BOARD OF INQUIRY INTO THE COVID-19 HOTEL QUARANTINE PROGRAM

WITNESS STATEMENT OF MELISSA SKILBECK

1. I make this statement in response to a Notice to Produce issued by the Board of Inquiry into the COVID-19 Hotel Quarantine Program, dated 26 August 2020.

2. I am the Deputy Secretary, Regulation, Health Protection and Emergency Management of the Department of Health and Human Services (**the Department**). I have held this position since June 2016.

3. This statement is true and correct to the best of my knowledge and belief. I make this statement based on my own knowledge and experience and documents and records of the Department. I have also relied on data and information produced or provided to me by officers within the Department.

ROLES AND RESPONSIBILITIES

1. Please describe your relevant professional experience and qualifications.

4. I was appointed Deputy Secretary, Regulation, Health Protection and Emergency Management in June 2016. Prior to this role I held a number of public service roles including:

   (a) Deputy Secretary, Budget and Finance, Department of Treasury and Finance (September 2012 – June 2016)

   (b) Deputy Secretary, Resource Management Reform, (February 2012 – August 2012);

   (c) Deputy Secretary, Independent Review of State Finances, Victorian Government, (February 2011 – February 2012);

5. I previously held a number of positions in both the public sector and private sector including in management consulting as a Partner at Deloitte (Economics and Strategic Advisory), Director at Allen Consulting Group as well as roles in the Department of Treasury and Finance, Department of Premier and Cabinet and at the Productivity Commission.

6. I also hold the following advisory board positions:

   (a) Member, Centre for Health Economics Advisory Board, Monash University (2018 to current); and

   (b) Member, Advisory Board of the Melbourne Institute of Applied Economic and Social Research (2018 to current).

7. I have a Bachelor of Commerce with Honours in Economics from the University of Melbourne and I am a fellow of the Institute of Public Administration and a member of the Australian Institute of Company Directors.

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

8. I am currently the Deputy Secretary, Regulation, Health Protection and Emergency Management (**RHPEM**) at the Department. I have been in this role since June 2016.

9. The RHPEM Division brings together both health and human services regulation. It is responsible for the public health functions of health protection and population health, and emergency management. The Division advances public health through the identification of risks by a variety of ways including through notification systems and the use of regulation to influence behaviours. It regulates services that range from radiation safety, drinking water safety and cooling towers to supported residential services and the carers' register. The Division also administers the medicinal cannabis compassionate access scheme and has developed the now-national real time prescription monitoring system known as 'SafeScript'.

10. In the Division's emergency management function it has also developed a real-time monitoring system of emergency department demand. This monitoring system is used to inform understanding of indications of an emergency. The Division is now also developing a syndromic surveillance system. Communicable disease teams within the Health Protection Branch of RHPEM formed the basis of the COVID Public Health Division, previously the Public Health Command, established to respond to the COVID-19 pandemic in Victoria.

11. The Division, through the Emergency Management Branch, also supports the Department in the fulfilment of its emergency management and business continuity responsibilities. These responsibilities include the control of public health emergencies, preparedness and support of the health system in response to mass casualty incidents and other health emergencies, and the command of departmental resources to provide relief and recovery services and coordination across the health and human services sector, local and state government, non-government organisations and national bodies in response to a range of emergency events. The Division also maintains the continuity of critical services to ensure we help communities, individuals and our clients plan, respond and recover in an emergency.

12. Under the whole of government emergency arrangements, the Department is a 'Control Agency' for health (human disease) emergencies (including food, water, chemical, biological and nuclear, radiation events) and is the 'Support Agency' for relief and recovery coordination of relief coordination of emergency accommodation (shelter), emergency financial assistance and psychosocial support in all emergencies. The Department is also support agency for any other emergency resulting in public health impacts or health system coordination.

13. My responsibilities in that role are the strategic direction and management of the Division. The Division typically has a workforce of around 400 staff..

HOTEL QUARANTINE PROGRAM

3. Do you consider that arrangements under the State Health Emergency Response Plan were:

(a) themselves sufficient for;

(b) activated sufficiently in relation to; and

(c) implemented at appropriate time(s) in,

the Hotel Quarantine Program? Why or why not?

(a) themselves sufficient for the Hotel Quarantine Program?

14. A consideration of whether the State Health Emergency Response Plan – Edition 4 (SHERP) was sufficient for the Hotel Quarantine Program (**Program**) requires appreciation of what the SHERP is designed to do.

15. The SHERP outlines the arrangements for management of health emergencies in Victoria. It is a subplan of the State Emergency Response Plan (**SERP**), made pursuant to the Emergency Management Manual Victoria (**EMMV**). Under the EMMV, the department is designated as a 'Control Agency' for class 2 health emergencies. The SHERP is one piece of the emergency management regime in Victoria. It is governed by the *Emergency Management Act* 2013 (EM Act) and coordinated by the Emergency Management Commissioner.

16. The SHERP was not and did not aim to be a plan or a blueprint for running a hotel quarantine program. The intention of SHERP is to be an overview of "the integrated approach and shared responsibility for health emergency management between the Department, Ambulance Victoria, the emergency management sector, the health system, and the community and how these differ to, or elaborate upon, the arrangements in the SERP."[1] The SHERP sets out the key roles of the State (tier) Health Incident Management Team (**SHIMT**), including the accountabilities for escalating a health emergency of sufficient potential consequence to Victorians to request activation of state-level emergency management arrangements at the State Control Centre, appoint a State Controller – Health and declare a Class 2 Emergency.

17. SERP and the SHERP reflect a general incident management structure and standard used and recognised throughout Australia[2]. It is designed to be applied in an 'all hazards–all agencies' environment. This incident management standard was the starting point for the first Operation Soteria Emergency Operations Centre (**EOC**) team structure.

18. The Operation Soteria Commander inherited the initial version of the Operation Soteria Plan (which I detail further in my response below) developed by the State Controller-Health and the Deputy State Controller, with the assistance of ADF personnel. The Operation Soteria Plan was endorsed by the Public Health Commander and the Emergency Management Commissioner on 28 March 2020.

[1] DHS.0001.0027.0883 SHERP edition 4, p1
[2] Known as Australasian Inter-service Incident Management System – or AIIMS.

19. I would note here that the Public Health Commander endorsed the Operation Soteria Plan, based both on their relevant expertise, and on the fact that the Operation implemented the Direction and Detention Notice[3] made under the *Public Health and Wellbeing Act* 2008 (**PHW Act**) and approved by the Public Health Commander (as the Chief Health Officer's delegate). As the Department's initial response to the Board sets out, the Program operated within two legal frameworks: the PHW Act and the EMMV.

(b) activated sufficiently in relation to the Hotel Quarantine Program?

20. The SHERP itself does not require 'activation'. It states that "the arrangements in this plan apply on a continuing basis and do not require activation'. Escalation of the arrangements in this plan is outlined in Section 6.3"[4]. The SHERP arrangements were escalated prior to the announcement of Hotel Quarantine, with declaration of a Class 2 emergency and appointment of a State Controller – Health on 1 February 2020.

21. Prior to this, on 20 January 2020, the health protection team in RHPEM had established an Incident Management Team to coordinate the public health and sector response.

22. In the initial days of the Program, emergency arrangements under SHERP for psychosocial support and primary health care were used to provide health and welfare services to travellers, before contracted providers were established.

23. I consider that the escalation of this emergency from an internal incident management team through January 2020, to activation of the State Control Centre and advice to the Emergency Management Commissioner of a health emergency, and the appointment of a State Controller – Health was sufficient and timely.

(**c) implemented at appropriate time(s) in the Hotel Quarantine Program**

24. The Department's role as Control Agency under the EMMV and reflected in the SHERP would usually require that it would be responsible for ensuring the establishment of a significant program to control the health 'hazard' like the Program. However, there were initial steps taken and responsibility assumed by the Department of Jobs, Precincts and Regions (DJPR) to establish the Program, soon after the National Cabinet decision to implement the Hotel Quarantine Program in all jurisdictions. I believe this was done with the best of intentions, however it was outside the emergency management arrangements, and in that sense, meant the SHERP was implemented later than it ought to have been for the Program establishment..

25. By reason of my role as Deputy Secretary, under SHERP, I was the State Health Emergency Management Co-ordinator (**SHEMC**) (from commencement of the current SHERP in September 2017 until 15 July 2020). My obligations as SHEMC included that I:

    (a) advised the Secretary of the Department about who should fulfil the function of the State Controller (with advice from the State Health Incident Management Team) according to

[3] While there was an initial reference to 'Isolation (International Arrivals) Detention Notices'; the individual notices given to travellers are called, and are listed throughout this statement as 'Direction and Detention Notices'
[4] SHERP, section 1.5, p 3

the nature of the emergency and response, and consistent with the instrument of appointment; and

(b) ensured that appropriate appointments were made to state tier functions (State Health Commander, State Health Coordinator and Public Health Commander) according to the nature of the emergency and response, and consistent with the instrument of appointment; and

(c) provided executive administrative support to ensure that the state tier functions operated effectively.

26. On 1 February 2020, I made a recommendation to Kym Peake, Secretary of the Department that she advise the EMC that she had appointed the Director, Emergency Management Branch (State Health Coordinator) as the Class 2 Controller for the '2019 novel Coronavirus outbreak'.[5] The appointment was made on 1 February 2020.[6]

27. I recommended the appointment of a Class 2 Controller after the Australian Health Protection Principal Committee (**AHPPC**) (the key decision making committee for public health comprised of all state and territory Chief Health Officers and chaired by the Australian Chief Medical Officer) advised on 1 February 2020 that to contain the spread of COVID-19, from 1 February 2020, entry to Australia should be denied for people who have left or transited through mainland China (apart from Australian residents or air crew).

28. The adoption of the AHPPC advice by the Commonwealth Government, under the SHERP, escalated the Department's response from Level 1 (able to be resolved through local and preliminary resources only – for example management of outbreak cases and their contacts and recommendation for isolation of those who had travelled from Hubei province) to a Level 2 response (larger and more complex than Level 1 involving multiple agencies and resources and potential overall community impacts) given the likely social and economic impacts of border closures to all Chinese citizens. Further, the potential for outbreak also met the definition of a 'major emergency' under the EM Act 7 as it then had potential to have significant adverse consequences for all or a part of the Victorian community warranting declaration of a Class 2 Emergency under the EM Act.

29. In the SHERP, it is presumed that the Public Health Commander (the Chief Health Officer or delegate) will be appointed State Controller for identified and anticipated public health emergencies, and the State Health Coordinator is appointed for all other emergencies.[8] However, operational policy[9] also provided me, in my role as SHEMC, with the discretion (informed by relevant advice) to recommend the most suitable appointment in all the circumstances.

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[5] DHS.0001.0013.1383 Email from Melissa Skilbeck to Kym Peake 1 February 2020
[6] DHS.0001.0001.0839 Instrument of appointment and brief signed by Kym Peake
[7] *Emergency Management Act* 2013 section 3 (definitions) *major emergency* means: a large or complex emergency (however caused) which (a) (i) has the potential to cause or is causing loss of life and extensive damage to property, infrastructure or the environment; or (ii) has the potential to have or is having significant adverse consequences for the Victorian community or a part of the Victorian community; or (iii) requires the involvement of 2 or more agencies to respond to the emergency; or (b) a Class 1 emergency; or (c) a Class 2 emergency.
[8] SHERP section 6.2 Table 1 p 23.
[9] DHS.0001.0001.0004 *Concept of Operations* v 1 endorsed 25 November 2019 p 3

30. In order to manage the growing social and economic impacts of the virus across government and provide access to the needed state-level logistics and communications support, rather than hazard (virus) control I recommended the State Health Coordinator be appointed as controller. This reflected the size and complexity of the response and the cross-department planning, logistics and communications support to the public health response to be undertaken, and the significant demands on the time of the CHO as a member of the AHPPC and in leading public health communications with the Victorian community.

31. For emergencies where the Public Health Commander is not appointed the State Controller, the Chief Health Officer's authority under the PHW Act remains unaffected, and public health decisions should not be overridden by a State Controller.

4. What was/were the aim(s) of Operation Soteria?

32. On 27 March 2020, National Cabinet made a decision requiring all passengers arriving in Australia after midnight on Saturday 28 March 2020 to enter mandatory quarantine in hotels for 14 days.

33. The 'mission' of Operation Soteria, as set out in the initial version of the plan approved on 28 March 2020,[10] was to implement the enforced quarantine measures for all passengers entering Victoria through international air and sea points-of-entry, in order to stop the spread of COVID-19.

34. The overarching objective of the enforced quarantine measures was to prevent the transmission of COVID-19 from returned travellers to wider members of the community, noting this was the predominant mode of transmission of COVID-19 into Australia at that time. This overarching objective applied both in the initial stages of Operation Soteria and throughout implementation.

35. The development of the initial Operation Soteria plan by necessity was rapid as noted at 18 above. The Operation Soteria plan covered the four phases of the program:

    (a) reception - the arrival of passengers into the country, and 'triaging' at the point of entry including an explanation of the requirement for 14-day quarantine;

    (b) transport – conveying the passengers to dedicated quarantine hotels;

    (c) accommodation – managing and co-ordinating the mandated 14 day stay for detainees;

    (d) return to the community - managing exit arrangements once detainees were cleared to leave quarantine.

36. The Plan identified the Department as responsible for managing, monitoring and responding to guests at the hotels and managing their return to the community at the end of the detention period. It had specific responsibilities in relation to traveller welfare, for providing health screening

[10] DHS.0001.0001.1475 Operation Soteria Plan v1, approved by the EMC on 28 March 2020

and access to social workers, mental health support (as needed), as well as medical and nursing support.

37. As the plan evolved and responded to the program, later versions of the Plan and its Annexures contained significantly more operational detail than at the outset of the Program. [11] These included procedures and policies in relation to:

(a) approving exemptions from quarantine, including how AOs enforcing directions issued by the CHO dealt with specific individual circumstances.

(b) the position of minors as detainees; [12]

(c) dealing with uncooperative detainees;

(d) temporary leave of detainees from hotel for medical or compassionate reasons (for example, to attend a funeral or visit a sick or dying relative); and

(e) procedures for release following 14 day isolation.

5. Which executive level members of the Department were involved in the implementation and delivery of the Hotel Quarantine Program and/or Operation Soteria? What are their usual roles and what role or input did each have in relation to Operation Soteria?

38. Key senior executives from within the Department were involved in the implementation and delivery of the Program including Operation Soteria.

39. Due to the sustained nature of the COVID-19 emergency and the work demands on Departmental officers, many of the executive level roles were shared or 'twinned'. It was a dynamic and uncertain environment, not only in respect of emerging knowledge of the virus and its transmission, but also logistically, where international flights were rescheduled frequently as airlines withdrew (and then reintroduced) flights and passenger information was usually incomplete prior to their arrival.

40. The commitment shown by each of the Department executives to the Program and the protection of Victorians cannot be overstated. One of the biggest concerns for me over this period was the sheer volume of work that each of them was undertaking. This is not unusual in an emergency response, however, not only was it on the back of their commitment to the bushfire recovery roles, it was also for a sustained period of time and during a period where all Victorians were impacted by restrictions. I witnessed this commitment across departments and agencies, as well as within the Department across our many functions including public health, hospital and other health

[11] DHS.0001.0001.1518 Operation Soteria Plan V2, as approved by the Emergency Management Commissioner on 26 April 2020, DHS.0001.0001.1444 Operation Soteria Plan V2.1, as approved on 8 May 2020; DHS.0001.0001.2245 Operation Soteria Plan V3, approved on 26 May 2020.

sector responses, as well as the human services response to the risk presented to the most vulnerable Victorians.

41. The State Controller position was twinned by Andrea Spiteri and Jason Helps (Deputy Director, Emergency Operations and Capability, Emergency Management branch). At my recommendation, Mrs Spiteri was appointed on 1 February 2020 and Mr Helps on 7 February 2020 [13] as Class 2 Controllers in anticipation of an increased and sustained need for an emergency management response having regard to the combination of both the summer bushfire and the COVID-19 pandemic.

42. The role of the Public Health Commander was performed by the Deputy Chief Health Officer (Communicable Disease) initially (Annaliese van Diemen) and other Senior Medical Advisers within the COVID Public Health division (including Simon Crouch, Finn Romanes and Clare Looker) as needed on roster, upon delegation of that role by the Chief Health Officer.

43. Relevant to Operation Soteria, the Public Health Commander role authorised directions, including the Direction and Detention Notice, under s 199(2)(a) and s 200 of the PHW Act giving effect to hotel quarantine; and approving exceptions to mandatory quarantine (for example, by allowing certain detainees to isolate at home or in hospital for compassionate or medical reasons).

44. The EOC for Operation Soteria became operational on or around 17 April 2020.[14]

45. As the central command team responsible for co-ordinating the Program (across a range of departments and agencies) it included the roles of Operation Soteria Commander (also known as the COVID-19 Accommodation Commander),[15] Deputy Commander Ports of Entry, Deputy Commander Welfare and Deputy Commander Hotels.

46. The Operation Soteria Commander role was responsible for the overall management of Operation Soteria at the EOC. This role was largely shared by Pam Williams, whose usual departmental role is Area Director, Barwon in the West Division, and Merrin Bamert, whose usual role is Director Emergency Management and Health Protection in the South Division.

47. The role of Deputy Commander Hotels was predominantly filled by Sandy Austin and Melody Bush, whose usual Departmental roles are Director Emergency Management and Health Protection in the East and West Division respectively. Sandy and Melody, along with other staff who filled the position for short periods of time, were responsible for overseeing Operational Team leaders who were located at the EOC and who were in turn responsible for oversight of the hotel team leaders on the ground.

48. The role Deputy Commander Welfare was largely filled by Anita Morris and REDACTED, with the position responsible for managing the operation of the welfare team and the CART team, and playing a role in the coordination of the welfare needs of detainees, working collaboratively with nursing and mental health nursing staff on site. The usual Departmental roles of these staff are

[13] DHS.0001.0011.1101 Instrument of appointment of Jason Helps
[14] DHS.0001.0001.0812 COVID-19 EOC OS operational structure v 2.0 18 April 2020 (page 5)
[15] DHS.0001.0001.2245 Operation Soteria v 3 Appendix 3 p 24

Statewide Principal Practitioner (Anita Morris) and Director - Secure Welfare and Disability Forensic Services (REDACTED).

49. The primary executive who held the role of Deputy Commander Ports of Entry was Michael Mefflin, whose usual departmental role is Director Emergency Management and Health Protection in the North Division, noting that other non-executives and executives undertook this role for shorter periods of time. This role was responsible for transporting arrivals from maritime ports to hotels.

50. As well as the Operation Soteria Command structure, senior Department officials held roles within the Enforcement and Compliance Command whose scope included enforcement and compliance activities under the Direction and Detention Notice regulating detention of travellers in the hotel quarantine program, among other Directions under the PHW Act.

51. The Enforcement and Compliance Commander, initially Ms Meena Naidu, whose usual departmental role is Executive Director, Health and Human Services Regulation and Reform, and then later by external appointments (Mr Murray Smith and Ms Leanne Hughson) into newly-created executive level roles: was responsible for leading compliance with all Public Health Directions, providing advice and input into complex compliance inquiries, advising and supporting the CHO on compliance matters, approving requests for alternative detention arrangements and conducting daily reviews of those in detention;[16]

52. Deputy Commander, AO Operations: was initially Anthony Kolmus (Director, Human Services Regulator) and then joined by Steve Ballard (Director, Community Services Operations for North Division) to provide a backfill. This became a formal twinning arrangement in June when Anthony Kolmus transitioned back to his substantive role and was replaced by Stuart Bailey, a new external appointment. This role was responsible for ensuring AOs are compliant with protocols, engaging with the EOC around hotel operations, leading and providing guidance to the AOs and reporting on daily review of those in detention.

6. To your knowledge, were any Australian Defence Force personnel:

(a) embedded within the Department;

(b) requested for, or on behalf of, the Department,

in relation to deployment or potential deployment within the Hotel Quarantine Program in Victoria? If so, when and where were they so embedded and/or requested, and by whom?

(a) embedded within the Department in relation to deployment or potential deployment within the Hotel Quarantine Program?

53. The Australian Defence Force (**ADF**) personnel have been a tremendous assistance to the Department in a variety of roles across the response to the health emergency.

54. In relation to the Hotel Quarantine program, ADF personnel provided significant assistance with the formulation of the initial Operation Soteria Plan and remained as part of the planning and

[16] DHS.0001.0001.2245 Annex 1 Operation Soteria Plan v 3 COVID-19 Compliance policy and procedures – detention authorisation v 2.0

logistics teams within the EOC. ADF personnel assisted in preparing and finalising approved policies and procedures for Operation Soteria. I am also aware that ADF personnel were embedded in roles within the Public Health Command.

(b) requested for, or on behalf of, the Department in relation to deployment or potential deployment within the Hotel Quarantine Program?

Potential deployment for planning and logistical support

55. In late May 2020, as the first wave of COVID-19 transmission was being controlled, and Victorian businesses were opening up and children were returning to schools, the Victorian Government was considering allowing international students to return to Victorian universities. This would have placed a significant demand on the Program. At the same time, due to the easing of restrictions, it was necessary for a number of staff (across agencies) to return to their usual roles, this meant that the number of personnel available, across agencies, to participate in the Program was also in decline.

56. As a result of these factors, on 23 May 2020, I responded to an email from Operation Soteria Commander Pam Williams which set out details of a discussion she had with the ADF about ongoing resourcing. In the email Ms Williams noted that 'we should probably move on to dedicated staff'. I responded that 'I think we will need ADF engagement to a greater scale given the withdrawal of staff from agencies and our own department and the aspirations for student accommodation'. This response had regard to the ADF's proven role in planning and logistics within the EOC.[17]

57. In the week beginning 15 June 2020, I had a discussion with an ADF officer about the scope of logistics support possible and also pre-arranged a meeting with Colonel REDACTE of the ADF for 24 June 2020 to discuss the matter further.

58. ADF personnel were not engaged to provide further logistical and planning support to Operation Soteria given the subsequent decision to pause Victoria's intake of international travellers, but they were utilised in enhanced testing and other operations for the Victorian COVID-19 emergency response.

Potential deployment for on-site security provision

59. Following the outbreak at the Stamford Plaza Hotel which raised systemic questions about the infection control among security guards, there was also consideration of the potential deployment of ADF personnel to assist in provision of on-site security.

60. I agreed with the Secretary in a telephone discussion on 23 June 2020 that I would coordinate development of a paper for her consideration setting out alternative options to the use of contracted security guards in hotel quarantine (**Options Paper**).[18] This included the potential for an increased role for the ADF.

[17] DHS.0001.0013.1232 Email from Melissa Skilback to Pam Williams 23 May 2020
[18] DHS.0001.0001.2236 Op Soteria Options Analysis V5

61. On the morning of 24 June 2020, I received a call from Ms Peake asking me about the use of ADF personnel and the numbers which would be required to assist with the transport of arriving passengers and with their exit at the end of the detention period. I indicated to her that between 50-100 personnel could support the transport operations. Ms Peake subsequently forwarded me an email she had sent to Chris Eccles, the Secretary of the Department of Premier and Cabinet, in which she requested additional ADF personnel for contact tracing, expanded community testing (including drive-in testing stations) and to support entry and exit arrangement for hotel detention.[19]

62. Later that afternoon, when State Controller (Ms Spiteri) and I met with Colonel REDACTED to discuss the ongoing role of the ADF in the Program, I primarily inquired as to how the ADF had been used in New South Wales. Colonel REDACTED explained that in New South Wales, ADF officers had acted in a support role to and at the instruction of police, who (unlike in Victoria) were responsible for running the hotel detention program. I described the role of AOs under the Victorian PHW Act in authorising compliance activity. The Colonel confirmed that our legal framework was one the ADF personnel could work within. His responses informed assessment of alternative options in development of the Options Paper (referred to below in answer to question 15).

63. Among the options canvassed in the Options Paper, the preferred option was for Victoria Police to lead the rostering of staff to replace contracted security guards with a mix of Police and Protective Service Officers (and potentially Sheriff personnel), in addition to utilising ADF personnel logistics expertise. The key implication of this preferred option was a requirement for Victoria Police to source on average, approximately 400 Police Officers per day, requiring total resourcing of between 650 to 800 FTE staff to cover all shifts for 20 hotels (19 were operating under the Program at the time).

64. I had advised Colonel REDACTED of the estimated requirement of between 650 and 800 personnel in discussing these options with him at our meeting, as part of the 'due diligence' in identifying a preferred option in the Options Paper.

65. Ultimately, the Victorian Government made the decision to utilise Corrections Victoria personnel, supported by Victoria Police, in delivery of security functions for hotel quarantine operations.

7. What challenges did you (and your Department generally) face in securing staff and physical resources for the Hotel Quarantine Program?

66. From the start of Operation Soteria, a key challenge was sourcing sufficient numbers of AOs to carry out required functions under the PHW Act including undertaking daily checks to monitor welfare and satisfy the requirements of section 200(6) the PHW Act.[20]

67. The requirements of the PHW Act limited the possible options for sourcing AOs to those employed under Part 3 of the PA Act, which is effectively, within the Victorian public sector and/or local councils.[21] This may be compared with, for example Queensland, where I understand the equivalent role of an AO is able to be performed pursuant to their relevant health legislation by a

[19] DHS.0001.0012.0580 Email from Kym Peake to Andrea Spiteri and Melissa Skilbeck dated 24 June 2020
[20] PHW Act, s 200(6).
[21] S 30, PHW Act.

number of different classes of persons including police, fire service and ambulance personnel.[22] This may be the case in Queensland for a variety for reasons including geographical, however, in the circumstances of the unprecedented demand that the Program entailed such an option would have been beneficial in Victoria had it been available.

68. All AOs initially came from RHPEM's ten in-house regulators usually working across health and human services regulatory schemes. Very quickly, all experienced AOs (with the exception of skeleton staff to respond to significant risks in supported residential services for example) were fully occupied in hotel quarantine.

69. Alongside the COVID Enforcement and Compliance Command and the department's corporate services staff, I engaged significant effort and time in seeking to source potential AOs from other departments and agencies with regulatory functions in-house – and employed under Part 3 of the *Public Administration Act* 2004 (**PA Act**) and by local government (and not Victoria Police for example) consistent with the requirements of the PHW Act.

70. In late March and early April 2020, many businesses, universities, schools and shops were still operating on a relatively 'as usual' basis, as were many areas within the Victorian departments and agencies that were regulating them. But, for example, as the closure of pubs and licenced clubs commenced, the Victorian Commission for Gambling and Liquor Regulation contributed a significant number of AOs (more than 10 at one stage).

71. As well as those with a background in regulation, those best suited to the AO roles included those with training in environmental public health, given their broad training and experience in responding to public health risks as varied as food safety and waste management to infection risks in hairdressers and cosmetic procedure clinics. There was significant support provided from local government through the Municipal Association of Victoria, especially Melbourne City Council and Wyndham City Council, and from two firms who provide contracted environmental health officers (EHOs) to local government.

72. By early June, of the 130 (approximately) AOs deployed for the Program, some 40 were from the Department, with 50 from local government, and the balance from other departments or agencies.[23]

73. In Victoria, the AO role under the terms of the PHW Act, has significant responsibilities to balance the public health risk with the restrictions placed on the freedom of travellers and their welfare. This is reflective of the fact that under the *Charter of Human Rights and Responsibilities Act* 2006 (**Charter**) any decisions taken by a public authority (including for example under the PHW Act) must have regard to the rights of individuals under the Charter.

74. In practice, this required considered and balanced decisions of AOs in providing permissions for travellers to leave the designated hotel room. For the COVID Enforcement and Compliance Command, it added to the substantial task of responding to requests for 'exemptions' from

[22] S 377 of the *Public Health Act (Qld)* 2005.
[23] DHS.0001.0093.0001 Critical EM Sector Workforce Needs 5 June 2020

quarantine and/or approving temporary (day) leave for medical treatment or other compassionate reasons (such as to visit a dying relative or attend a funeral). This also placed a significant burden and complexity on organisational, administrative and human resources skills.

75. Throughout May 2020, I was engaged in the development of proposals for trials to permit international students to return to Victoria. Given forecasts of student arrivals, this would necessitate expanding quarantine arrangements, potentially at hotels or at alternative accommodation, requiring a substantial increase in AOs at a time when the need to sustain their existing resources was expected to be challenged due to the prospect of closed services reopening to the community and requiring AOs to return to their usual regulatory roles.

76. Because of this, the Department's corporate services team developed a recruitment and training package to develop a new source of AOs, utilising former Virgin Airlines staff and other suitable workers. It was considered that airline staff have relevant experience as they work in highly regulated and safety driven environments and have sophisticated skills in service. In mid-June 2020, the first two-week training course commenced to familiarise AOs with the regulatory requirements of an Authorised Officer and the Hotel Quarantine Program more generally. This program has contributed AOs to the continuing Hotel Quarantine Program.

Resources – Personal Protective Equipment

77. In the initial few days of the program, I understand there were concerns regarding the ready access to PPE, including for Department staff, when private sourcing of some equipment was undertaken by Operation Soteria staff. I believe these concerns were overcome relatively early in the Program with establishment of supply lines.

78. In the first weeks of the program, the advice from Public Health Command, consistent with the public health advice across Australia and internationally, was that the use of gloves and masks other than in a hospital environment was not necessary unless physical distancing could not be maintained. At this time, consistent with worldwide shortages of PPE, priority was given to distribution of PPE to health care workers ahead of other frontline staff (including hotel quarantine staff). [24]

79. I understand the Department was responsible for supplying PPE to its staff and to travellers, including on arrival, during transit to the hotel and when receiving treatment or interacting with staff (for example, during fresh air breaks). I understand that under contracts with DJPR, contracted firms were obliged to provide PPE to their own staff.

80. However due to difficulties in sourcing PPE generally at the start of April (because of worldwide demand, uncertainty about the quality of many brands which were being produced in response to demand, and the focus on provision of PPE to health care professionals), I understand there was an agreed, informal arrangement under which the Department was making PPE available to others working in the hotels if required.

[24] DHS.5000.0054.7445

8. In your opinion, was the Hotel Quarantine Program adequately resourced and staffed? Why or why not? Please provide details. If your answer differs for different time periods please specify.

81. A number of issues emerged during the early days of the Program, as noted in my response to question 7 above, due to the difficulties associated with finding sufficient suitably qualified staff to fill AO roles at the hotels.

82. At times, especially during April, when the influx of detainees was at its highest, it was difficult, for all agencies, to keep ahead of staffing needed for all sites in operation. This was especially hard when the number of returned travellers regularly exceeded the practical maximum of 3700 that we had planned for and advised Commonwealth departments and agencies within the Managing International Arrivals National Coordination Mechanism (NCM).[25] The NCM was established to coordinate the allocation of flights to jurisdictions and other logistics issues.

83. Resourcing was difficult day-to-day due to the quality of the advice that was received regarding incoming flights. The NCM provided best estimates of flights and passengers numbers expected at each destination, but the accuracy of this information was difficult to maintain. The Commonwealth had some control over specially-arranged repatriation flights, especially if they were arranged by the Australian Government. However, commercial flights became unpredictable as flight paths became uncommercial or unavailable around the world. At times there were significant differences in expected passenger volumes and composition compared to the travellers who disembarked at Tullamarine Airport.

84. There was also significant impact on planning associated with factors such as children being rarely accounted for in the information that was received by the Program and family groupings that were also not advised. This meant that there was a significant drain on resources at the airport and check in to match arriving passengers with suitable hotel accommodation, particularly as numbers grew to 600 children among 3000 travellers accommodated in early June 2020.

85. There was also a considerable amount of time and resourcing involved in dealing with exemption requests. These requests sought a variation to a person's detention to allow them to either leave quarantine earlier than the mandated 14 days, or to isolate at a location other than a hotel, for example at home. Additional staffing was required to manage the scale of claims from people seeking to avoid hotel quarantine. This required considerable resources for the exemptions team to identify genuine claims for a variation to the Detention Notice for consideration by Public Health Command (and then later, under delegation by the COVID Enforcement and Compliance Commander).

86. Significantly one of the implications of the Department managing health and welfare supports for travellers was that the Department was able to source its own expertise to respond to more complex traveller health and welfare needs in detention. Accordingly, variations to the Detention Notices were typically only granted in circumstances such as those requiring urgent medical treatment, those with a terminal illness, unaccompanied minors whose parent or guardian were

[25] DHS.5000.0026.1096 Operation Soteria Minutes 21 April 2020

unable to join them in quarantine, and those with mental health needs requiring in-facility treatment.

87. In the event of the two hotel outbreaks, the strain on staff resources was exacerbated by the requirement for those working within the Program to self- isolate if they were a 'close contact' of someone who had tested positive for COVID-19. Given the source or means of virus transmission was not identified at the time, the Public Health outbreak management team was conservative in its requirements and all staff who had been on-site during the relevant potential infectious period of a case was required to self-isolate in case the virus had been transmitted via environmental contamination (such as a lift button or a balustrade) rather than only staff who had worked with the case. This had implications for the Program as greater numbers of staff were unavailable for 14-days. Following the outbreak at the Rydges for example, the hotel could not source sufficient staff to manage the facility, and Operation Soteria ceased operations there for a period, transferring travellers to another hotel.

9. In your opinion, what skills, qualifications or experience in health are required for a person in order for that person to:

(a) be the person in charge of a quarantine facility?

(b) hold a leadership role in a quarantine program?

(c) work in the Hotel Quarantine Program?

(a) be the person in charge of a quarantine facility?

88. I do not believe any specific qualifications or experience in health are required for a person in order to be the person in charge of a quarantine facility. The majority of detainees had no health issues. However, it is imperative that those that do have physical and mental health concerns have ready access to qualified health staff.

(b) hold a leadership role in quarantine program?

89. The breadth and complexity of the Program meant that a wide variety of skills and experience from people across many government departments and agencies was required, particularly in leadership roles. That experience was not confined to those from a health background, but also welfare and social support expertise, emergency management operations, logistics including rostering, program planning and public administration.

(c) work in the Hotel Quarantine Program?

90. There was a need for staff and leadership to understand, at all levels, the public health purpose of quarantine but that did not require all of them to have health skills, qualifications or experience. Those with such skills, qualifications and experience were used in health and welfare support roles within the hotels. Those with a background in emergency management have the skill and

experience of putting together an operation at very short notice. This was of particular value given the rapid circumstances in which the Program was established.

91. There are also other staff and third-party providers with technological and data skills who were required to co-ordinate and manage records associated with the mass arrivals of detainees (from the moment they landed). For instance, an application for use by the AOs and later welfare teams which they could use on a tablet to capture traveller quarantine information was developed and adopted in the space of weeks, rather than months (as would have been the case in normal circumstances).

92. Within the Department, highly qualified and experienced staff (including those with clinical experience) were equipped to provide the relevant health and welfare response. This included specialist supports such as for travellers who had physical or mental health issues or where there were concerns around family violence. This was critical as while the Program had a public health overlay aimed at reducing the risk to those outside detention, there was also an obligation to protect the safety, well-being and individual rights of travellers in detention, including under the Charter. This was of particular relevance for those working as AOs in striking a balance between managing the public health risk and attending to other health or welfare needs in considering any departure of a detained guest from their room. I discuss this further in my response to question 11 below.

93. The sheer number of people required to staff the Program, on a 24-hour basis, seven days a week, meant that staff were drawn from all across the public service, health sector and third-party providers.

AUTHORISED OFFICERS

10. What was required, under relevant legislation, regulations and policy, for a person to be appointed as an Authorised Officer? Were there any challenges in relation to this? If so, what were those challenges?

94. Please note I have addressed some of the relevant issues in relation to AOs in my answers to questions 7 and 8 above. I recall that there was a preliminary interpretation of the PHW Act that it required that only staff who were direct employees of the Department could be engaged as AOs. This meant that employees from other departments or agencies had to be seconded into the Department to be suitable. However, it was soon clarified (after additional review) that agency and other departmental officers could be engaged. Appropriately qualified staff for specialised AO roles were therefore sourced from other departments and local government.

95. As set out above, under section 30 of the PHW Act, for a person to be appointed as an Authorised Officer, they are required to be (already) employed under part 3 of the PA Act, or by a local council. The pre-condition in relation to the PA Act applies to all Victorian public service staff, not including Victoria Police. The appointment of an AO may be made by the Secretary of the Department or their delegate such as (as happened under the Program) the CHO. I hold this delegation and have personally signed off many AO appointments.

96. A person appointed as an AO must be someone who the Secretary (or their delegate) considers to be 'suitably qualified and trained'.[26]

97. In practice, suitability or aptitude varied, and some people were not comfortable working as an AO as they found public health risk and/or incidents of mental health and family violence or public complaints confronting.

98. The delivery of the Program was constantly evolving at a fast pace due to changes in the traveller cohort and as knowledge about the virus and its transmission increased. Understandably, the pace of change proved challenging for some staff. For example, the characteristics of traveller cohort changed over time. Initially, the cohort comprised principally of returning holidaymakers and then those returning after a number of years as expatriate workers, then as time went on, there were higher proportions of those with more complex welfare needs, along with higher numbers of unaccompanied children and also large family groups.

99. This change in needs was due to a number of factors one of which was the level of connection the traveller had in or with Australia. The initial cohort having only left Australia on short term holiday had strong connection and resources in Australia. Some in the latter groups had very few supports in Australia and had up-rooted their lives in other countries to return to Australia. These changing needs required regular changes in procedure. For instance procedures that may have assumed a returned traveller had an Australian address were challenged. The influx of arrivals also stretched the capabilities of the hotels in the Program when a greater number of family size rooms were required. All of these issues increased the level of support and involvement required in the more challenging cohorts in the later period of the Program.

100. Further, the public health response and advice on risk also altered as knowledge of the virus and responses to it changed, including appropriate infection control methods.

101. Another key challenge having regard to the number of AOs available and required to cover the shifts at the hotels was the regular checking that had to be done based on the Department's understanding of its obligations under the Charter. This is discussed in my response to question 9 above and 11 below.

11. In practical terms, any by reference to the differences between the respective roles, what was the function and the responsibilities of the:

(a) Authorised Officer;

(b) Senior Authorised Officers;

(c) Department Team Leaders,

in the Hotel Quarantine Program?

[26] PHW Act s 30(2)

(a) Authorised Officers

102. AOs were responsible for:

(a) issuing and amending detention notices;

(b) undertaking daily checks on each detainee to satisfy obligations under the Charter;

(c) ensuring compliance with notices,

(d) issuing and managing permissions for temporary leave (allowing detainees to exit temporarily for medical treatment or on compassionate grounds, eg to visit a dying relative or attend a funeral);

(e) facilitating approved exemptions (those allowed to leave detention and complete their isolation elsewhere);

(f) attending to the exit of detainees from hotels; and

(g) engaging Victoria Police for assistance as required to ensure compliance.

(b) Senior Authorised Officers

103. Authorised Officers are a statutory role under the PHW Act. There is no legislative difference between a Senior Authorised Officer and Authorised Officer. However, within the Program, a hierarchy was introduced to reflect that Senior Authorised Officers provided assistance and advice to Authorised Officers and dealt with staff management issues such as briefing staff and engaging new staff members. I understand Senior Authorised Officers were also often called upon to deal with issues that needed to be escalated such as failures to comply or travellers who had complex needs and to advise on more complex permissions. Senior Authorised Officers were otherwise empowered and often performed all of the other roles set out above in answer to 11(a) of an Authorised Officer.

(c) Department Team Leaders:

104. Department staff acting as hotel-based team leaders were responsible for:

(a) convening regular on-site meetings with hotel security, relevant DJPR staff, and other departmental staff to discuss any issues arising;

(b) managing and ordering PPE for Departmental staff and contractors;

(c) ensuring clinical waste bins and sharps were placed out for collection;

(d) supporting AOs with operational requirements for hotel exit, including calling rooms and escorting guests to taxis;

(e) placing orders for requested health equipment including ordering pharmaceuticals if necessary;

(f) working with 'site leads' (equivalent of team leaders) from the DJPR and hotel management to resolve any issues at the hotel, or otherwise escalate concerns to the EOC; and

(g) attending daily tele-conferences with the EOC.

One hotel team leader was on site at each hotel 7 days a week, rostered in two shifts between 7am and 10pm, There was also a 'shared' team leader rostered overnight to serve all hotels.

COMPLAINTS AND ESCALATION

12. What were the processes in place for:

(a) people in quarantine;

(b) those working with the Hotel Quarantine Program; or

(c) others,

to make complaints or escalate grievances? How were the processes conveyed to each of those groups of people, and in your view, were those processes adequate and/or effective?

105. There were a range of mechanisms for complaints or grievances to be raised.

(a) People in quarantine;

106. Complaints from guests in detention were made either via the Government Support Service (a DJPR phone line) or the Hotel Team Leaders on site. Given the duration of the stay, the most effective complaints mechanisms were local to the relevant hotel - in order to resolve practical issues quickly. Travellers were advised of these avenues for complaint verbally on arrival at the hotel and in a 'welcome pack' given to guests on arrival.

107. If a complaint could not be resolved at the local level, it would then be escalated to a deputy commander (through the EOC), or as relevant, a Commander.

108. Daily handover notes were made at each hotel by the team leaders recording any issues which had arisen including complaints by guests, and how/whether they had been resolved.

109. Issues arising on site were escalated through appropriate reporting lines to those who were able to address those issues, for example matters involving contractual arrangements with the hotels or third-party service providers could be taken up through a DJPR site manager (who in the early stages of the Program was on site at each of the hotels).

110. Welfare calls made to guests by Department staff and contractors (such as nurses checking up on guests) would prompt complaints or grievances on occasion such as about food variety or quality or safety (when the traveller had a food intolerance for example). These would be referred to the Hotel Team Leaders for the relevant site or other appropriate person for resolution.

111. Exemptions requests from quarantined travellers were often a way of complaining about the fact of being detained, but sometimes revealed health treatment requirements that warranted

consideration additional health support on site or an amendment to the Detention Notice to change the place of detention.

112. Complaints about quarantine were made by guests, or their relatives, writing to their local MP or a Victorian or Commonwealth Government Minister. These types of complaints were referred to me to provide a response. They were relatively few in number. Overall, I received some 800 pieces of correspondence relating to the COVID-19 emergency, including the Program, for which a team established for the purpose in the RHPEM division would source responses. Most days, reviewing and approving responses to correspondence, even with the assistance of a team, required more than one hour of my time.

113. Unless an issue was urgent, a written response was provided to each written complaint in relation to the Program. Due to the volume of the correspondence involved (and depending on when in the 14 days a person had complained), sometimes by the time a complaint was investigated and a response was provided, the person had left quarantine.

114. If a matter involved a serious incident at a hotel, such as death or injury, this required a formal incident report prepared by the Operation Soteria staff on-site, investigation by Operation Soteria Command, and review by me prior to delivery to the Secretary.

115. Complaints could also be made to the Ombudsman.

***(b)* those working with the Hotel Quarantine Program.**

116. Departmental staff grievances were addressed through site leaders on site and or to Deputy Commanders in the EOC or in the COVID Enforcement and Compliance Command structure. All departmental staff continued to have access their usual departmental management, wider supports available through the People and Culture Branch and other dedicated staff support mechanisms.

Grievances raised by contractors (for example contract nurses) were often raised with hotel team leaders, through the relevant command structure or directly to the company that employed them.

(c) others.

117. The mechanisms for complaint from people not in quarantine and not working in the Program included the options above.

118. In my view the complaint mechanism, particularly given the Program was run as an emergency response, was adequate. The most serious complaints were dealt with swiftly.

13. What complaints and concerns (if any) came to your attention, arising from the Hotel Quarantine Program? In relation to each, please

(a) provide the details of each complaint or concern;

(b) explain how the complaint or concern was dealt with, including any persons to whom the complaint was relayed; and

(c) describe what outcome, if any, was achieved in relation to the subject matter of the complaint?

119. As set out above at my answer to question 12, there was a significant volume of correspondence reflecting complaints and concerns about aspects of the pandemic and the response to it, some of which related to the Program. I have restricted my answer to this question to the high-level complaints and grievances and/or common complaints (most made by telephone or raised directly by the hotels) arising out of the Program.

120. I was notified about certain complaints or issues, which were passed to the appropriate teams to resolve, for example:

(a) Islamic detainees in quarantine during Ramadan who were breaking their fast at sunset but not receiving any meals until hours later[27] – this was referred to DJPR (in charge of accommodation and catering) to raise with the hotel.

(b) Complaints about not being allowed to leave the room for fresh air breaks. The Operation Soteria Command and COVID Enforcement and Compliance Command developed policies concerning fresh air breaks as part of temporary leave permissions authorised by the AOs and operational protocols were developed at each site.

(c) Complaints about the inability to obtain alcohol, or have it delivered by friends or relatives in 'care packages' sent to the hotel. The initial policy was that alcohol could not be purchased and/or brought to the hotel for detainees, though this was relaxed over time with alcohol able to be purchased on site.

(d) An incident involving a social media post about a tree frog found in a salad at one of the hotels[28] which was referred to Melbourne City Council food safety officers to investigate.

(e) Complaints from a guest stating she had been bitten by a bed bug – after some initial inquiries it was unclear whether the guest had brought the bug in their luggage.[29] They were nonetheless given the option to move rooms if they chose.

121. There were incidents involving protocol breaches at the hotels of which I was made aware by the Operation Soteria Commander:

(a) In one instance, a mental health nurse took a guest out for a fresh air break wearing no PPE and without the authorisation of the AO.[30] The nurse was spoken to and removed (by the nursing contractor) from the quarantine roster.[31]

(b) There was also an incident of reported of sexual harassment of Departmental staff at a hotel. I was informed that the subcontracted security staff had been immediately dismissed by the lead contractor (following investigation and action by DJPR as the contract manager).

[27] DHS.0001.0012.1736
[28] DHS.5000.0008.3853
[29] DHS.0001.0012.1361
[30] DHS.0001.0012.0713
[31] DHS.0001.0012.0715

(c) I was also made aware of concerns relating to the incorrect use of PPE by security guards in that they were relying on and wearing single use gloves for too long, rather than regularly using hand sanitiser (which was the recommendation from the Public Health team), following an infection prevention and control review.

(d) The State Controller advised me that a staff member observed security staff not practising physical distancing at the Stamford Hotel (some 70 staff having a meeting in a closed room after their shift) on the weekend prior to the outbreak at that hotel being advised, they raised the complaint directly with security on site, rather than the DJPR site manager at the hotel, this led to DJPR to advise that the Department should go through DJPR for such complaints.[32]

122. As noted in the response to question 12 above, the exemptions team in the COVID Enforcement and Compliance Command received many hundreds of letters and emails about the Program concerning claims for exemptions from quarantine. A majority of these were not actually exemption requests but rather complaints about the fact of being in quarantine or the prospect of the correspondent or their family being required to go into quarantine.

Incident Reports and inquiries

123. While I had no visibility of day to day issues that were being dealt with on site at the hotels, I received correspondence, and did become directly involved if the issue involved a major incident (as I was required to sign off on relevant incident reports).

124. The nature of the incidents ranged from matters such as a child breaking an arm when falling off a bed in a hotel room, through to physical and sexual assaults, domestic violence and the death of a detainee. I deal in more detail with a number of these incidents below.

125. I had a specific involvement in relation to an unexpected death at one of the hotels on 11 April 2020. This was a massive shock for everyone concerned and I directly contacted the person's next of kin to express the department's condolences and offer support. COVID Enforcement and Compliance Command prepared an initial incident report on the incident for Ms Peake.[33] This incident was the subject of a later report by Safer Care Victoria requested by the Secretary, of which I received a copy.

126. There was another incident which was also the subject of Safer Care Victoria report involving delays in transporting a guest to hospital who had developed COVID-19 symptoms. Due to the delay the guest deteriorated rapidly and required admission to the ICU.

[32] DHS.5000.0006.1535
[33] DHS.0001.0013.1755

127. Other incident reports included:

(a) several reports involving claims of domestic violence, including threats of violence involving guests – these were managed through welfare supports and on occasion, the involvement of police.

(b) on 16 April 2020, a guest who fell and broke their jaw during a cigarette break which they had demanded after acting in an agitated and violent manner. [34]

(c) on 7 May 2020, a guest who injured their foot while frog- jumping during a fresh air break[35]

(d) on 13 May 2020, an incident involving a housekeeping contractor believed to be making an unwanted sexual advance to a guest by inviting them to make contact through social media forum 'Snapchat'.[36]

(e) on 16 May 2020, police being called due to concerns about guests with mental illness (including threats of harm and self-harm). In one incident, where the person was screaming at nursing staff and threatening to leave their room, the situation was dealt with by having the police and hotel team leader speak with the guest to calm them down;[37]

(f) on 19 May 2020, complaints about inappropriate sexual behaviour by a contract nurse (involving another nurse)[38]- this was taken up with the nursing agency.

(g) on 5 June 2020, a REDACTED who absconded to REDACTED while receiving psychiatric treatment (during a period of temporary leave) from the REDACTED Hospital. Police located REDACTED at REDACTED home in REDACTED and due to REDACTED mental health issues, REDACTED completed the final two days of REDACTED detention in the REDACTED hospital. [39]

(h) on 14 June 2020, a member of the public attempting to enter the hotel by following nurses back from their coffee break. This situation was dealt with by recommending that a process be implemented to ensure that security escort nurses when they took their breaks.[40]

(i) on 15 June 2020, a REDACTED who attempted suicide by taking REDACTED own prescription medication. The REDACTED was already being attended to by the mental health nurses due to REDACTED level of distress. The REDACTED was taken to REDACTED Hospital.[41]

(j) on 22 June 2020, an incident of overuse of medication by a guest – this was dealt by a referral to the Department's specialist mental health team.[42]

[34] DHS.0001.0094.0001
[35] DHS.0001.0093.0001
[36] DHS.0001.0009.0067
[37] DHS.0001.0009.0077
[38] DHS.0001.0009.0018
[39] DHS.5000.0019.3924
[40] DHS.5000.0005.1000
[41] DHS.5000.0005.1290
[42] DHS.0001.0009.0168

128. The Ombudsman also undertook inquiries into complaints by a number of detainees. A number of these inquiries came to me and I referred them to the relevant Command to develop their portion of the response. I reviewed the final response before it was forwarded to the department's central executive service branch for delivery.

129. One Ombudsman inquiry with which I was directly involved concerned the availability of 'fresh air walks' for detainees, following a complaint by a guest that they were allowed only 15 minutes out of their room per day.[43]

130. The Department responded noting that AOs under the PHW Act can grant permission to leave a room (access to open air) and this is generally facilitated by security at the hotels, but this is limited by the capacity of the hotel environment to enable fresh air and exercise while protecting the safety of staff and the wider community (with longer breaks generally available for smaller hotels). The response also referred to the Department's role in providing guidance, information and support services to understand individual needs including methods to support wellbeing and keeping active. I was also aware of an inquiry, involving a family concerned about the effect of detention on their autistic child.[44] The Department provided a response following a telephone conference in which the various paediatric and welfare supports available to the family were explained. [45]

14. Did you, at any time, have any reservations about the use of private security contractors in the Hotel Quarantine Program? If so, what were those reservations and to whom did you convey them? What was their response?

131. I was not involved in any discussion about the use of private security guards prior to the commencement of the Program.

132. Practically, there is very little option but to have security guards involved, to some extent, given the scale and the speed of expansion of the Program in Victoria and this was the case in most other jurisdictions as well as I understand it. The Program, requiring staffing for up to 19 hotels by the end of June (that is approximately 600 staff across shifts on a daily basis) meant they were required as (at least) a surge workforce.

133. At question 13 above, I refer to complaints and concerns raised by others in relation to security guards of which I was made aware.

134. These were cause for some reservations, but in each event, the employer or lead contractor of the guard removed them swiftly from the hotel workplace.

135. Greater cause for concern was the evidence of poor physical distancing (meals at shift breaks shown by CCTV at Rydges Hotel and after-shift meetings observed by our hotel site staff at the Stamford) and poor hand hygiene (reported to me by the Operation Soteria Commander following an infection prevention and control review) because this showed that neither the policies provided

[43] DHS.0001.0001.0040
[44] DHS.0001.0012.0702
[45] DHS.0001.0012.0520

or the extensive community messaging on these key precautions had effectively impacted their behaviour. Operation Soteria Command and I discussed this shared concern and they included work with the Behavioural Insights Unit at the Department of Premier and Cabinet to develop opportunities to drive behavioural change within the security workforce, alongside their more intensive infection prevention and control training and temperature and symptom screening of guards prior to each shift in mid-to-late June 2020. These concerns were also the subject of discussion between the Secretary and I, (referred to at 59 above) which partly triggered the opportunity to develop the Options Paper on alternative security arrangements in late June 2020.

15. Did you have any views about the use of:

(a) Australian Defence Force personnel;

(b) Victoria Police Officers or Protective Services Officers;

(c) Private Security Contractors; and

(d) others,

in supporting and enforcing the Detention Orders in relation to the Hotel Quarantine Program?

If so, what were those views; when did you form them; to whom did you relay them; and what response, if any, was there to your expressing those views?

Victoria Police Officers or Protective Services Officers

136. I was not involved in any decision-making about the extent of the police presence 'on site' at hotels – that is whether they should have a 'round the clock' presence (as opposed to being in place at certain sites during the day and otherwise 'on call' via 000). However, I did discuss the merits of seeking more frequent patrols and greater visibility at hotel sites with the State Controller for the safety of staff rather than the enforcement of the Direction and Detention Notice. I understand these requests were made to the Senior Police Liaison Officer at the State Control Centre at various times.

137. Absconding by travellers in breach of the Direction and Detention Notice did not, despite concern in the initial days of the program that it might, eventuate as a problem. I am not aware of any issue during the Program where police were requested to assist any incident at a hotel and they did not respond in a timely way. Police played an important role in dealing with situations arising for detainees involving domestic violence or other forms of abuse, threats of physical harm, or behaviour associated with mental health issues.

138. I had presumed prior to this health emergency, that the Victoria Police would have a more extensive role in the implementation and control of a detention program required under a direction by the CHO under the PHW Act. That is also the option I put forward in the June 2020 Options Paper (referred to at 59 above). The PHW Act does not provide for Victoria Police to be directed to implement and lead the program unlike statutory schemes in other jurisdictions, and they cannot be AOs. While I consider these options ought to be examined in future proposals to amend

the PHW Act, it is difficult to estimate the difference in outcomes a Victoria Police-run hotel quarantine would have from a Department-run hotel quarantine operation.

139. While there were limits in the PHW Act that prevented Victoria Police officers from being AOs, powers to enforce other Directions were delegated to Police, and in my opinion this limitation did not impact their participation in supporting the hotel quarantine program in the role they played. If required, AOs present at the hotels were able to authorise Police action to detain a traveller under the Direction and Detention Notice.

ADF and private security

140. In relation to the use of ADF and private security, the enforcement of a Direction and Detention Notice can only be done by Victoria Police (as delegated under the PHW Act) and by AOs. ADF or private security cannot and were not options for enforcing PHW Act powers. In the broad sense, in the roles they had in Operation Soteria or the hotel quarantine operations, each supported the objective of the Direction and Detention Notice; which was effective detention to reduce the serious public health risk presented by returned travellers given international community transmission.

141. As noted in answer to question 14, I consider that given the scale of the hotel quarantine operations and the at times, uncertain and unpredictable arrival of travellers, the surge capacity that contracted security can provide is likely to be required to some degree in these operations.

16. What, if anything, do you consider that:

(a) the Department;

(b) other government departments or private organisations;

(c) you,

should have done differently, in relation to the Hotel Quarantine Program?

142. I have attempted to comment throughout my statement on matters where I think there were shortcomings or difficulties in the Program. I believe a number of these shortcomings were a result of the urgency of the emergency environment and the substantial logistical task that was undertaken.

FURTHER INFORMATION

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

143. I have commented throughout on matters I believe could be improved in any future Hotel Quarantine Program.

144. I would like to highlight four improvements for the future I would suggest be examined for implementation based on my experience in this health emergency and previous ones:

(a) ***Educating more of the Victorian Public Service about the emergency management*** arrangements in order to enable the full range of skills and experience of the Victorian Public Service (VPS) to be called upon for roles in emergency management in large-scale, long-duration and/or concurrent emergencies. With a greater understanding of the roles and structure of emergency management, including their own agencies' roles as Control or Support Agencies, members of the VPS would be able to more fully provide surge response to an emergency impacting the community.

(b) ***Expand the emergency workforce surge capacity across the VPS:*** The effective management of emergencies in Victoria relies on a pre-identified surge workforce. Prior to last summer's season for example, the Department's surge list included approximately 600 pre-identified, approved and trained staff, willing to be called away from their usual roles to assist. The Department has customarily maintained a substantial surge workforce largely due to its accountabilities as a Support Agency in financial hardship relief across the state, but the composition and availability of this surge capacity reduced considerably with the transfer of disability support services under the National Disability Insurance Scheme to the non-government sector.

An emergency of the scale and duration of this COVID health emergency has required many thousands of staff (with regulatory, communication, specialist emergency management, clinical and social work expertise and corporate, policy and administration skills) well beyond the capacity of Victorian government departments and agencies.[46] This followed the bushfires experience where the limited pool of surge specialists in areas such as drinking water, food safety, environmental health and epidemiology/surveillance outside the Department was apparent in responding to its public health impacts. This experience highlights the need for strategies to grow and sustain a multi-agency 'reserve' workforce of generalist and specialist staff, ready and able to deploy on demand and typically for more frequent, complex, longer duration emergencies.

(c) I have mentioned earlier the need for ***consideration of legislative change to the PHW Act***. First, changes that would reduce unnecessary calls on AO 'surge' for hotel quarantine by adopting approaches in other jurisdictions such as use of a general quarantine order issued to all returning travellers rather than each individual, travellers can then be required to provide necessary information or undertake tests, and a wider range of officers can be appointed as AOs. In particular, the current requirement under section 200(6) that AOs are engaged to check that detention remains 'reasonably necessary to eliminate or reduce a serious risk to public health' for each individual detainee each day seems unnecessary when detention can only occur under a state of emergency in order to reduce a serious public health risk presented by the cohort of 'returned travellers'. Second, as discussed earlier I consider a mechanism for requiring

[46] DHS.0001.0093.0001 Critical EM Sector Workforce Needs 5 June 2020 – Mission Coordination Committee paper

and enabling the Victoria Police to lead a detention program established to protect public health should be developed and tested, perhaps using a similar mechanism to the declaration of a state of emergency itself (that is, advice to a Minister by the CHO of the need being necessary and then cabinet consideration of the action).

(d) ***Redesign of the 'Class 2' health emergency arrangements to better fit the nature of public health emergencies***, which differ from Class 1 (fire and flood) emergencies is the following key ways: each tend to be fundamentally unique and long running; control is often exercised only at state level, and not the traditional regional and local incident management assumed in the arrangements; and the relative roles and responsibilities of the Emergency Management Commissioner and the CHO under the PHW Act in the event of concurrent emergencies is not clear. Despite these differences, and the relatively low priority and focus provided to Class 2 emergencies within the emergency management arrangements currently, I do not advocate moving away from the *'all agencies all hazards'* approach. In the current COVID emergency, the State Control Centre incident management structure has adjusted in response to the multiple response and policy decision-making required at many levels, from incident control under the PHW Act in the Department, to the Mission Coordination Committee (of Secretaries), Victorian Cabinet and National Cabinet. It is flexible. The Department's response to the health and human services impacts of emergencies has benefitted of greater coordination with the emergency management sector in recent years. However, the understanding and documentation of effective arrangements for class 2 emergency needs to mature from a current tendency to apply a class 1 emergency model with only minor modifications to ensure they can be fully effective in managing health emergencies.

145. Having noted those proposed opportunities for improvements, I do believe, however, that the Program that was implemented in Victoria at such short notice (ie within 48 hours) was an enormous effort by all agencies involved. I cannot think of another operation that has required so much cross-agency cooperation for such a significant period.

146. All of us involved in the Program were committed to its contribution to reduce the public health risk by preventing COVID transmission into the community from returning travellers. As we have now seen in other jurisdictions, a risk of transmission exists from returned traveller to workers despite the differences between the programs. This knowledge makes the consequences of community transmission in Victoria from the three outbreaks in the Program no less disappointing.

147. I also acknowledge the great impact that this pandemic has had on the Victorian community. Particularly those who have lost loved ones or have become unwell. The 20,300 travellers that were quarantined in the hotels up to 30 June 2020 also made significant commitment through their cooperation with the program, to the health protection of everyone in Victoria.

Signed by ……..…….. **Print name**…Melissa Skilbeck……

at MELBOURNE on 4th September 2020