatched, instead the AV clinician sought further information from others at the hotel.

The decision to not dispatch an ambulance was reached during a conversation between the AV clinician and a nurse attending to REDACTED in RE room. REDACTED was considered at high risk of being COVID-19 positive. Considering RE age and comorbidities, the shared decision not to dispatch an ambulance appeared to be based in part on the nurse's observations that RE was 'standing', 'not dehydrated' and on incomplete clinical assessment outlined in Findings 1 and 2. It was also influenced by consideration of the risk of community and occupational risk of COVID-19 transmission. The AV clinician and nurse purported the importance of 'community interests' as a factor in deciding whether to dispatch an ambulance – a formal agreement would perhaps have provided guidance on whether factors outside of clinical need should be considered in making dispatch decisions.

The initial conversation between the AV clinician and REDACTED was interrupted by the nurse who had entered their room which meant their concerns may not have been fully heard, they disagreed with cancelling the ambulance and protested the decision.

Returned travellers safety implications

In the absence of a formal agreement, balancing the acute health needs of deteriorating returned travellers with broader community safety risks relies solely upon the individuals working at the time to determine the most appropriate response. The concerns of returned travellers, which reflects their understanding of their own health, is an important consideration in any hospital transfer decision.

LEARNINGS

Learnings describe system issues for which there was insufficient evidence that they contributed to the incident, but nonetheless provide important opportunities to improve.

	Learnings
1	There was limited to no standard process for routine early screening for COVID-19 of returned travellers in hotel quarantine. For returned travellers both with and without demonstrated or reported COVID-19 symptoms, testing was performed on an ad hoc basis, at the discretion of clinical staff. As a result, it was common for asymptomatic returned travellers to not undergo testing for the duration of their hotel quarantine period.
2	Staff working in the hotel quarantine setting were not aware of the process for managing instances in which a COVID-19 positive result was obtained for a traveller accommodated in the same hotel room as another returned traveller(s). Staff were unclear on the process of separating returned travellers in these instances, and relocation to a different room for the remainder of their quarantine period was at the discretion of the returned travellers involved.
3	The in-room communication system (i.e. hotel room telephone) was not able to be used by some returned travellers in order to make calls external to the hotel. As a result, it was necessary for some returned travellers to use their own personal mobile telephones to communicate. However, some returned travellers did not have suitable access to a functioning mobile telephone (e.g. if they had been overseas for an extended period or did not have adequate reception or access to suitable telephone charger or credit to make calls).
4	There was inconsistent language used to describe returned travellers in hotel quarantine (e.g. passengers, guests, detainees). Some of the terms have connotations that could bring unconscious bias to the way they are cared for by the staff working in the hotel quarantine environment.
5	Inconsistent rostering practices exacerbated the perception by staff working in the hotel quarantine environment that their work was temporary in nature. Some staff were rostered to work a single shift across different hotels, which prevented them from gaining familiarity with the operations of the specific hotel, the other staff members, or the returned travellers in their care, and may have contributed to a lack of shared understanding, team development and accountability.
6	A lack of systems and capacity existed in the hotel quarantine system to ensure concerns and needs raised by returned travellers were managed and resolved in a timely, systematic, responsive and reliable manner. This led to returned travellers expressing their frustration with various aspects of their hotel detention. In some instances, deteriorating health concerns expressed by returned travellers may have been misinterpreted as expressions of frustration with the lack of systems and resources to resolve a broad range of hotel detention issues in a timely way.

RECOMMENDATIONS

Recommendations describe actions that should be taken to address the findings and/or learnings identified in the review and achieve system improvement.

The strength of recommendations (weak, moderate or strong) describes the overall likelihood that their implementation is likely to succeed in establishing sustained system changes to achieve the desired risk mitigation and safety outcomes. This likelihood is determined based on general evidence about human factors, systems improvement and change management.

	Recommendation	Associated findings / learnings	Strength
A	As a matter of priority, implement measures to ensure an adequate and reliable on-site supply of Personal Protective Equipment (PPE) that is readily accessible to all staff working in the hotel quarantine system.	Finding 1	Strong
B	Develop and implement robust, fit-for-purpose, readily accessible policies and procedures relating to the appropriate use of PPE for staff working in hotel quarantine.	Finding 1	Weak
C	Develop and implement processes to enable clinical staff working in the hotel quarantine system to conduct visual telehealth (i.e. video calls) consultations for returned travellers who are willing and able to use these methods, particularly those identified as higher risk. This would enhance initial 'contactless' clinical assessments for returned travellers. These processes should be co-designed. The visual telehealth platform should be capable of including external family members, community caregivers in telehealth consultations, at the discretion of the returned traveller, particularly in circumstances requiring a case management approach. The visual telehealth platform should also enable participation of language interpreters, consider the specific needs of returned travellers with visual or hearing impairment and other physical and/or mental disabilities, as needed.	Finding 1 Learning 2	Strong
D	As a matter of priority and in consultation with clinical leads, implement measures to ensure an adequate and readily accessible on-site clinical equipment and the resources required to effectively sanitise this equipment. This would ensure timely assessment, monitoring and first line treatment of returned travellers.	Findings 1 & 2 Learning 1	Strong
E	Develop and implement a policy with clear guidance and specific criteria for when medical staff are required to assess returned travellers via visual telehealth or face-to-face whilst in mandatory hotel quarantine.	Findings 3 & 7 Learning 1	Weak
F	Implement an off-the-shelf, fit-for-purpose (or easily customised), single, centralised and real-time information sharing and tracking system containing all individual returned traveller information (including their health and welfare), accessible by all staff with a role in providing services, care, support and oversight for returned travellers. This should include functionality to provide 'alerts' to identify to staff working on each shift, returned travellers with significant health and/or welfare risks requiring monitoring or follow-up.	Finding 3 Learning 2	Strong
G	Undertake ongoing needs analyses to strategically match the number and designation of staff rostered on shifts to ensure there are adequate staff available to be able to provide a rapid response surge capacity to meet the dynamic needs of specific cohorts of returned travellers. This should include a mechanism by which if necessary additional resources can be mobilised to respond to evolving situations.	Findings 4 & 5 Learnings 1 & 5	Moderate
H	Expand the daily COVID-19 assessment symptom screening calls to include other basic health and welfare questions to screen for unmet support needs or issues. For returned travellers with medium to high risk health conditions, this presents an opportunity to discuss their specific issues. Ensure adequate, dedicated and appropriately qualified staff are available to conduct these calls daily for the duration of returned travellers' period of mandatory quarantine.	Findings 5 Learnings 2 & 6	Moderate
I	Implement formal, standardised processes for the recording and tracking of issues raised by returned travellers with hotel quarantine staff (via all means – including screening calls). This should include assignment of these issues for follow up, tracking progress to completion, and alerting relevant staff when issues have not	Findings 5 Learnings 2 & 6	Weak

	Recommendation	Associated findings / learnings	Strength
	been actioned and closed.		
J	Co-design with frontline staff and implement the use of specific fit-for-purpose materials, methods and systems suitable for recording returned traveller health and welfare information in a consistent, comprehensive and systematic way. This includes record keeping templates and information systems. Ensure the availability of resources so these systems are readily accessible to all relevant staff, and feedback mechanisms ensure continuous evaluation and improvement relating to the suitability of related current policies and processes.	Finding 6 Learnings 5 & 6	Weak
K	Develop and implement formal policies and procedures for recording information provided by external health providers about returned travellers in quarantine, and ensure that relevant information be reviewed, actioned as needed and evaluated by an appropriate clinician on-site.	Findings 3, 6 & 8 Learning 6	Weak
L	Implement formal processes for conducting handover and communication within and between teams working in the hotels in the quarantine system.	Finding 8 Learning 4	Weak
M	Co-develop with staff detailed descriptions for all roles in the hotel quarantine system, and a visual and simple written guide to how these roles work together. Provide this to all existing and future staff and include this information in staff orientation and in-service training.	Findings 6, 8 & 9 Learning 5 & 6	Weak
N	Based on experience to date and staff input, revise methods for determining the staffing level and mix needed around the time of large returned traveller influxes and implement revised models of staffing and rostering based on these. Ensure readily available increased staffing capacity for surges in workload associated with arriving cohorts of returned travellers.	Findings 4 Learning 4, 5 & 6	Moderate
O	Co-develop agreed formal processes with relevant entities (e.g. Australian Border Force, the Department of Foreign Affairs and Trade) to improve the accuracy, detail and optimise timeliness of information received about incoming returned traveller cohorts to facilitate planning and preparedness.	Findings 3, 8, 10 Learning 4 & 6	Weak
P	Co-develop and implement a formal agreement between all relevant parties in the hotel quarantine system and Ambulance Victoria regarding the ambulance service requirements of returned travellers. This agreement must provide specific guidance to support decision-making by frontline staff; reflect the rights and role of consumers (returned travellers or their significant others) in participating in these decisions; and provide clear guidance on ambulance dispatch and cancellation.	Findings 7 &11 Learning 1	Weak
Q	On arrival, all returned travellers and their external family members should be routinely provided with clear information about how to escalate unaddressed or inadequately addressed concerns. This information should be easily accessible for those from culturally and linguistically diverse backgrounds, the elderly, the visually impaired, and be suitable for varying levels of health literacy.	Findings 10 Learnings 2, 3, 4 & 6	Weak
R	On arrival, all returned travellers should have suitable access to a functioning mobile telephone for the duration of their mandatory detention, (e.g. telephone handsets, chargers, Australian SIM cards and access to credit and top-up methods to be able to make calls).	Learnings 3 & 6	Moderate

APPENDIX 1: RECOMMENDATION ACTION PLAN TEMPLATE

Please outline the plan for how recommendations will be enacted.

If a recommendation has been wholly enacted when the report is received, indicate 'wholly' in column two of Table 1. Write N/A in subsequent columns of Table 1. Then complete Table 2 for that recommendation.

If a recommendation has been partly enacted when the report is received, indicate 'partly' in column two of Table 1. Complete the remaining columns in Table 1 for aspects of the recommendation that have not yet been enacted. Then provide details in Table 2 for aspects of the recommendation that have been enacted.

If no part of a recommendation has yet been enacted when the report is received, indicate 'no' in column two of Table 1. Complete the remaining columns in Table 1. Do not use Table 2 for that recommendation.

Table 1.

Recommendation	Already enacted (Write: 'wholly', 'partly' or 'no')	Actions still required to enact recommendation	Outcome measure(s)	Executive position sponsor
A				
B				
C				
D				
E				
F				
G				
H				
I				
J				
K				

RECOMMENDATIONS ALREADY IMPLEMENTED

If any recommendations have been wholly or partly implemented when the report is received, use Table 2 to provide details of what has been done, how implementation has been monitored (e.g. monitoring on-the-ground uptake and impacts – intended and unintended), and outcomes (using appropriate outcome measures).

Table 2.

Recommendation	Actions already completed	Monitoring undertaken

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APPENDIX 2: KEY THEMES FROM HOTEL QUARANTINE INCIDENTS 1 AND 2

Operation Soteria Hotel Quarantine – Common themes arising from two incident reviews as of 15 May 2020.

Below is a summary of key quality and safety issues, and associated contributing factors, identified by Safer Care Victoria during their review of two separate incidents involving returned travellers in hotel quarantine in Victoria.

Based on evidence and information available to Safer Care Victoria at the time of writing, these issues were evident at the time of the two incidents (3 to 13 April 2020). It is noted that certain information sought by the team was unable to be provided or obtained during the data collection period. In addition, some individuals invited for interview in relation to these incidents declined to be interviewed during the data collection period.

Due to the ongoing detention of returned travellers in hotel quarantine as a result of the COVID-19 pandemic, a rapid review method was employed. This review approach has some limitations regarding data collection and scope. These limitations were considered against the need for a rapid review process to inform system improvement in real time. With that approach and goal in mind, the review teams share a summary of issues identified below.

Issue	Comments
Selection of staff	Victorian public sector staff putting themselves forward to take up temporary new roles in the hotel quarantine system did not have an adequate opportunity to pre-emptively nominate the types of roles for which they would or would not be suitable. In selecting and assigning staff to new roles, there were limited checks regarding their relevant skills, experience, education or professional background, in order to assess their suitability for particular roles. As a result of the above (and possibly other situational factors arising from the state of emergency declared in Victoria) some staff were assigned to roles for which they did not have the appropriate knowledge base, skill set or relevant experience.
Onboarding and training of staff	For many of the new roles created for the hotel quarantine system, there was a lack of clear and detailed job descriptions and/or job cards available to staff when they commenced in their roles. This resulted in a lack of clarity about individual roles and responsibilities. There was limited to no formal and standardised training, orientation or opportunities for mentoring available to staff commencing new roles within the hotel quarantine system. Some individuals reported taking the initiative to develop and provide training for their teams. However, these efforts were individually driven by frontline staff and were therefore not consistently adopted across the system. On the day of their first shift in their new role, some staff did not experience adequate handover from their counterpart who had worked the previous shift.
Continuity of staffing	Continuity of staff rostered at hotel locations was limited. This resulted in staff reporting challenges relating to their roles. These included issues relating to hotel familiarity, teamwork, clarity regarding roles and responsibilities, and continuity of support provided to returned travellers. Some staff reported requesting to be rostered at the same location and/or team. However these efforts were individually-driven by frontline staff, and therefore were not consistently adopted across the system.
Collection, storage and access to personal information about returned travellers	There were reports of inadequate and inconsistent systems and resources (paper or electronic) available for the recording information about returned travellers. As a result, such information (e.g. health and welfare notes, returned traveller requests and concerns) was commonly recorded in ad hoc ways (e.g. staff member's personal note books, post-it notes, whiteboards etc). During a returned traveller's period of detention, they were required to complete (either on paper or via phone) a variety of forms, questionnaires and assessments. These were administered by multiple entities and teams (i.e. nursing staff, welfare check team, hotel staff and the Department of Jobs, Precincts and Regions).

Issue	Comments
	The information gathered through the multitude of channels was not centrally coordinated and stored, and thus was not available to all staff who required it. As a result, staff often did not have the information needed to perform their roles optimally and provide adequate support and care to returned travellers. For example, welfare check callers did not have access to nursing notes or the hotel questionnaire when making calls to returned travellers.
Policies and procedures	Several policies and procedures considered necessary to ensure safe operation of the hotel quarantine system were reported to be either under development or not readily accessible by frontline staff at the time these incidents occurred. For example, policies regarding appropriate use of personal protective equipment, escalation of concerns about returned travellers not answering calls, how to conduct handovers, record-keeping and issues tracking, or managing ambulance attendance. Some policies or procedures reflected plans and intentions that were not operationalised or achieved in practice (e.g. differences between planned frequency of welfare checks and actual frequency of these).
Escalation and leadership responsibilities	There was a reported lack of clarity among frontline staff about escalation processes and pathways, and the circumstances under which they should be utilised. Where formal policies or processes had been formulated, frontline staff reported being either unaware of these, or these were not operationalised fully. There was a reported lack of understanding amongst frontline staff in relation to decision-making hierachies in complex and unprecedented situations. For example, deciding on the appropriate level of clinical care, or when to escalate concerns about a returned traveller not responding to phone calls and door knocks. There was no dedicated role on-site with specific responsibility for decision-making regarding returned traveller health and wellbeing. This role was often either shared between nurses, or an informal 'lead' nurse was appointed for the shift by the nursing team, with access to consultation with a doctor (most often off-site) if required. Some team leaders, authorised officers and nurses reported not receiving adequate information about to whom they should escalate concerns (e.g. specific names, roles and direct phone numbers). Staff sometimes had to use indirect means to request escalation and assistance about issues and concerns (such as use of general email or 'helpline' phone numbers), leading to reported delayed or no response or definitive action.

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APPENDIX 3: REPORT VERSION TRACKING

Date	Action
2 June 2020	Draft report (V1.5) approved by Euan Wallace, CEO, Safer Care Victoria. Sent to REDACTED Director, Centre of Patient Safety and Experience.
2 June 2020	Draft report shared with Merrin Bamert, Commander, Operation Soteria, requesting fact checking.
7 June 2020	Feedback on draft report received from Merrin Bamert.
12 June 2020	Fact checking completed and report finalised (V2)