WITNESS STATEMENT OF PAM WILLIAMS

Name:	**Pam Williams**
Address:	Level 16, 50 Lonsdale Street, Melbourne, Vic, 3000
Occupation:	Department is Area Director – Barwon
Date:	9 September 2020

1. I make this statement to the Board of Inquiry in response to **NTP-139,** the Notice to produce a statement in writing (**Notice**) dated 1 September 2020. This statement has been prepared with the assistance of lawyers and Departmental officers.

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

QUESTIONS

Roles and Responsibilities

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

3. In my career, I have worked in Government and consulting, in people, issues and risk management roles. I have experience in operational, program and project management, partnerships and governance. I have also undertaken roles requiring strategic planning, policy development and advice, and management and conduct of research, audit and evaluation. Through these roles, I have undertaken extensive stakeholder engagement with community and sector leaders, and across Commonwealth, State and Territory Governments. I have also led efforts to embed responsiveness to population and client diversity into health and wellbeing policy and programs, focusing on more equitable access and outcomes for cohorts with specific and complex needs, such as refugees and asylum seekers, LGBTI and CALD people.

4. Roles of particular relevance include:

   (a) From 2000 to 2003, I was the General Manager of Performance Audit in the Victorian Auditor General's Office, leading the preparation of more than 25 reports to Parliament examining the efficiency and effectiveness of government service provision.

(b) In 2003 – 2004, as Director of Social Policy in the Victorian Department of Premier and Cabinet, I provided policy advice to the Premier and Cabinet on social and justice issues, and Secretariat services to two Cabinet Committees (Social Development and Community Support Fund) and to the Premier's Children's Advisory Committee (culminating in the establishment of the Children's Services Coordination Board and the Office for Children).

(c) Since 2004, I have worked in the Victorian Department of Health and Human Services (**Department**), initially managing the conduct of strategic projects to improve the planning and quality of health and human service provision. I have also led development of cross departmental diversity strategies in refugee and asylum seeker, LGBTI, CALD and men's and women's health, strategic projects and portfolio and corporate support services.

(d) Over the last 10 years, I have worked in a number of operational roles in the Department:

(i) Between 2009 and 2011, I managed the Department's bushfire recovery services following the Black Saturday Bushfires. Initially I managed relief in the severely impacted area of Flowerdale. For the following two years, I directed all Departmental bushfire recovery services: case management (over 5,500 households and individuals), community services hubs (in 10 most affected areas), temporary housing (over 520 families in 150 units in 4 temporary villages, donated caravans on private properties and public and community housing), and the community development program. I was an executive of, and oversaw the People side of the recovery for, the Victorian Bushfire Recovery and Reconstruction Authority.

(ii) From 2014 to 2015, I was Director Regions and Regional Strategy, responsible for Departmental operations through 8 regions, including health protection, emergency management, preventative health, rural health services, and community, alcohol and other drug and mental health services. I also had oversight of cemeteries and crematoria legislation, including governance of around 500 cemetery trusts.

(iii) Since 2016, I have been the Director, Barwon Area, with responsibilities as set out in response to Question 2.

5. I hold a Bachelor of Economics (Hons-First Class) from Monash University. I have also undertaken the following relevant further professional development courses and programs:

   (a) Mediation skills training and accreditation at the Resolution Institute in 2019;

   (b) Emergency Consequences Management, AIIMS 4 and CFA Organisational Leadership Courses in 2013-14;

   (c) Leadership Victoria Folio Program in 2013;

   (d) Company Directors Course at the Australian Institute of Company Directors in 2012; and

   (e) several courses undertaken through the Australian Emergency Management Institute in 2009-10.

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

6. My usual role within the Department is Director – Barwon Area. I have been in that role since 2016.

7. In that role, I am ordinarily responsible for:

   (a) leading and managing delivery of integrated human services at a local level to support vulnerable people to achieve the best possible outcomes. This work is done in partnership with external service providers, other government agencies and the local community and businesses;

   (b) delivery of child protection, social housing, and (until recently) disability accommodation and services. In transitioning to the National Disability Insurance Scheme, in 2019 I led closure of the last disability institution in Victoria, Colanda, and rehoused 74 residents in 15 purpose-built homes.

   (c) commissioning and performance monitoring of children and family services, family violence services, community health, mental health and drug and alcohol services, population health and community wellbeing programs; and

   (d) supporting the Department's emergency management responsibilities, specifically in recovery and the local responses to COVID-19.

8. Reflecting my experience in leading recovery from emergencies, I have advised and led on elements of the response and recovery from emergencies, including the 2015 Wye River fires, the 2018 St Patrick's Day fires and the 2019-20 Eastern Victoria bushfires (assisting in the establishment of the new agency, Bushfire Recovery Victoria).

Question 3: What role did you play in the Hotel Quarantine Program and for what were you responsible?

9. Within the COVID-19 hotel quarantine program, my role was Commander, Operation Soteria. This title was used interchangeably with the title DHHS COVID-19 Accommodation Commander.

10. On 3 April 2020, I commenced in the role of COVID-19 Accommodation Commander. Initially this role was intended to oversee a range of COVID accommodation programs, including Operation Soteria, Hotels for Heroes and relief accommodation for vulnerable people who could not safely self-isolate in the community. It quickly became clear that Operation Soteria's hotel quarantine program would be a significant and complex program that required specific attention. Over the following two weeks, I transitioned to focus solely on the command of Operation Soteria.

11. On 16 April 2020, the Operation Soteria Emergency Operation Centre (**EOC**) was established in the Department's office in Fitzroy. At this time, Operation Soteria was led out of the State Control Centre (**SCC**) by the Deputy State Controller (a role shared by REDACTE and REDA REDACT from the Department of Environment, Land, Water and Planning) and State Controller (a role shared by Andrea Spiteri and Jason Helps from the DHHS). On around 1 May 2020, the role of Deputy State Controller ceased and Operation Soteria command formally transitioned from the State Control Centre to the EOC under my command.

12. Given the 24/7 nature of the operation, it was necessary that the role of Commander be shared to manage fatigue and maintain operations. After initially rotating the twin role amongst the Deputy Commanders, Merrin Bamert became my 'twin' and shared the role of Commander. Ms Bamert was an appropriate person to share the role as her substantive role is an Operational Director of Emergency Management and Health Protection in the Department. Ms Bamert had been involved from the beginning of the COVID-19 emergency, and she is a trained nurse with experience in hospital emergency departments. Her skill set was highly complementary to my own.

13. I ceased working as Commander on 30 June 2020.

14. The primary purpose of Operation Soteria was to contain the COVID-19 virus by keeping people who had returned from international travel in a room in a hotel for 14 days. Unlike other States, very few exemptions from hotel quarantine were granted in Victoria. Our secondary purpose was to keep guests safe and comfortable for 14 days within their room.

15. The hotel quarantine program was a significant effort which involved the quarantine of 20,000 guests over three months. In the first week of the hotel quarantine program, the number of guests quickly reached over 2,000. After that, at any one time there were between 1,500 to more than 4,000 individuals in 10 – 16 hotels. Initially arrivals were mainly business travellers or people returning from holidays overseas, including people who had been on cruise ships with high rates of COVID-19 infections. Later, the Commonwealth worked with other countries to repatriate Australian citizens who may have been living overseas for some time. This led to many more families with young children, people with diverse languages and cultures, and complex medical and mental health issues being in the cohort of people in hotel quarantine.

16. Given this was a complex emergency with shared accountability across a number of agencies, I was responsible for the collaborative response of all the agencies in accordance with Part 7 of the Emergency Management Manual Victoria (**EMMV**).[1] The DHHS was the control agency given that this constituted a class 2 health emergency, and in the context of the collaborative response, each support agency retained responsibility for their own staff and contractors. As noted in paragraph 11 above, this collaborative response was managed through the State Control Centre until 30 April 2020. From 1 May 2020, the Commander role took up this responsibility and I became chair of the daily SCC meetings, which were the inter-agency coordination meetings between all agencies involved in the emergency response, including the Australian Federal Police (**AFP**), Victoria Police, Department of Transport (**DOT**), and Department of Jobs, Precincts and Regions (**DJPR**).

17. I also represented Victoria (along with the State Controller - Health) at the National Coordination Mechanism Managing Returns to Australia Working Group, which had membership of Commonwealth agencies including Australian Border Force, Department of Foreign Affairs and Trade and those State based personnel who held the equivalent of my role in hotel quarantine operations in other States. I also invited the Accommodation Commander, DJPR to attend given the importance of this information for their role in hotel activation.

[1] Emergency Management Manual Victoria (EMMV), Part 7, at 7-1. A copy of the EMMV is at DHS.0001.0027.0108.

18. As Commander, I was responsible for the day to day management of Operation Soteria command. My duties and responsibilities included:

    (a) oversight of the DHHS operations in Operation Soteria, through the EOC;

    (b) oversight of the Operation Soteria chain of command, being:

        (i) Deputy Commanders: Deputy Commander Hotels; Deputy Commander Welfare; and Deputy Commander Ports of Entry (Airports and Maritime);

        (ii) Operational Team Leaders;

        (iii) Hotel Team Leaders (being one DHHS Team Leader on the ground at each hotel, and the airport); and

        (iv) EOC Support, including planning, logistics, communications, public information, welfare coordinator and staff safety officer.

    (c) Reporting to the Deputy State Controller until 30 April and from 1 May 2020 the State Controller – Health.

19. Operation Soteria Command worked with other parts of the Department's response, and with other government departments and agencies involved in the emergency response, including the AFP, Victoria Police, DOT, and DJPR. Operation Soteria Command did not have direct authority or legal or practical control over:

    (a) contracting, contract management and performance monitoring of hotels, private security companies and cleaning companies, which was the responsibility of the support agency, DJPR; or

    (b) authorised officers (**AOs**), who, as regulators of hotel quarantine detention, were managed through the Department's Enforcement and Compliance Command; or

    (c) clinical direction to onsite medical services, including nursing and mental health nursing, which was provided in accordance with the clinical governance framework developed by the DHHS' Public Health Command.

20. Further detail on the role of Operation Soteria command over time is included in the Operation Soteria Plans:

Date of document	**Document Name**	**Document ID**

28 March 2020	Operation Soteria Plan V1	DHS.0001.0001.1475
26 April 2020	Operation Soteria Plan V2	DHS.5000.0079.0864
8 May 2020	Operation Soteria Plan V2.1	DHS.0001.0008.0517
26 May 2020	Operation Soteria Plan V3	DHS.0001.0001.2245

Accommodation

Question 4. In your view, were hotels suitable and adapted from the perspectives of:

(a) infection control; and

(b) the health and wellbeing of people in quarantine?

Why or why not? Please provide relevant documents.

21. In relation to infection control, hotels have limitations as quarantine facilities. Hotels are not hospitals or COVID wards in hospitals. The features which make hotels comfortable for guests, such as carpets, drapes and soft furnishings, are not found in hospitals. Hotels also do not have some of the features found in hospitals such as wide corridors and large lifts which enable physical distancing and easy access to handwashing facilities and clinical and other waste disposal. However, a range of actions were taken by the hotels to manage infection control, which are described further in response to Question 8.

22. In relation to the health and wellbeing of people in quarantine, many guests found it difficult to spend 14 days in one room, especially families with young children and those experiencing mental health issues. This was particularly challenging for guests having made long journeys, and who in some instances had already been subject to restrictions in their country of departure. Particular concerns related to access to supplies and food brought in from outside the hotel, access to alcohol and tobacco, and access to fresh air.

    (a) While guests were confined to their rooms, the Department, DJPR and the hotels aimed to make guests comfortable, providing cleaning products, linen and towels on request, tea and coffee supplies, free internet access, and other essential needs such

as baby supplies (including cots and nappies) and sanitary products. These were requested through the Government Support Service (**GSS**) which had been set up by the DJPR, and were sourced, funded and provided by DJPR. Through May and June, these requirements increased significantly as more families with young children arrived – at times we had up to 600 infants and children under 18 years staying in the hotels. From early June, DJPR started to tighten up provision of the essential supplies, referring people to supermarkets where they could purchase their own supplies through on-line ordering. Guests were able to receive two care packages from family/friends and were able to order groceries and food deliveries. Initially this was very controlled, with strict limits restricting perishable food, home cooked food, etc, as the hotel rooms did not have food storage or cooking facilities. There were also concerns about guests receiving dangerous or illegal items, such as knives or drugs.

(b) Alcohol provision was a source of concern for guests and debate between DJPR and the Department. Hotels were prepared to sell alcohol to guests but were not comfortable with guests bringing in or buying their own alcohol. In some cases, individuals with alcohol dependence were, following medical review and decision, permitted to buy alcohol in a controlled manner to manage their dependence. Given the hotels were smoke free, tobacco was not permitted in hotel rooms.

(c) Access to fresh air and recreation was difficult to provide in the hotels. The fresh air breaks were difficult to implement safely and without transmission risk due to the limitations of many of the hotels (many did not have balconies, rooftops, or open areas that could be sectioned off from the public to reduce flight and transmission risk). The DHHS developed a fresh air policy and DJPR and Department safety officers worked with the hotels, AOs and security firms in April and May to develop specific fresh air procedures for each hotel.[2] For example, in one case we leased a section of laneway from the City of Melbourne and in other cases we used rooftops and balcony areas.

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[2] The Fresh Air policy is within the COVID-19 – DHHS Physical Distancing and Public Health Compliance and Enforcement Plan dated 4 April 2020 and available at [DHS.0001.0008.0674]. Subsequently, the Exercise and Fresh Air Implementation Plan (v 1) dated 15 April 2020 was developed and is at [DHS.5000.0003.2831]. The Implementation Plan included an Exercise Area Checklist which was to be completed by the Site AO, DJPR Site Manager, Hotel General Manager and Security General Manager. Completed checklists for hotels include Mercure Welcome [DHS.5000.0023.6495], Crown Promenade [DHS.5000.0028.7672 and DHS.5000.0028.7670], Crown Metropol [DHS.5000.0028.7671], Crowne Plaza [DHS.5000.0024.5277], Four Points Hotel [DHS.5000.0022.7165], Travelodge Southbank [DHS.5000.0003.7519], Holiday Inn Melbourne Airport [DHS.5000.0028.7683], Holiday Inn Flinders Lane [DHS.5000.0028.7684], The Marriott [DHS.5000.0028.7695], Novotel Collins [DHS.5000.0028.7707], Pan Pacific Hotel [DHS.5000.0028.7718], Park Royal [DHS.5000.0028.7719], Rydges on Swanston [DHS.5000.0028.7720] AND Stamford Plaza [DHS.5000.0028.7721]. Subsequently an exercise protocol was developed for Rydges Hotel, The Exercise Protocol – Rydges Hotel dated 12 May 2020 which is at [DHS.5000.0003.1195].

Despite best efforts, most guests received very few fresh air breaks in their 14 day stay. This was particularly difficult for some people, especially smokers (who were provided nicotine replacement therapy), those with claustrophobia or anxiety, and families with young children. As a result, the nurses prioritised those guests for more fresh air breaks. My understanding, based on conversations I had with counterparts in other States, is that in other States at this time, guests were rarely permitted to leave their rooms (other than, for example, for health emergencies). Application of the Charter of Human Rights and Responsibilities Act 2006 (Vic) (**Charter**) was the driver for the greater level of movement out of rooms in Victoria. Guests appealed to the Victorian Ombudsman, their MPs and the media to support their access to leave for compassionate reasons and fresh air. To assist people to cope, the Department commissioned a bespoke wellbeing program prepared by Peter MacCallum Cancer Centre which included exercise sessions suitable to undertake in a hotel room, activities for children and wellbeing resources. This became available from 12 June 2020.

23. In addition, in relation to the health and wellbeing of guests, some guests required substantial physical and mental health and welfare support, including pharmacy supplies. This was particularly so as the volume and complexity of guests increased, consistent with the changing demographic, from holiday makers and business travellers to individuals and families being repatriated.

    (a) From arrival, information was collected on the health and welfare needs of guests. Often there was an urgent need for pharmacy supplies and there were guests with significant medical and mental health conditions, and social complexity.

    (b) Many guests applied to be allowed to home quarantine due to their health conditions or complex personal circumstances, but these permissions were rarely granted. This decision was made by the Department's Enforcement and Compliance team after consultation with the Deputy Commander – Welfare, who provided an assessment of whether it would be possible for the guest to be supported within hotel quarantine. As a result, we had guests with significant health and mental health issues who found it very difficult to be in hotel quarantine.

    (c) Guests with medical, mental health or other complexities were able supported by the nurses, mental health nurses and doctors on site, as well as remotely by the Department's Complex Assessment and Response Team (**CART**). The CART was established at the commencement of the program to support guests with complex welfare concerns, including family violence, child protection, care of the elderly and

potential homelessness on departure from detention. It also supported decision-making of the Enforcement and Compliance team (as described in paragraph (b)) and assessments for the provision of additional accommodation post the quarantine period (primarily for interstate guests). The CART staff were mostly qualified social and welfare workers. Arrangements were made for referrals of guests where indicated to other health and social services. Communication with guests also included the 24 hour GSS telephone line, a weekly newsletter, daily screening check telephone call (provided by nursing staff), and days 3 and 9 welfare survey calls. Guests were also able to contact hotel reception, who could pass on concerns to Department Team Leaders.

Question 5: In your view, would another or other environment(s) or facility/facilities have been more suitable or better adapted from the perspective of:

(a) infection control; and

(b) the health and wellbeing of people in quarantine?

Were these options considered either in lieu of, or in addition to hotels, as part of the Quarantine Program? Why or why not? Please provide relevant documents.

24. Given the direction on 27 March from National Cabinet in relation to hotel quarantine which was required to be in effect by 11.59pm on Saturday 28 March, and the substantial numbers of people who arrived within the first few weeks of the hotel quarantine program and continued arriving, my view is that it is unlikely that any alternative option to hotels could have been stood up effectively. Victoria had experienced non-compliance with the isolation directions from some individuals in self-isolation at home. I am not aware of bespoke quarantine facilities for such a large number of people. Also, at the time, hospitals were on stand-by for a feared influx of COVID-19 patients.

25. However, other possible mixed models include hospitalisation for all COVID-19 positive guests or admission to a hospital managed medi-hotel or a mixed model of hotel and home quarantine (discussed further in my response to Question 15 below). Consideration was being given by the Department to these models at the time when I ceased working in hotel quarantine. This work was being led by the Deputy Secretary, Regulation, Public Health and Emergency Management, to consider sustainable models for quarantine going forward. From around late April, I contributed to this work by feeding back lessons learned and what was and was not working operationally in hotel quarantine.

Cleaning

Question 6. Please describe the cleaning practices, procedures and standards in quarantine hotels. If those practices and procedures differed during different time periods or at different locations, please specify.

26. Responsibility for hotel cleaning was as follows:

    (a) Guests were responsible for:[3]

        (i) cleaning their own rooms and were given cleaning materials for that purpose;

        (ii) placing rubbish, dirty linen and towels in bags outside of their hotel room.

    (b) DJPR contracted with hotels on the basis that the hotel was responsible for cleaning of guest rooms prior to the start of their stay and as soon as practicable after their stay.

    (c) the hotels had their usual obligations for cleaning their own common areas although DJPR later contracted the cleaning of the common areas with commercial cleaners at the Stamford Hotel following the outbreak; and

    (d) DJPR was responsible for contracting the commercial cleaning of COVID positive rooms in hotels at the end of each quarantine period.[4]

27. Over the course of the hotel quarantine program, the Department provided advice to DJPR about the practices, procedures and standards to be expected of cleaning in quarantine hotels, consistent with then current public health advice. As knowledge of COVID-19 and public health advice evolved, that advice was updated, but remained generally consistent.

28. On 20 March 2020, the Department publicly released a guidance document on "Cleaning and disinfecting to reduce COVID-19 transmission: Tips for non-healthcare settings". A copy of it is available at DHS.0001.0015.0323**.** This advice was described to "all non-healthcare settings in Victoria… equally to domestic settings, office buildings, small retail businesses, social venues and all other non-healthcare settings". This document was published on the

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3 COVID-19 – DHHS Physical Distancing and Public Health Compliance and Enforcement Plan dated 4 April 2020 page 35 [DHS.0001.0008.0674], Annex 2 – Health and Wellbeing (v2) dated 1 June 2020 contained within OS Plan (v3) dated 26 May 2020 [DHS.0001.0001.2245].

4 Annexure A, Agreement for Professional Services: Cleaning Services at Hotel Quarantine Sites between The State of Victoria as represent by its DJPR and IKON Services Australia Pty Ltd dated 13 April 2020 at DHS.5000.0001.3943.

Department's website on 22 March 2020, with a minor update made on 22 March 2020. Requirements included:

(a) routinely (at least daily) clean frequently touched surfaces;

(b) wear gloves for cleaning and disinfecting, and for cleaning and disinfection of spaces where there had been suspected and confirmed cases of COVID-19 , wear a full-length disposable gown in addition to the surgical mask, eye protection and gloves if there is visible contamination with respiratory secretions or other body fluid;

(c) thoroughly clean surfaces using detergent (soap) and water;

(d) apply disinfectant (for instance, antiviral, bleach or methylated spirits) to surfaces using disposable paper towel or a disposable cloth, ensuring surfaces remain wet for the period of time required to kill the virus (contact time) as specified by the manufacturer or otherwise for 10 minutes;

(e) in situations where a suspected or confirmed case remains in a facility that houses people overnight (for example, a boarding house or hotel), focus on cleaning and disinfection of common areas. To minimise any risk of exposure to staff, only clean or disinfect bedrooms/bathrooms used exclusively by suspected or confirmed case as needed; and

(f) soft furnishings or fabrics that cannot be bleached or washed in a machine should be cleaned with warm water and detergent to remove any soil or dirt then steam cleaned.

29. On 4 April 2020, the Department published an additional guideline "Cleaning and disinfecting to reduce COVID-19 transmission: Building and construction sites". The advice was consistent with the advice provided in "Cleaning and disinfecting to reduce COVID-19 transmission: Tips for non-healthcare settings" with the:

(a) omission of the advice specific to housing overnight guests referred to in paragraph 28(e) above; and

(b) confirmation that DHHS will notify employers when a worker has been diagnosed with COVID-19 and has been at the relevant work premises whilst infectious and advise the employer if cleaning and disinfection was required. The employer remained responsible for applying the principles of the advice to conduct relevant cleaning and disinfection.

30. On 8 April 2020, prior to the activation of the Rydges Hotel, I was copied on to an email sent from the Department to DJPR, in response to a request from DJPR for confirmation of the cleaning requirements for rooms once vacated, specifically those that have had confirmed COVID-19 cases, and whether disposal of rubbish should be treated any differently in hotels that are housing quarantined or isolated guests. A copy of that email is at DHS.0001.0015.0287. The email:

    (a) referred to and attached the then current guidelines for health services and general practitioners, which was included the detail on cleaning for COVID-19. A copy of the guidelines titled "Coronavirus disease 2019 (COVID-19) Case and contact management guidelines for health services and general practitioners" dated 5 April 2020 is at DHS.0001.0095.0001.

    (b) referred to and attached the Department's 20 March 2020 cleaning advice ("Cleaning and disinfecting to reduce COVID-19 transmission: Tips for non-healthcare settings"), as described in paragraph 28 above. The email stated that the advice "would work for every space aside from those with COVID positive people in rooms".

31. The requirements of the guidelines referred to in paragraph 30(a) above included:

    (a) cleaning using a neutral detergent followed by disinfection using a chlorine-based disinfectant at a minimum strength of 1000ppm, or any hospital-grade, TGA-listed disinfectant with claims against coronaviruses or norovirus, following manufacturer's instructions;

    (b) droplet and contact precautions (i.e. single-use surgical mask, eye protection, gown and gloves) should be used during any cleaning and disinfection of a room;

    (c) airborne and contact precautions (i.e. P2/N95 respirator mask, eye protection, long sleeve gown and gloves) should be used during any cleaning and disinfection of a room where there has been an aerosol generating procedure performed within the previous 30 minutes;

    (d) disposal of all waste as clinical waste; and

    (e) bag linen inside the patient room, with wet linen to be double bagged.

32. During an Operation Soteria meeting at the SCC on 13 April, DJPR advised that they had arranged a contract for hotel room cleaning for COVID-19 positive guests, but were still awaiting a response on the cleaning protocol for non-COVID-19 positive rooms. A copy of the

meeting minutes is at DHS.5000.0032.0492. I had many discussions with Rachaele May over the following two weeks; however, I do not now specifically recall what we discussed about cleaning.

33. On 27 April, I received advice from the Department's Public Health Command that cleaning contractors for hotels should be referred to the document "Cleaning and disinfecting to reduce COVID-19 transmission: Tips for non-healthcare settings" described in paragraph 28 above. A copy of that email is at DHS.5000.0001.8769. I forwarded this advice to DJPR the same day.

    (a) On 27 April, DJPR replied requesting confirmation that the advice applied equally to hotel rooms, and whether any period of settling was required for COVID-positive rooms prior to cleaning. A copy of that email is also at DHS.5000.0001.8769.

    (b) On 28 April, the Department's Infection Prevention Control (**IPC**) team provided advice to DJPR that the cleaning and disinfection advice document previously provided to DJPR is equally applicable to the hotel setting for cleaning COVID positive hotel rooms and that there is no period of 'settling' required unless an aerosol generating procedure (e.g. nebuliser on a confirmed case) was undertaken, which is highly unlikely to have occurred in a hotel room. A Team Leader from the Department subsequently confirmed that to their knowledge, no nebulisers were used. A copy of that email is at DHS.5000.0002.1028.

34. On 29 April, during an Operation Soteria meeting at the SCC, DJPR advised that they were finalising the contract with commercial cleaners for cleaning of the Rydges hotel. A copy of the minutes is at DHS.5000.0032.0548.

35. Following the identification of a positive case in a staff member at the Rydges hotel:

    (a) On 26 May, I received advice from the Department that a clean of all common areas, and the cases' direct work areas will need to occur, and requesting certain information about the Rydges hotel. I forwarded that email to Rachaele May at DJPR, asking her to discuss with me and stating that we needed to speak with the Rydges management as soon as possible. A copy of those emails is at DHS.5000.0001.9597. I had many discussions with Rachaele May over the following days, including about the need for the contact tracing team to deal directly with the hotel management and other companies, and giving the contact tracing team the names and contact details for people who had been on site. I do not now specifically recall what we discussed about cleaning.

(b) On 27 May, following a site visit, the Department's Outbreak Management team advised that a bio clean and deep clean were required. A copy of that email is at DHS.0001.0021.0025.

(c) On 27 May, I received advice that DJPR had contracted a private supplier, IKON, to clean the hotel on the morning of 28 May. I received that advice by email from the Deputy Commander Hotels, forwarding an email chain from DJPR. A copy of that email is at DHS.5000.0016.5724. The Deputy Commander, Hotels advised that the clean was required for that night of 27 May DHS.5000.0002.0484. DJPR advised that IKON was unavailable to clean that night and the clean took place the following morning, the 28 May.

(d) On 29 May, I was copied in to advice provided to COVID-19 Health Coordination recommending that there be "at least once daily cleaning + disinfection (using a disinfectant for which the manufacturer claims antiviral activity) of all common areas at the Rydges hotel frequently by staff including all high touch surfaces AND lifts", recommending that a commercial cleaning company should be able to provide that level of cleaning, and attaching the guidelines "Cleaning and disinfecting to reduce COVID-19 transmission Building and construction sites- 4 April (1)" referred to in paragraph 29 above. Health Coordination forwarded the advice to DJPR and asked for confirmation of when the arrangements were locked in. A copy of the email chain is at DHS.5000.0076.4849.

(e) On 1 June, I was copied on to an email from DJPR requesting public health advice on the preferred approach to providing infectious cleaning across COVID positive guest rooms in all quarantine hotels, a Rydges full bioclean and a cleaning regime for the Novotel (where guests from the Rydges were to be transferred). A copy of that email is at DHS.0001.0015.0208.

36. During the month of June, DJPR received input from the Department's IPC Cell, the Public Health Command and Safer Care Victoria, to reiterate the cleaning guidance that had been provided, including more specific detail, in response to DJPR's request of 1 June.

37. On 16 June, the Department issued advice titled "Hotel Quarantine Response – Advice for cleaning requirements for hotels who are accommodating quarantined, close contacts and confirmed COVID-19 guests updated". A copy of that advice is at DHS.5000.0003.1597. I provided a copy of the advice to DJPR on 17 June 2020, confirming it had been approved by the Deputy Chief Health Officer for immediate use DHS.5000.0001.8954. In summary, the advice provided for:

(a) cleaning and disinfecting (as provided in paragraph 28(a) to 28(d) above) of frequently touched surfaces in all common areas of COVID positive hotels twice daily using gloves;

(b) carpets and other fabric surfaces in common areas to be vacuumed with a vacuum cleaner containing a HEPA filter and hard floors to be cleaned and disinfected daily;

(c) COVID positive or transiting passenger guest room to be deep cleaned, including soft furnishings and fabric covered items cleaned as provided in paragraph 28(f) above) upon exit;

(d) waste to be disposed in the general waste stream; and

(e) when cleaning and disinfecting rooms of confirmed COVID-19 cases or transiting passengers, wear a full-length disposable gown, surgical mask, eye protection and gloves.

38. Following the release of this updated advice, I had a number of discussions with DJPR regarding the operational impact of the cleaning protocol, which they advised would result in a hotel taking 11 days to be ready for new arrivals after an exit. I discussed this impact and possible solutions with Safer Care Victoria and the Department's IPC Cell. Advice was provided on 25 June and then updated with a final version on 28 June 2020. Copies of the 25 and 28 June advice are at DHS.5000.0107.7462 and DHS.5000.0001.9636.

39. On 8 June, the Department had also issued a formal policy for the disposal of clinical waste titled "Operation Soteria Clinical and Waste Related Guidance" dealing with the disposal of clinical waste (including any items used to treat or test a patient). Clinical waste was required to be disposed of in specially provided clinical waste bins. A copy of the policy is at DHS.5000.0003.9660 and I understand may have been available on Microsoft Teams and was included with the guidelines for the DHHS Team Leaders.

Question 7. Did specific cleaning practices or procedures apply in respect of spaces occupied by guests who had tested positive for COVID-19? If so, what were they? If those practices and procedures differed during different time periods or at different locations, please specify and provide details.

40. As set out in my answer to Question 6 above, specific cleaning practices or procedures applied in respect of spaces occupied by guests who had tested positive for COVID-19:

(a) The cleaning requirements described in "Coronavirus disease 2019 (COVID-19) Case and contact management guidelines for health services and general practitioners" referred to in paragraph 30 and 31 above, which the Department instructed could be applied to COVID positive hotel rooms.

(b) The advice provided to DJPR on 28 April described in paragraph 33(b) above (that the cleaning and disinfection advice document previously provided to DJPR is equally applicable to the hotel setting for cleaning COVID positive hotel rooms).

(c) At least once daily cleaning and disinfection (using a disinfectant for which the manufacturer claims antiviral activity) of all common areas including all high touch surfaces and lifts, as per the advice provided to DJPR on 29 May 2020, as referred to in paragraph 35(d) above.

(d) The requirements set out in the updated advice "Hotel Quarantine Response – Advice for cleaning requirements for hotels who are accommodating quarantined, close contacts and confirmed COVID-19 guests updated" provided to DJPR on 17 June 2020 and described in paragraph 37 above.

(e) The requirements set out in the revised advice provided to DJPR on 28 June 2020 [DHS.5000.0001.9636] and described in paragraph 38 above.

Infection Control Training

Question 8. What measures did the Department take to ensure that:
(a) hotel properties utilised; and
(b) staff working,
within the Hotel Quarantine Program had adequate infection control measures (including education, training and protocols) in place? What were they?

41. The following aspects of the hotel quarantine program were designed to reduce transmission risk and support specific infection control measures:

(a) **at entry ie the airports or ports**. Procedures were established to limit risk, with a clear focus on containment, infection risk and use of social distancing, hand hygiene and PPE by Victorian and Commonwealth staff and contractors.[5] Special arrangements were put in place for the plane from Uruguay carrying people from the

[5] See procedures in COVID-19 – DHHS Physical Distancing and Public Health Compliance and Enforcement Plan dated 4 April 2020, pages 18-19 [DHS.0001.0008.0674] as well as in Operation Soteria Plan (v1) dated 28 March 2020 [DHS.0001.0001.1475], (v 2) dated 26 April 2020 [DHS.5000.0001.3583] and (v3) dated 26 May 2020 with Annexures dated 1 June 2020 [DHS.0001.0001.2245]

Gregory Mortimer cruise ship (arrival at a separate hangar and all processing airside with no movement through the terminal). For all incoming flights, nurses undertook symptom and temperature testing and anyone with COVID-19 symptoms or other significant medical or mental health issues were transported directly to Royal Melbourne Hospital by ambulance. To limit risk and delay at check-in at the hotels, couples and family groups were identified and the information relayed to the hotel (via DJPR) to enable room allocations to occur while people were being processed at the airport and transferred to the hotel. This became increasingly complex as the numbers of families and related family groups increased over May and June. It was not always possible to allocate rooms according to family preferences, for example it was rarely possible to allocate rooms with balconies when requested since these existed in very few hotels. In addition, to limit transmission risk and simplify operations in the hotels, attempts were made to house all arrivals from each plane in the one hotel so that their transit to the hotels was a continuation of any contact with the same people with whom they had shared a flight.

(b) **transport to the hotels, and allocation into rooms**. Skybus were contracted by the Department of Transport for transport and made special arrangements to limit the numbers in the bus for social distancing and to protect drivers. AFP and Victoria Police escorted the buses. As set out above, transit to the hotels was generally a continuation of any contact with the same people with whom they had shared a flight. On arrival at hotels, buses were unloaded sequentially to ensure social distancing and guests were allocated rooms. Luggage was unloaded with the help of security and concierge staff. Each hotel varied in its capacity to maintain safe social distancing depending on the size of its foyers and the number of lifts. At entry, all staff wore PPE and guests wore masks and had access to hand sanitiser.

(c) **face to face interaction with guests in/at rooms**. The Detention Notice confined guests to their rooms and prevented them from allowing entry of any other person into the rooms, unless approved by the AO.[6] To operationalise this, there was no room cleaning service – guests were provided with cleaning products and were able to request linen and towels that they could change themselves. Meals and other items (parcels, linen, etc) were left outside the doors for guests to pick up. Meals were provided in disposable containers which were not re-used. Otherwise, most interactions with guests were via telephone, including the 24/7 GSS line (managed by DJPR), daily calls by the nurses and two more detailed welfare survey calls during

[6] A template detention notice is available at page 48-49 of Annex 1 – COVID-19 Compliance Policy and Procedures – Detention Authorisation v2, 24 May 2020 [DHS.0001.0013.0006].

each guest's period in quarantine. However, if guests were unwell with COVID-19 or any other medical or mental health issues, nurses and doctors in PPE would come to the rooms accompanied by the AO. Most interactions were at the door to the rooms but this was not always possible. There were significant numbers of people who required attendance at some point during their stay, but most did not. The number of these interactions, and the associated risk, increased significantly to include all guests at least twice during their stay with the introduction of testing of all guests on Day 3 and Day 11 from early May. This was established quickly with clear protocols to reduce infection and transmission risk for the testing teams allocated to each hotel on testing day. The protocols required that the nursing staff wore PPE and undertook the swabbing at the door to the room to reduce infection risk; the nurse performing the swabbing procedure was required to doff PPE after each room, and the whole team changed PPE when they changed floors.[7]

(d) **hotel environment adapted:** modifications were made to the physical set up of the hotels to reduce transmission risk. Hotel lobbies were cordoned off to encourage swift movement through the spaces. Hotels were encouraged to remove or limit soft furnishings. Lifts were assigned to 'clean' and 'dirty' purposes to reduce cross-infection. Staff on site were separated into specific zones to prevent cross-infection.

(e) **movement of guests out of and return to their rooms.** While guests were detained to their rooms, they were permitted to leave and then return to their rooms if authorised by an AO, to receive medical care, for compassionate reasons and for fresh air and exercise, as well as where identified positive COVID guests were moved from their rooms as described further in sub-paragraph (e) below. There were both flight and transmission risks posed by these movements which were managed through use of AO permissions, PPE and appropriate transport arrangements. Medical care included emergencies where ambulances were used and travel to appointments (eg cancer treatments) where non-emergency patient transport (**NEPT**) was used. Compassionate leave was provided for people to, for example, attend funerals and visit dying relatives. In these cases, taxis were mostly used with the taxi companies implementing specific PPE and infection control and cleaning strategies.[8]DJPR were responsible for arranging taxis and enforcing PPE and cleaning policies for taxis. DJPR also kept records that could be used in contact tracing where need be. The

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7 PPE requirements for nursing staff were set out in the document titled "PPE Advice for Hotel-based Healthcare Workers Contact with COVID-19 Quarantined Clients", as described in my answer to Question 9 below. A copy of the advice is at [DHS.0001.0001.1358].

8 PPE measures required for the transfer of COVID positive guests were set out in "Operation Soteria Positive Diagnosis Guidance" [DHS.0001.0001.1348] discussed further below.

fresh air breaks were difficult to implement safely and without transmission risk due to the limitations of many of the hotels (for instance, they did not have open areas that could be sectioned off from the public to reduce flight and transmission risk). The DJPR and DHHS safety officers worked with the hotels, AOs and security in April and May to develop specific fresh air procedures for each hotel as discussed in response to Question 4.

(f) **when a guest became COVID positive.** Until the end of June, around 218 guests tested positive for COVID while in the hotel quarantine program. This number represented around one per cent of the 20,000 guests in the program to the end of June. In late May and June when the community numbers of positive cases were very low, positive cases in hotel quarantine represented up to 30% of all active cases in Victoria. Initially, COVID positive guests and in some cases their close contacts were moved to a separate floor in their hotel – often known as the red floor – to reduce the potential for transmission risk and to focus staff on appropriate infection control. However, the numbers of COVID positive in any hotel were quite small and holding a whole floor for those guests limited access to all the rooms in the hotel at a time when there were between 3,000 and 4,000 guests to be accommodated at any one time. On 22 April, the Deputy CHO agreed that all COVID positive guests should be moved and held in a specific COVID hotel (Rydges on Swanston) to improve operational efficiencies and focus support for those with COVID. Rydges on Swanston had already been activated to house the passengers from the Gregory Mortimer cruise ship which had a high rate of COVID positive cases. From late April, all guests who became COVID positive and in some cases their close contacts were moved by NEPT to the COVID hotel. This focused the highest transmission risk in one hotel. This was consistent with the approach taken in NSW, except that NSW had access to two medi-hotels, located in the grounds of the Royal Prince Alfred Hospital, which were used for all COVID positive guests and those with significant medical issues. In Victoria, this was not available, so we continued to care for people with COVID in the COVID hotel and people with medical issues remained in the other quarantine hotels, unless they received permission to quarantine at home.

(g) **cleaning and re-filling of hotels**. The process of placing plane-loads into a single hotel until it was full and moving COVID positive guests to a specific hotel meant that after about 14 – 16 days we would have a totally empty hotel which would be able to be fully cleaned, re-stocked and be ready for a new set of guests after a few days. This resting of a hotel possibly reduced risks, although the IPC Cell advised that there was no scientifically proven length of time after which any COVID virus would no

longer be active. DJPR held the contracts relating to cleaning, both through hotels who undertook day to day cleaning and specific cleaning companies who undertook cleaning of rooms where COVID positive guests had stayed. DJPR sought clarity around cleaning protocols from the early days, and the Department passed on advice from the Public Health Command IPC Cell which directed DJPR to advice on the Department's website for commercial premises and then health services, as described in my response to Questions 6 and 7 above. The Infection Control consultant from Infection Prevention Australia visited hotels and made suggestions for improvement that were shared at the hotels and with DJPR. Following the outbreaks, there was further, more focused, work done by the IPC Cell to advise on the best approach to cleaning as discussed in more detail in my responses to Questions 6 and 7, above.

42. Operation Soteria Command sought and followed public health advice about IPC measures for the hotel quarantine program. That advice was continuously improved over time, as the understanding of COVID-19 and public health advice evolved. As set out in paragraph 42 above, the hotel quarantine program was designed to reduce infection risks; in particular, to reduce physical contact with guests and thereby reduce the need for more stringent and specific IPC and PPE measures. Aside from medical and nursing staff personally assisting guests, it was generally expected that all staff working on site would maintain physical distancing from guests during their stay in hotel quarantine. All other staff were expected to comply with the same physical distancing and hygiene (in particular, hand hygiene) requirements that applied in the community. Staff were expected to follow policies created to reduce IPC risk and described further in paragraphs 43, 44 and 45 below.

43. Procedures for entry and exit were designed to reduce transmission. The process for entries is discussed in paragraph 42 (b). For exits, guests were advised beforehand of the approximate time they would be leaving. To limit time in the lobby, End of Detention Notices were delivered and hotel check-out procedures such as payments for telephones, special meals, etc were undertaken the night before. At the allocated time, guests received a knock on the door from security and were escorted to the lobby. The numbers exiting at any one time were controlled to ensure social distancing and guests wore masks. After the End of Detention Notice was signed off, guests were escorted directly to taxis. By providing transport at exit, the potential for community interaction was reduced.

44. Policies for transfer of persons identified as COVID positive to the COVID positive hotel were designed to reduce transmission risk. For instance the “Operation Soteria Positive Diagnosis Guidance” dated 27 April 2020, provided that transfer from hotel quarantine to the COVID positive hotel should be by the rear seat of a maxi taxi to support social distancing, with the guest wearing PPE (masks and gloves) and provided with wipes and/ or sanitiser. Taxis were

to be advised of transfer requirements to ensure adequate hygiene measures and were requested to arrive with PPE (masks and gloves) or be provided PPE by the exiting hotel. A nurse and security guard in PPE were to meet the arriving guest and escort them to their room. Taxis were to be cleaned observing IPC measures after transport. A copy of the guidance is at DHS.5000.0003.1249.

45. Policies for fresh air breaks and evacuations were designed to reduce transmission. From around 20 April, a Department safety officer was appointed for hotel sites, who worked with DJPR safety officers and hotel management to finalise protocols for fresh air breaks and evacuations specific to each hotel.[9] In relation to fresh air breaks:

    (a) they were not conducted during entries and large exits, while meals were being delivered and while medical emergencies were taking place, to decrease the likelihood of contact between guests and staff;

    (b) immediately before a guest was allowed to leave their room for a fresh air break, they were to confirm they were well, confirm they have washed their hands immediately prior to leaving the room, don a facemask and perform hand hygiene. Guests were additionally reminded to not touch any surfaces internal to the hotel whilst travelling to the fresh air exercise area;

    (c) COVID positive and symptomatic guests were not permitted to leave their room for fresh air breaks.[10]

46. A supplementary evacuation procedure developed by the Department and DJPR, with Safer Care and Victoria Police input, provided that guests were to wear PPE, security were to remain 1.5 metres away from guests and wear masks in the event of an emergency situation requiring evacuation.

47. Written policies and procedures applicable to Departmental roles within the hotels, such as AOs and Department Team Leaders, were communicated to Department staff via email, soft copies were accessible on dedicated Teams sites, hard copies were available at the hotels from various dates, and they were also referred to and reinforced at team leader meetings.

[9] Copies of the fresh air plans and policies are referred to in paragraph 22(c).

[10] Annex 1 – COVID-19 Compliance policy and procedures – Detention Authorisation, dated 29 April 2020 [DHS.5000.0030.1397].

48. Policies on PPE were established for circumstances in which physical distancing was not achievable, including the higher risk circumstances described in paragraphs 43 to 45 above. Those policies are described in further detail in my response to Question 9 below.

49. Reinforcing consistent uptake of IPC messaging by security and other staff was a challenge. The Department early on sought specialist advice to identify IPC risks and improve uptake of IPC messaging, and continued to do so throughout my time in the hotel quarantine program. Messaging was reinforced to staff on site through team leader briefings.

    (a) In April 2020, Infection Prevention Australia (**IPA**) was engaged to support infection control procedures at the hotels, including reviewing IPC measures and the use of PPE by staff at hotels and providing recommendations.

    (b) On 5 May, IPA provided a report on the Rydges hotel, recommending that regular nursing staff with competence in caring for patients requiring transmission based precautions be rostered at the hotel, but otherwise had no further recommendations for the COVID hotel. The report also covered a review of the other hotels, and confirmed that managers at the various hotel sites considered the information for correct use of PPE to be very useful, and IPA found the set ups for the health care teams were very good, and PPE was appropriate. I was provided the report on 14 May. A copy of the report is at DHS.5000.0095.8961.

    (c) On 17 May, IPA was tasked with reviewing IPC and PPE use by healthcare workers for day 3 and 11 testing across hotels and for security at Rydges.

    (d) On 17 June, the Department engaged the Behavioural Insights Team of the Department of Premier and Cabinet to improve understanding and uptake of IPC and PPE advice, particularly amongst security guards. I supported this project, which was led by the Deputy Commander Welfare, and ultimately handed over to health coordination and the clinical lead. The team provided a report on 23 June, a copy of which is at DHS.0001.0001.0711.

50. After the identification of positive cases at the Rydges and later the Stamford hotels, the Department continued to seek advice, work to identify gaps, and embed IPC and PPE practices. In the context of the Department's outbreak response, the Outbreak Management Team identified that security contractors at Rydges were not practising social distancing or using appropriate PPE, and hotel staff were also not using appropriate PPE. At the Stamford hotel, the team identified gaps in PPE and IPC knowledge and the need for ongoing

educational resourced to address a fluid workforce. The response, under the direction of the Outbreak Management Team, included the following.

(a) Additional cleaning measures were put in place and cleaning advice refined and formalised, as described in my answers to Questions 6 and 7 above.

(b) From 27 May, the Outbreak Management Team visited on site to review the site. During their review, they demonstrated correct hand hygiene and PPE education to staff on site over a number of days, including security guards, hotel staff, nurses and Department staff.

(c) A deep clean of the hotel (as referred to in paragraph 35(c) above) followed by a further deep clean when the Outbreak Management Team determined the first team was not sufficient. Subsequently, the Outbreak Management Team continued to monitor cleaning standards, with concerns being passed back to DJPR.[11]

(d) The Infection Prevention and Control Outreach Team conducted site visits to the Stamford Hotel and provided education on site to cleaning staff.

(e) On 22 June, separate meetings were held with each of the three contracted security companies to discuss amongst other things appropriate IPC and PPE usage, co-chaired with Rachaele May of DJPR and me, and led by the Department's Infection Prevention Control cell. This followed on from an email exchange between Rachaele May and me about seeking a formal response from the security company at Rydges in respect of security staff briefings, training, PPE usage, and expectations.[12]

(f) From 22 June, temperature and symptom screening was required for all staff working on site.

(g) In late June, infection control consultants delivered PPE training to cleaning staff at the Stamford Hotel and observed cleaning practices.

51. From late May Operation Soteria Command began working with Alfred Health to engage them to provide all clinical staff and infection control governance and training at the hotels, envisaging a senior nurse to take responsibility for infection control issues. It was also proposed that they should provide streamlined clinical governance and oversight of all functions at the COVID-19 positive hotel, with clinical staff, auxiliary staff and security staff all being drawn from individuals experienced in the infection prevention and control requirements

11 See, for example, email from Merrin Bamert to DJPR dated 17 June 2020 at DHS.5000.0001.6586 .

12 DHS.5000.0001.7672.

of hospital environments. This was to be implemented sequentially, beginning with the Brady's hotel for COVID positive cases in mid-June. This work was underway when my assignment completed at end June 2020.

Personal Protective Equipment (PPE)

Question 9. Who was responsible for providing:
(a) PPE; and
(b) training as to correct use of PPE,
to people (including nursing staff, hotel staff, private security staff and employees of the Victorian Public Service) working at quarantine hotels? If your answer differs for different locations or different time periods, please specify.

PPE

52. To achieve the primary purpose of containing the COVID-19 virus, it was important to ensure that staff remained safe and well. It was expected that each agency undertook responsibility for their own staff and contractors, including to ensure their contractors were provided with suitable PPE.

53. This meant that the Department was responsible for providing PPE to Departmental staff including Hotel Team Leaders and AOs, as well as nursing staff contracted by the Department. The Department required a designated staff member on site at hotels to be responsible for managing stocks of PPE, including designating a secure room for storage and checking and recording daily stocks of PPE, with an aim to have 5 days' worth of stock, and otherwise to order further PPE. This advice was confirmed in a policy titled "Operation Soteria – PPE for Quarantine Hotels" dated 6 May. A copy of the policy is at DHS.5000.0003.1256_.

54. It was my understanding that DJPR was responsible for providing PPE to DJPR staff on site and providing training as to its correct use, as well as for making contractual arrangements with hotels and security guards in relation to PPE and training as to correct use of PPE. I understood that the security contracts between DJPR and security firms required security firms to source and provide their own PPE and charge the cost to the DJPR. Similarly, I understood that hotels were required to source and provide their own PPE for hotel staff. However, in practice:

    (a) I understand that, in the first few days of the program, DJPR's contractors were initially unable to access sufficient quantities of suitable quality PPE. As a result, the Department made surgical masks, gloves and hand sanitiser available to all staff who

required it on site. Department staff on site were instructed to ensure there was enough PPE on site.

(b) On 19 April 2020, I received an email from Rachaele May at DJPR which referred to shortages of PPE for DJPR's hotel based staff. A copy of the email is at DHS.5000.0027.0889.

(c) Around 17 May, Rachaele May from DJPR again raised with me the issue of responsibility for the provision of PPE. I discussed the matter with people in the Department and responded to Rachaele the following day. At that time, the only hotels at which DHHS had formally agreed to supply PPE for security and hotel staff, in addition to its own staff and contractors, was the Crown complex hotels. However, I understood that the supply of PPE to non-Department staff and contractors by the Department had nonetheless continued at some other hotels to ensure that PPE was always available. By this time, PPE was readily available. I suggested that the Department communicate (what I understood had been the original intention) that all departments be responsible for supplying appropriate PPE for their allocated workforce including contractors. Rachaele May replied the following day, suggesting that the DJPR's contractors be given two weeks to begin supplying their own PPE, with the Department to continue supplying PPE in the interim. A copy of that email chain is at DHS.5000.0001.6170.

(d) I subsequently initiated an audit of PPE usage by non-Department staff at each hotel site, and sought costings for the Department to take responsibility for all PPE provision in the hotels. The audit identified that the Department continued to supply PPE to non-Department staff at 8 hotels, including the Crown complex. A copy of the results are at DHS.5000.0015.0179.

(e) Operation Soteria Command determined that it would be better if the PPE were provided by the Department so it could be managed more directly. As at 30 May, the Department's hotel team leaders were advised to provide PPE to all staff onsite, including security and hotel site, for consistent use of PPE.[13] At the same time, discussions were occurring regarding the transfer of the security contracts from DJPR to the Department (something that did not ultimately occur). I intended to codify the responsibility for purchase and provision and capacity to direct PPE usage as a Departmental responsibility in the contractual arrangements with hotels and security firms from 1 July. This work was underway when my assignment completed at the

[13] DHS.5000.0015.0179.

end of June, but I understand the transfer of contracts to DHHS did not ultimately occur.

Training as to correct use of PPE

55. I expected that each agency undertook responsibility for their own staff and contractors, including to ensure their contractors were provided with training as to correct use of PPE.

56. The Department was responsible for providing training to its own staff on site (hotel team leaders and AOs) as to correct use of PPE. The Department was also responsible for providing training to its contracted staff on site, noting that the Department's contracted nursing and medical staff could be assumed to have familiarity with correct use of PPE.

57. The Department published formal advice on what PPE was required to be used for particular activities at hotel quarantine sites, based on the then current public health advice. Posters were displayed on site and the policies formed part of the standard operating procedures for Team Leaders in the hotels:

    (a) On 1 May 2020, the Department issued "PPE Advice for Hotel-based Healthcare Workers Contact with COVID-19 Quarantined Clients". A copy of the advice is at DHS.5000.0003.9690. The advice set out the requirements for health care workers (that is, nursing and medical staff) working at quarantine hotels, in different situations.

    (b) On 5 May 2020, the Department issued "PPE Advice for Hotel-Based Security Staff & AOs in Contact with Quarantined Clients". A copy of the advice is at DHS.5000.0023.1373. The advice was emailed to Unified Security and to DJPR on 12 May, following a meeting that had been held with Unified Security that day. A copy of the email is at DHS.5000.0023.1372.

        (i) The advice provided that security staff were to wear a mask when physical distancing was not feasible, and otherwise to maintain hand hygiene. Gloves were not recommended for any security staff at any time.

        (ii) The advice included instructions on hand hygiene and cough etiquette, and the appropriate procedure for putting on and removing a mask.

    (c) On 8 June, the Department issued a revised version of "PPE Advice for Hotel-Based Security Staff & AOs in Contact with Quarantined Clients". A copy of that advice is at DHS.5000.0001.8212. The advice regarding the use of masks remained the same as the advice of 5 May 2020, and included additional information about the

circumstances in which hand hygiene was required and further details about appropriate mask usage.

58. The Department:

(a) provided PPE signage at hotel sites which depicted how to don and doff PPE which was prepared with advice and assistance from the Royal Melbourne Hospital in April 2020 (an example of the signage is at DHS.5000.0003.2294);

(b) conducted daily stand up phone calls with Department team leaders on site reiterating the need to practice social distancing, hand hygiene, cough etiquette and appropriate PPE use;

(c) through team leaders on site, reiterated PPE messaging and called out practices in the hotels in their discussions with staff on duty, including security, as required;

(d) contracted a specialist IPC consultant to review practices in the hotels and to provide advice on use as described in paragraph 49 above;

(e) implemented additional IPC and PPE training measures following the identification of transmission at the Rydges Hotel, as described in paragraph 50 above.

Question 10. In your view, was the PPE and training as to its correct use provided to people working at quarantine hotels adequate? Why or why not?

59. The availability of appropriate PPE, and understanding of, and training in, how to use PPE, were challenging issues.

(a) Initially, there was insufficient PPE across Australia, so, while the hotels and security primarily provided their own PPE, the Department sourced and provided PPE to staff on site if required.

(b) Throughout the program, there were disagreements about the PPE that was required. Security guards were keen to wear gloves, when the Public Health advice was that hand hygiene was more effective where there was no direct contact with guests. Nursing staff were keen to use P2 and N2.5 masks when the advice from the Department's Public Health team (and at the time the Commonwealth Government[14] and the World Health Organisation) was that surgical masks were sufficient other than for aerosol generating procedures.

[14] A copy of Australian Health Protection Principal Committee's statements published on their website on 14 May 2020 is available at DHS.1000.0003.0001.

(c) As set out in my answer to Question 9 above, in around 30 May, we discussed with DJPR making a clear requirement for security to purchase and pay for their own PPE and preventing access to the Department's supplies.

60. There were a range of challenges in understanding of, and training in, how to use PPE.

(a) As described in paragraph 49 above, through May, Operation Soteria Command became aware of some instances of improper use of PPE by some security guards. This was reinforced by the reports provided by the infection control consultant from Infection Prevention Australia, who had been engaged to review practices in the hotels and to provide advice on use. The consultant discussed with security staff their over-usage of PPE and insufficient focus on social distancing and hand hygiene. Accordingly, the initial focus was on to educating people about social distancing and when to use appropriate PPE to address the following issues:

(i) people using PPE that was not fit for purpose (e.g porous gloves);

(ii) people using PPE inappropriately (e.g. wearing gloves to the bathroom);

(iii) people using PPE that was not consistent with then current public health advice for the particular circumstances (e.g. security guards using PPE when physical distancing was achievable).

(b) In late May, when the Department audited PPE usage across hotels as described in paragraph 54(d) above, it became apparent that not all staff were receiving PPE training, in large part due to different shift times when training was conducted.

(c) Following the Rydges outbreak, the Outbreak Management Team identified a range of challenges in embedding correct PPE usage at hotels as described in paragraph 50 above.

Cooperation with other departments and agencies

Question 11. 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?

Australian Defence Force personnel

61. Decisions about the use and allocation of ADF staff in security roles were made before I commenced in my role. In late May, I had discussions with people leading other State hotel quarantine programs in which I learned that ADF personnel were used in some States for a period of time to assist with security. Based on my discussions with interstate colleagues, I understood that use of the ADF was likely to have been short term and in support of other security personnel. In my previous experience, ADF emergency support can also be tightly constrained in its scope and can be withdrawn for other uses when other ADF operational imperatives intervene.

62. On around 15 April, ADF members (reservists) were deployed to Operation Soteria Command to assist to develop standard operating procedures for the hotels and set up a document management system. They were later withdrawn with a few days' notice to assist in planning for the opening of the Victorian ski fields.

63. Many travellers had a difficult journey on their way back to Australia. When people arrived at the airport, it was confronting for them to face nurses in full PPE, Australian Border Force personnel, AOs, as well as usual airport staff. They were then directed through the rear of the arrivals terminal to board buses to be transported to the hotels. I believe that an ADF presence upon their arrival at the hotels may have been a daunting experience, particularly for people from war-torn countries.

64. I did not express any views about the more extensive use of ADF during my time in the hotel quarantine program.

Victoria Police Officers or Protective Services Officers

65. Decisions about the use and allocation of Victoria Police in security roles were made before I commenced in my role. In late May, I had discussions with people leading other State hotel quarantine programs in which I learned that police played the primary role in security in all other States. However, I understand that they were usually assisted by private security who played a greater role as time went on. As with the ADF, in my view, police were unlikely to have been available in significant numbers in the longer term due to other operational priorities.

66. In Victoria, police supported the hotel quarantine program and took a leadership role, including calling a forum on 16 April with key agencies and the security companies to discuss better coordinating the shared interest in security, law enforcement and community assurance roles during the self-isolation and release period. I was not present at this forum because I was not rostered on that day.

67. Police were not generally in attendance at the quarantine hotels, except on entry and exit days when they provided traffic management support. I requested police presence at the initial exit.

68. When an incident occurred in the hotels, staff rang 000 to seek police attendance. Police would attend quickly to the hotel, but at times the officers were reluctant to go up to the floors, presumably due to concerns about the virus. I understand that individual instances were fed back to the relevant superintendents. I did not personally raise issues about this at the time.

69. As the hotel quarantine program continued, in around early June, I formed the view that it would be useful if police had a constant, visible presence at the hotels, which would have improved enforcement and response times for incidents in the hotels and supported the enforcement role of the security services (including potentially reducing the number of for security presence on site). I intended to raise this once DHHS assumed the contract responsibility from DJPR, but my assignment ceased before that time.

70. Protective Services Officers were not used during my time working in the hotel quarantine program and I have no view about their use.

Private security contractors

71. I was not working in the hotel quarantine program when the initial decisions were made regarding employment of private security guards. I am aware that initially there was a high level of concern that guests would depart the hotels without authorisation, so high numbers of security were put in place by DJPR, in consultation with Victoria Police and the Department. However, in my experience, guests were very compliant, with few known attempts to leave hotels without authorisation and rare cases of guests attempting to leave their rooms unauthorised. In some cases, guests became agitated and threatened to leave. Security were instructed not to attempt to physically restrain guests, so the police were called and some guests were fined. This happened rarely. A few guests claimed on social media that they had left their rooms. The Department Team Leaders and the AOs investigated any instances of which they were made aware, and found no evidence that guests had left their rooms. In these cases, the AO reminded guests that they could be fined for leaving their rooms.

72. As a result, in around 25 June, I came to the view that it would be appropriate for there to be reductions in the number of security staff, with security staff to monitor exit doors and work on a roving basis in the hotels. I felt that this would also reduce boredom among security staff, and therefore reduce the risk of these staff engaging in behaviour that could increase the risk of transmission. I discussed this with the DJPR Accommodation Commander and in mid-June

DJPR consulted with the security contractors and reduced security staffing by 25%. DJPR indicated that there were further reductions possible that would not compromise the detention arrangements.[15]

Question 12. 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?

73. Please see my answer to Question 11 above.

End of detention

Question 13. What was the policy for when people were permitted to exit quarantine? If a different policy applied at different times, or in different locations, please specify. Please provide any relevant documents.

74. Between 28 March and 28 June, consistent with the public health advice and then current public health directions, all guests were permitted to exit quarantine after the 14 day quarantine period expired. In the event a guest had tested positive during their stay in hotel quarantine:

(a) the guest was permitted to depart if the guest could safely self-isolate as required by the *Isolation (Diagnosis) Direction* (as amended from time to time)[16] consistent with the requirements that applied to other members of the community who tested positive;

(b) travel to an interstate residence was not permitted until after the relevant isolation direction has been completed and clearance provided;

(c) if the guests were subject to the *Isolation (Diagnosis) Direction* (as amended from time to time) and did not have a safe place to self-isolate, the Department would support the guests to stay in emergency relief hotel accommodation, subject to the relevant public health direction.

75. AOs were responsible for monitoring the ongoing requirement for mandatory quarantine during the 14 day period and issuing exit documentation to guests at the end of the 14 day period. Information about this policy and process is contained within Annex 1.[17] This policy was also broadly canvassed in Annex 3 – Covid-19 Operational guidelines for mandatory

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15 See email from Rachaele May on 25 May 2020 titled FW New Model Security [DHS.5000.0001.9077].

16 Copies of the various versions of the *Isolaion (Diagnosis) Direction* are available at [DHS.2000.0001.0029], [DHS.5000.0003.3169].

17 Annex 1 COVID-19 Compliance Policy and Procedures – Detention Authorisation (v 1) dated 29 April 2020 [DHS.5000.0030.1397], Annex 1 COVID-19 Compliance Policy and Procedures – Detention Authorisation (v2) dated 24 May 2020 [DHS.0001.0013.0006] and Annex 1 COVID-19 Compliance Policy and Procedures – Detention Authorisation (v 2) dated 1 June 2020 [DHS.0001.0001.2245].

quarantine (v2) dated 1 June 2020 which is at DHS.0001.0001.2245 (at page 16). The Operation Soteria Exit of Accommodation Arrangements which is at DHS.5000.0003.1356 also outlined the operational arrangements for the exit of guests.

76. On around 20 April, I sought advice from Public Health on the arrangements for guests leaving quarantine when positive or awaiting test results. Based on that advice, on 27 April 2020, I approved “Operation Soteria Positive Diagnosis Guidance”. A copy of the guidance is at DHS.0001.0001.1348. The guidance is consistent with the summary in paragraph 74 above.

77. From around 4 May, all guests – even if asymptomatic – were offered voluntary COVID-19 testing on days 3 and 11 of their detention. I understand that Victoria was the first jurisdiction to offer testing even where people were not symptomatic. Prior to this time, consistent with then current public health advice, COVID testing was only offered for symptomatic guests.

78. The day 3 and 11 testing policy was subsequently codified in the policy 'Operation Soteria Enhanced Testing programme for COVID-19 In Mandatory Quarantine”, which was issued on 21 May 2020. A copy of the policy is at DHS.5000.0003.2647. Additionally, a fact sheet about the availability of day 3/11 testing was published for detainees. A copy of the fact sheet is at DHS.5000.0003.1670.

79. On 1 July 2020, a further public health direction (the Detention and Direction Order (No. 6) was issued requiring that guests who refused a COVID test were required to undergo a further 10 days of hotel quarantine. Guests who had been tested on day 11 and were awaiting results were permitted to leave hotel quarantine if they could safely home quarantine in Victoria. Although the direction did not come into effect until 1 July 2020, from 27 June, the Department offered all guests who had not consented to day 11 testing a further opportunity to be tested before their 14 day quarantine period expired. All guests consented to testing and were able to leave quarantine at the end of the 14 day period.

Complaints and issues

Question 14. Did you or identify or receive notice of any poor or unacceptable conduct by any person in connection with the Hotel Quarantine Program? If so:

(a) what were the details;

(b) how were those issues dealt with; and

(c) what was the outcome?

80. Two significant clinical incidents occurred in hotel quarantine. Safer Care Victoria reviewed the incidents and made no findings of poor or unacceptable conduct but made some

recommendations for improvements. I was in the process of setting up a governance structure and Implementation Plan to address the findings at the time my assignment ceased.

81. On 12 April, I became aware of complaint about a security contractor making inappropriate and suggestive comments to a guest.[18] I understand the guard was subsequently not rostered to the hotel quarantine program (however, as security rostering was a matter for DJPR, I cannot confirm).

82. On 14 April, I became aware of a complaint about a security contractor leaving an inappropriate note under the door of a guest.[19] I understand the guest was provided with welfare support and DJPR addressed the matter with the relevant security company.

83. On 20 April I was forwarded an email chain dated 8, 9, 10, 11, 14 and 20 April between DJPR and Wilson Security regarding concerns about the adequacy of the security contractors at the Pan Pacific arising from a number of matters, including an incident where security contractors failed to intervene when a guest became aggressive towards a nurse.[20] I understand that DJPR followed this matter up directly with Wilson Security.

84. On around 10 May, I became aware of complaints about security contractors at Rydges on Swanston including in relation to IPC, inappropriate use of, and missing, PPE, sexual harassment, and non-compliance with directions from AOs, Department team leaders, and hotel and nursing staff.

    (a) The complaint was made by a Department team leader on site by telephone to the Deputy Commander Hotels, and subsequently followed up by email.[21]

    (b) The Deputy Commander Hotels escalated the complaint to DJPR.

    (c) On 12 May, DJPR commenced an inquiry into those allegations, with the assistance of the Deputy Commander Hotels, the Operation Soteria Command Safety Officer, and a DHHS Operations Team Leader. The Operations Team Leader coordinated an information gathering exercise from Department Team Leaders and nursing staff on site, which was provided to the Deputy Commander Hotels.

    (d) The outcome was that the security company stood down the subcontracted security company responsible for the incidents.

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18 DHS.5000.0001.8657.
19 DHS.5000.0001.8552.
20 DHS.5000.0001.8418.
21 DHS.5000.0022.8608.

85. On 14 May, I also became aware of an allegation that a housekeeping contractor left a note of a sexual nature under a guest's door and sent an explicit message to one of the guests at the Novotel Southwharf on 13 May 2020.[22] I understand that the Hotel followed the matter up with the cleaning company and the contractor was subsequently stood down. The guests were moved to a different room for the remainder of their stay, were followed up by nursing staff after they reported the incident and arrangements were made for the guests to only be contacted by female nurses, AOs and Department Team Leaders. Additionally, the matter was referred to DJPR for investigation.

86. On 15 May, I was informed that there had been an issue with two AOs sleeping during their shifts at the Park Royal Hotel and Holiday Inn.[23] The matter was escalated to, and handled by, Enforcement and Compliance Command.

87. In May, I became aware of an allegation about security guards sharing a couch and blanket at Rydges, which was inconsistent with social distancing requirements and therefore potentially created a transmission risk. One of the responses to this was the engagement of the DPC behavioural insights team, as described in paragraph 49(d) above.

88. In May and June, the Department's Outbreak Management Team identified a range of concerns around PPE and IPC, which I have described in paragraph 50 above.

89. On 10 June, I was copied into correspondence relevant to concerns raised by Pullman on Swanston hotel that a concierge contractor had potentially not used appropriate PPE while searching for guest belongings in a hazard bag.[24] This matter was followed up by Merrin Bamert.

90. On 14 June, I was copied into correspondence relevant to concerns raised about approximately 70 security contractors being observed onsite at the Stamford Hotel standing shoulder to shoulder in a six by six metre room.[25] This matter was escalated to DJPR by Jason Dodson and Merrin Bamert.[26]

91. On 22 June, I was advised that security contractors who worked at the Stamford Hotel were attempting to obtain work with Unified Security while they were potentially being required to self-isolate for 14 days as they were considered a close contact. I passed this information on to Simon Crouch (Public Health) and to Stuart Bailey (Enforcement and Compliance) who

22 DHS.5000.0002.0541.
23 DHS.5000.0076.9960.
24 DHS.0001.0023.0305.
25 DHS.5000.0095.5259 .
26 DHS.5000.0001.5453.

were the appropriate persons to deal with the matters raised. Stuart Bailey replied: "I understand that Unified Security declined to provide work to these individuals."[27]

92. I was aware of a couple of incidents involving inappropriate conduct of nursing staff. The Deputy Commander – Hotels assisted in dealing with those issues with the contracted nursing agencies.

Reflections on the Hotel Quarantine Program

Question 15. What, if anything, do you consider that:

(a) the Department;

(b) other government departments or private organisations;

(c) you,

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

93. Taking account of the operational context of the hotel quarantine program (discussed in response to Question 16), I make the following comments in relation to what should have been done differently in the hotel quarantine program.

The Department

94. **More nuanced assessment of the balance between transmission risk and guest health and wellbeing and human rights**: Hotel quarantine was based on the simple premise that detaining a person arriving from overseas inside a hotel room for 14 days would reduce the risk of transmission of the virus into the Australian community. Underpinning this premise is an assumption that the detention is possible (ie appropriate facilities exist and people will be compliant) and that the detention can be achieved without undue impact on the health and wellbeing of the detainee. From the beginning, the program was criticised on human rights grounds by guests, in the media, by MPs and by oversight bodies such as the Victorian Ombudsman for its impact on the mental health and wellbeing of guests. The program was required to support some people with significant medical and other complexities, who had expected to be granted an exemption to quarantine at home. There was pressure to provide opportunities for people to leave their rooms, not only for essential medical care, but also for compassionate reasons (for example, to visit sick relatives or to attend funerals) and for fresh air and exercise. This was challenging because any movement from rooms increased the risk of transmission, potentially defeating the purpose of quarantine. The flight and transmission

[27] DHS.0001.0101.0003

risks posed by these movements were managed through use of Authorised Officer permissions, PPE and appropriate transport arrangements.

95. **Consideration at some time earlier than May, of using a public health service to provide comprehensive medical, nursing, testing, mental health nursing and infection control services in the hotels**: The extent and complexity of clinical needs in hotel quarantine was substantial; direct service provision by a public health service would have assisted in managing those needs, both at the hotel and when escalation to hospital care was necessary. At the start of the program, hospitals were cancelling elective surgery and preparing for the possibility of large numbers of COVID positive patients as had occurred in other countries. However, by late May, this pressure on the health system had abated and we commenced discussions with Alfred Health. Alfred Health took responsibility for the Brady Hotel in mid June and was preparing for a roll out to all other hotels as I finished my assignment in the program. Given the cessation of visitor arrivals, Alfred Health's role was less extensive than originally envisaged.

96. **Consideration of cohorting all COVID-19 positive guests in hospital or a hospital managed medi-hotel**: This would be consistent with the approach taken in NSW, where two medi-hotels were located in the grounds of the Royal Prince Alfred Hospital and were used for all COVID positive guests and others with significant medical issues. In Victoria, a medi-hotel was not available, so we continued to care for people with COVID-19 in a designated COVID hotel; while guests with complex medical and mental health issues remained in the other quarantine hotels. Despite initial concerns about the State's hospital capacity, given the feared increase in COVID cases in hospitals did not occur, by mid-May, there was hospital capacity that could have been accessed, possibly in private hospitals.

97. **Better integration of elements of the COVID-19 response**: The response required the rapid implementation of public health advice which was itself changing as more became known about the virus. Information transfer and the development and approval of practical and policy responses to operational challenges around the implementation of the Directions, infection control, and cleaning needed to happen much more quickly than would usually be the case. Workplaces also had to change rapidly with most people working remotely. These new mechanisms for working together remotely, while challenging at first, have great potential to improve responsiveness and collaboration in future emergencies.

98. **More rapid appointment of longer-term staff:** In emergencies, the Department stands up a surge workforce, which is made up of staff who volunteer to assist on a short term basis while often still undertaking their business as usual role. The surge workforce approach works well in an emergency over a few weeks, but is harder to sustain over months. People working in

the program came from many different backgrounds and work experiences and there was significant turnover of staff over the period. Making longer-term appointments would have enabled more consistent staffing and a more conventional supervisory and team structure to support consistency in delivery through familiarity with the role and target training where necessary.

99. **Different options to meet the primary purpose of containing COVID spread from overseas arrivals**: as set out in paragraph 22 and 23 above, fourteen days of detention in a hotel room was difficult for many people, and relatively few proved to be carriers of COVID – of the approximately 20,000 guests up to end June, almost 99 per cent did not become COVID positive while in hotel quarantine. Guests who became positive usually did so within 7– 8 days of entering quarantine, so it may have been possible to consider a regime that quarantined people for a shorter period. Under this approach, those Victorian guests who tested negative, were not symptomatic or were not close contacts of those who were positive and who could effectively self-isolate at home could have been released under home isolation directions. Technology (mobile phone tracking, bracelets, etc) which was being developed in other countries, could then have been used to ensure compliance with the home isolation directions. In situations where people were not compliant with home isolation, they could have been returned to hotel quarantine to complete their 14 day stay. This approach would have reduced the distress of many guests, reduced the operational pressure on the program and reduced the costs of the program.

Other governmental departments and private organisations

100. Australian Border Force and Department of Foreign Affairs and Trade could have been more directive in their dealings with airlines to manage the numbers and arrival port of incoming travellers. This would have assisted the states to better plan for arrivals, especially NSW and Victoria who received the majority of returned travellers, including significant numbers from other states. Some witnesses to the Inquiry have been critical of the lack of planning and notice given of arrivals into hotel quarantine. This was not in the control of Operation Soteria. Hundreds of people flew into Melbourne every day and we had no choice but to accommodate them. The hotel quarantine program needed more notice of the number of flights, the number of travellers arriving and any specific needs of those travellers, especially the number of families with young children. I learnt from Western Australian colleagues that they had been receiving more detailed information for some flights, but this was not provided to all states or for all flights. I raised this issue at the National Coordinating Mechanism meetings and I also sought assistance from the Commonwealth agencies to enable more travellers to transit directly to their own state to undertake quarantine. This did not happen. At times, the Program received flights with 40% of arrivals from other states. Many of these people found it difficult to

get home to their own state, where they were sometimes required to undergo a second period of quarantine.

101. DJPR hotel team leaders could have been more present on site. The contractual arrangements by DJPR meant that DJPR hotel team leaders were the point of contact for hotel, concierge and security managers on site. Throughout the program they were responsive to issues raised with them. But, over time, the number of DJPR hotel team leaders reduced and they were not always on site, which reduced their situational awareness, their availability and their ability to proactively manage the day to day concerns which arose.

102. When the program was being stood up, many hotels had essentially closed their doors and laid off their staff. The contracts made the hotels were for very short periods and did not require them to re-employ their staff to provide a full range of hotel services. Hotels could have been contracted for longer periods with specific performance requirements including sole use by the program, improved food service (with increased quality and choice), reduced the rates for empty rooms and provision of more extensive concierge services (using their own re-employed staff, rather than Dnata staff contracted by DJPR).

103. Security services could have been reviewed earlier to reduce numbers and limit sub-contracting, the extent of which was not clear to me until this Inquiry. Initially, high levels of security were put in place by DJPR, in consultation with Victoria Police and the Department, as there was a high level of concern that guests would depart the hotels without authorisation. In fact, guests were very compliant, with few known attempts to leave their rooms without authorisation.

104. Monitoring and addressing the performance of security staff by the security companies and DJPR needed to take into account the specific needs and competency of a largely unskilled, casualised workforce, with high levels of turnover. The roles undertaken by security in the program were different to the roles many of these workers usually played. While on-line training around infection prevention and control was required of the security staff and additional reminders and advice were provided on site at hotels, the expectations needed to be reinforced more by the employers and by the contract managers.

105. As set out in paragraph 69 above, Victoria Police could have had a constant, visible presence at the hotels, which would have improved enforcement and response times for incidents in the hotels and supported the security services. I expected this would become more essential as the economy re-opened and people returned to the CBD.

Operation Soteria Command

106. **Fatigue management**: Operation Soteria required extraordinary effort from the leadership teams and staff across all the agencies involved. The expectations were high and the pressure was intense, with long hours and difficult situations to address, with operational guidance being developed contemporaneously. Many staff had just finished working through the bushfire emergency and, without a break, had moved onto hotel quarantine. The majority of staff were not able to be backfilled in their usual roles which added to the pressure. There was significant demand for staff across the whole COVID response, with hotel quarantine being only one part of the response. Resources were stretched. While action was being taken to fill roles more long term, it was difficult to keep pace with the demand.

107. **Information management**: Data quality issues contributed to the operational challenges in the program. Multiple data sets were not adequately harmonised. I commissioned work to identify the source of the data integration issues and to provide an approach to improvement. However, improvements were slow to be realised due to the pressures of delivery, the shortage of skilled and willing data specialists and the need to develop bespoke technological solutions across the whole operation.

108. **Policy influence**: The Department staff working in Operation Soteria performed their roles professionally, delivering against the standards set at the time. They provided advice and feedback on areas for improvement, which were acknowledged and implemented swiftly if that was appropriate and within the remit of the program. The leadership team provided feedback on all key policy documents and all our protocols and procedures received appropriate approvals before finalisation. Despite this, there were instances where the policies and protocols were disputed by those who needed to operationalise those policies and protocols (and by some guests in hotel quarantine – as being expressed in evidence to the Inquiry). The priorities of managing the day-to-day operations and its imperatives limited the capacity of staff in Operation Soteria to pursue the speedy resolution of these policy tensions more persistently, potentially incurring more risk for the program.

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

109. I wish to comment on the context in which the hotel quarantine program was operating. As experience across the world has shown, the COVID19 virus is difficult to contain; countries that appeared to have it contained are now facing new outbreaks. Knowledge of the virus and how it spreads has changed and the responses have therefore changed. Everyone working to address the spread of the virus has had to be agile and prepared to adjust policies and

procedures quickly. Even in the settings where you might expect there to be established, well-grounded policies, procedures and trained workforces, such as in our hospitals, there are outbreaks. When the virus is in the environment - even one case - it has the potential to spread through human contact. Once it starts to spread, contact tracing must be swift and accurate and infectious people and close contacts must be prepared to self- isolate immediately and completely. All elements of the response are inter-dependent, needing to work harmoniously and effectively in a complex, rapidly changing environment. It is in this context that hotel quarantine operated. My comments below speak to that interdependency, complexity and rapid change,

110. The hotel quarantine program was very large - in 3 months from end March to end June, 20,000 guests were quarantined in 10 – 16 hotels. At any one time there were 1,500 to more than 4,000 individuals in quarantine. During those 3 months, 218 guests tested positive for COVID-19. Seven of these guests, in 3 rooms, are implicated in the transmission of the virus out of the program in late May and early June. Hence 96.8% of those who tested COVID positive in hotel quarantine were successfully managed and not implicated in transmission. Hotel quarantine did initially help Victoria to flatten the curve and to protect its health system for a potential outbreak.

111. As expert evidence has shown, a small number of cases led to an explosion of infections. At the end of May/early June when the outbreaks occurred, overall numbers of COVID infections were falling and restrictions on movement had been relaxed. However, there were still high numbers of COVID positive overseas travellers, many with complex health and welfare needs, arriving into Victoria. If the community transmission profile of the first wave had been sustained for the hotel quarantine outbreaks, the numbers of infections would have been significantly lower.

112. Through my time in Operation Soteria, the understanding of COVID was evolving and all relevant government agencies were grappling with a range of COVID issues. Hotel quarantine was not the only program that required attention and resources. Experienced and knowledgeable staff were in short supply. The program went from concept to operational in two days. The speed of its establishment, the inability to predict incoming traveller numbers (and any special needs) before arrival, and the rapid escalation in numbers to be accommodated were challenging for everyone. While Melbourne rapidly transitioned to the majority of people working safely from home, hotel quarantine staff and contractors worked

on-site in the airports and hotels. They were seeing the reports of the devastation from the virus in other countries, and still they came to work.

113. Information and guidance were developed and adjusted as the program grew. While the Inquiry has heard criticism of changing policies and protocols, the alternative of not changing these in the face of new information would have been unthinkable. Extensive reference was made to training materials available on government websites about working in the COVID environment. ADF staff working in the program developed Standard Operating Procedures and processes for document management and change approval. This was the key reference document for Department staff working in the quarantine hotels. Reflecting the rapidly changing environment, DHHS Team leaders joined thrice-daily briefings with the Operation Soteria Emergency Operations Centre Operations Manager to raise issues and receive guidance. They passed this information on to relevant staff in the hotels.

114. The size of the hotel quarantine program meant that there were many organisations involved in its delivery. These organisations and their staff demonstrated high levels of flexibility and commitment to the task. In more conventional operations, the policies and protocols are developed over years, with the benefit of experience leading to continuous improvement. Ordinarily staff are appointed that bring high levels of relevant experience and skills to the program. However, the hotel quarantine workforce was brought together from diverse backgrounds and had not dealt with a similar program, or a program of this scale, with an unknown and invisible 'enemy' and a range of changing risks.

115. The Inquiry has heard evidence that those working in the program did not have timely information about guests that they felt they needed. Sometimes this was because the information could not be provided any earlier; for example, the details of traveller arrivals from Australian Border Force. At times there was no necessity for private information about individuals to be shared. Two examples demonstrate this:

    (a) Security companies raised the issue that they were unaware of who was positive and who was not. The staff in hotels were instructed that they needed to treat all guests on the basis that they could be carrying the virus. The transfer of COVID positive and close contact guests to the COVID hotel also minimised the likelihood of a guest with an infection being in the hotels.

    (b) DJPR raised the issue that, when they were preparing for exits, they did not know whether guests were positive or awaiting tests. DJPR was not involved in the exits from the COVID positive hotel, which reduced the risk that they were dealing with guests who were positive. For guests in the other hotels, DJPR's contractors in the

Government Support Service would contact guests to determine their onward travel plans so they could book taxis for them and give them an estimate of the exact time of their departure on Day 14. COVID tests were conducted on Day 11 and results were often not received until Day 13. However, as the vast majority were negative, taxis could be booked with a slight risk that one or two may not be needed or be directed to another hotel. While the lack of absolute certainty made the task less straightforward, the implications were minimal. The actual exit was always controlled by the Authorised Officer who had the most updated information regarding each person.

116. While hotel quarantine guests were legally detained, the vast majority complied because they wanted to help Victoria and Australia avoid the shocking outcomes that were occurring in the countries they had left behind. They deserve our thanks. The Department placed a high priority on providing for the health and wellbeing of guests within hotel quarantine. We also tried to maintain their privacy and protect their dignity. This focus on our clients is business as usual for our Department, particularly in the operational areas in which I work. I would like to record my thanks to the hundreds of workers who faced many challenges and worked so hard in the hotel quarantine program.

Signed at Melbourne

in the State of Victoria

on **9 September 2020**

Pam Williams