Name:	**Merrin Bamert**
Address:	Level 1, 50 Lonsdale Street, Melbourne, Vic, 3000
Occupation:	Director – Emergency Management, Health Protection & Population – South Division
Date:	9 September 2020

1. I make this statement to the Board of Inquiry in response to **NTP-140,** 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. I have the following qualifications:

   (a) Bachelor of Nursing;

   (b) Post Graduate Certificate in Critical Care, Emergency Nursing;

   (c) Graduate Diploma, Clinical teaching;

   (d) Masters of Education; and

   (e) Executive Masters of Public Administration.

4. I am a registered nurse.

5. I have worked for the Department of Health and Human Services (**Department**) (and its predecessor) since 2008 including in a number of Executive roles, including:

   (a) Assistant Director, System Design, Planning and Decision Support;

   (b) Acting Assistant Director, Person Directed Care and Worker Wellbeing;

(c) Acting Assistant Director, Workforce Planning and Capability;

(d) Acting Assistant Director, Integrated Care for Chronic Disease; and

(e) Acting Assistant Director, Workforce Strategy.

6. Prior to working for the Department, I held a number of nursing educator roles within both the private and public hospital sectors.

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

7. My usual role within the Department is as the Director – Emergency Management, Population Health and Health Protection, South Division. I maintained that role during the period I worked in the hotel quarantine program. The role is responsible for emergency planning, building community resilience, health protection and population health and wellbeing across the south of Victoria from Southern Metro Region through to Gippsland to Mallacoota. The role specifically involves:

(a) providing leadership in improvement, innovation and quality in preparedness planning, capability development and building resilience that minimise the impact of emergencies and health incidents on people, communities, clients and services, especially those most vulnerable;

(b) delivery of emergency management services involves the coordination and management of divisional emergency relief and recovery activities. Delivery of service occurs in accordance with the legislative provisions of the *Emergency Management Act 2013* and the Department's Emergency Management policy framework;

(c) being responsible for divisional health protection and related issues, such as the provision of advice on a range of public health areas such as communicable diseases, food safety, immunisation, environmental health and health protection related matters in emergencies;

(d) supporting the implementation of strategies that aim to improve the health and wellbeing of whole populations, reduce inequities among and between specific population groups, and address the needs of the most disadvantaged.

8. In an emergency, Directors of Emergency Management and Health Protection also hold the role of Regional Health Coordination. The Regional Health Coordinator (**RHC**) is an emergency function named in the State Health Emergency Response Plan and is responsible for coordinating activities of the Department and the broader health sector in response to a

health emergency at the regional tier. During this Class 2 emergency, I have fulfilled this position for the Southern Metro and Gippsland Region.

9. The RHC is responsible for coordinating activities that facilitate the health system to respond appropriately in an emergency at the regional tier. The functions include the provision of information and advice to the affected community, preparing situation reports, active briefing of the Department Commander (divisional and state tier) and State Health Coordinator, and maintaining communication flow at a local, regional and state level including with other agencies.

10. The Department also has responsibilities under the Emergency Management Manual Victoria to support elements of recovery post an emergency. I am currently responsible for leading a team supporting social recovery activities post the East Gippsland Complex Fire.

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

11. From the commencement of the hotel quarantine program from midnight on 28 March 2020 through to 30 June 2020, my role continuously evolved based on operational need, as I describe further in paragraphs 12 to 18 below.

12. On about Friday, 27 March 2020, I was tasked by the Public Health Incident Management Team, along with other executives, to be responsible for overseeing the COVID Directions call centre. This was in the capacity of my divisional health protection executive role. The call centre was a service made available by the Department for the public to call in and request further information and clarification of the public health directions (not specific to hotel quarantine) which had been issued under the authority of the Chief Health Officer (CHO) and Deputy Chief Health Officer (**DCHO**), such as the *Non-essential Activity Directions*.

13. On 28 March 2020, I was asked by Braedan Hogan, Department Agency Commander at the State Emergency Management Centre (**SEMC**), to establish a call centre to conduct a daily check-in of all returning passengers in hotel quarantine, commencing 30 March. I worked with Family Safety Victoria to develop a script for use by Department staff at the call centre, to assess immediate physical and mental health, family and social needs, that would trigger either their needs being met or the review by nurses onsite, medical review or review by a team of complex care specialists.[1] This call centre subsequently became the welfare cell, or welfare check team, tasked with making welfare calls to guests in hotel quarantine. I discuss welfare calls in more detail in my answer to Questions 7 to 10 below. I ceased leading this work on around 1 April, handing the welfare cell over to two fellow executives, Melody Bush and Sandy Austin (who later became Deputy Commanders in Operation Soteria).

[1] A copy of the revised script dated 14 April is at **DHS.5000.0029.2919.**

14. From 28 March, related to the task I had been given to establish a call centre as described above, I also set about coordinating a range of services that I felt would be needed to escalate issues arising from the welfare calls, given the possible range of complex health or physical issues that returning passengers faced. This included:

    (a) on day one of hotel quarantine, working with the Chief Mental Health Nurse both to ensure that the script I had worked to develop (referred to in paragraph 13 above) would elicit any high risk triggers, as well as to request help to set up a mental health escalation point for the general and ED nurses on site; and

    (b) the establishment of a mental health triage service by NorthWest Mental Health (managed by Melbourne health) to take calls and respond to any person referred to the service.

15. At the direction of the SEMC I responded to tasks they required to support the response or where I deemed there was a gap or need. I was not in any allocated role during this time and continued to manage my regional responsibilities, however I assisted given the urgency to establish the hotel quarantine program, and given my experience with health care provision and the health care system. For example within the first week of the hotel quarantine program, I:

    (a) provided resources from my Emergency Management divisional team to support hotel team leader positions and establish on site leadership and processes, including as described in paragraph 26 below:

        (i) emailing the SEMC to suggest establishing daily briefings with DJPR site managers;

        (ii) emailing Department staff on site to reinforce the need for shift handovers of team leaders on site, including Department Team Leaders, DJPR site managers, nurses and AOs.

    (b) visited hotel sites to make contact with Department Team Leaders and nursing staff to provide support, and provide PPE information printed from the Department's COVID-19 website;

    (c) engaged with medical staff on site to understand risk and other services required;

    (d) sourced and delivered gowns to the hotels onsite for nurses and medical staff;

    (e) worked with the Department's Public Health branch to source swabs and develop the process for swabbing and collection;

(f) worked with colleagues to establish referral and transfer process for returning passengers requiring medical assessment care within the health system, including tertiary adult/ paediatric and obstetric care;

(g) became the escalation point for staff on site to manage complex issues, for example case managing an extremely complex guest and her family by negotiating with mental health staff, the mental health branch, and the maternal child health nurse program to address their significant support needs, and working with members of the Department's Enforcement and Compliance team and Tracy Beaton (the Chief Practitioner Human Services), to arrange an exemption for the guest and her family to complete isolation in their own home;

(h) worked with the Enforcement and Compliance team about implementing public health policy for fresh air walks, and worked with DJPR to develop a template for an exercise regime for each site;

(i) assisted in managing significant incidents, including organising counselling, onsite debriefing for staff, and arranging police intervention.

16. In addition, one of the most important tasks within the first two weeks was to draft and assist in finalising the Emergency Operations Centre (**EOC**) structure and set up of the EOC. This involved the development and agreement of a structure and the sourcing and establishment of an appropriate location and logistics to make it operational, as well as identifying resources to staff the roles set out in the structure. I had raised the need to establish an EOC with the SEMC in the first two weeks of the program, acknowledging the size of the operation and the need for staff to have a clear chain of command.[2]

17. From Friday 17 April to Wednesday 29 April, my formal role became Deputy Commander – Hotels. This was a twin role that I shared with Melody Bush, Director Emergency Management, Population Health and Health Protection, West Division. In the role of Deputy Commander – Hotels, I continued to progress initiatives to support the health and wellbeing of guests and was also the escalation point for overnight calls. The role of the Deputy Commander – Hotels was to oversee the functions and operations of activities performed by Department staff on site at all contracted hotels. In that role:

(a) I connected with the other Deputy Commanders within the operation including the Deputy Commander – Ports and Deputy Commander – Welfare, as well as engaging with the Enforcement and Compliance Command.

(b) I worked closely with Public Health to ensure all the policies they established and drafted were operationalised in each hotel. My role was not to develop public health

[2] See emails from Merrin Bamert dated 7, 9 and 10 April [DHS.5000.0074.7764; DHS.5000.0053.5058]

policy, but to work with the planning and operations teams to develop standard operating procedures for team leaders that provided instruction on how to implement the public health policies. These operational procedures were approved by the Public Health Incident Management Team (ordinarily, at the start of the program, by Dr Finn Romanes) and the Operation Soteria Commander.

(c) On a daily basis I worked closely with colleagues at other departments including DJPR, Victoria Police and others, on issues that intersected with activities for which they were responsible.

(d) I provided updates to the Commander on issues pertaining to hotels.

(e) I was tasked by the Commander to lead the portfolio of returning passenger health and wellbeing. To that end:

(i) On 24 April, I started attending the Operaton Soteria internal meetings chaired by Professor Euan Wallace (CEO of Safer Care Victoria (**SCV**) and State Health Coordinator), where issues about health and public health coordination were raised, such as testing criteria (and the eventual development of the day 3 and day 11 testing regime), and the further development of the Operation Soteria Plan, which I became familiar with after attending these meetings. I had responsibility for the ongoing drafting of Annex 3 of the Operation Soteria Plan ("Emergency Operations Structure") for the EOC.

(ii) I engaged with SCV on the 17 April to instigate a process for incident reviews, specifically two incidents discussed further in response to Question 11 below. The interim and final SCV reports were discussed at the internal meetings described above and quality and safety improvements and recommendations were discussed, agreed and actioned over time.

18. On around 30 April 2020, I became Commander, Operation Soteria. In that role I twinned with Pam Williams. I worked four days on and four days off, but was also often on call overnight. I ceased performing that role on 30 June 2020. As Commander, I was responsible for the day to day management of Operation Soteria. The Commander was responsible for providing strategic and operational direction and leadership to Operations in the fulfilment of the Department's command, relief and health coordination responsibilities. For hotel quarantine, this included providing operational leadership for returning passengers from arrival at the airport, whilst quarantined in the hotels, and until exit. The responsibilities were to operationalise the public health policy developed by the Chief Health Officer and Public Health command as well as coordinate activities for which other agencies were responsible. This included chairing the Agency Operation Soteria meeting when I was on shift and coordinating

activities across all hotels that involved working with agencies such as DJPR for issues related to food, hotels and security resources.

Personal Protective Equipment (PPE)

Question 4. What:

(a) PPE;

(b) directions or instructions about the use of that PPE,

was provided 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.

19. PPE is one aspect of infection prevention and control (**IPC**): PPE works in conjunction with other public health measures, including social distancing, hand hygiene, and cough etiquette. Although this question and my response is directed specifically to PPE provision, direction and instruction, it must be understood in the context of the Department's then current public health advice (which has evolved as global understanding of COVID-19 has evolved – particularly in relation to mask-wearing),[3] community messaging and standards being enforced in the broader community (particularly in relation to social distancing, hand hygiene and cough etiquette), and the features of the hotel quarantine program that were designed to limit face-to-face interaction with guests (and hence the need for PPE).

PPE

20. The department was responsible for providing PPE to departmental staff (such as DHHS Team Leaders and Authorised Officers), to nursing staff contracted by the Department, and to guests. Department staff members on site were responsible for managing stocks of PPE, including designating a secure room for storage and checking and recording daily stocks of PPE, with the aim of having 5 days' worth of stock on site. A system was established for Department staff on site to make requests for PPE by submitting an order to a designated Operation Soteria email address included masks, gloves, eye protection, gowns and sanitiser.[4]

21. It was my understanding, based on my interactions with DJPR staff and subsequently advice provided by DJPR as to the content of their contracts,[5] that DJPR was responsible for providing PPE to DJPR staff on site and also for the contractual arrangements with hotels and security firms that ensured those staff also had their own PPE and understood how to use it.

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3 For instance, the Public Health Incident Management Team referred me to the World Health Organization *'Rational use of personal protective equipment for corona virus disease (COVID-19) and considerations during severe shortages'* [DHS.0001.0108.0001] and the Department's 'Coronavirus (COVID-19) Healthcare worker personal protective equipment (PPE) guidance, 3 April 2020 [DHS.5000.0054.8327]

4 "Operation Soteria – PPE for Quarantine Hotels" at DHS.5000.0003.0799.

5 DHS.5000.0001.6170.

22. However, in practice, the Department would provide PPE from our own stocks if it was requested of us, for instance because security companies or hotels were unable to source their own PPE (noting there were national shortages of PPE at the commencement of the program). When a concern was raised with me by DJPR about access to PPE, I instructed staff on site that PPE should be made available to all who needed it. In addition, shortly before,[6] and following,[7] the Rydges outbreak, hotel team leaders on site were instructed to provide PPE to all staff on site (including hotel and security staff) to ensure consistent access to appropriate quality PPE.

23. The PPE required for particular tasks was identified in the guidance documents described in paragraph 24 below.

Directions and instructions about the use of PPE

24. The following documents which provided guidance to staff on site in relation to the use of PPE at quarantine hotels:

    (a) On 15 April, draft advice was prepared in conjunction with Infection Prevention Australia, an independent IPC consultant contracted by the Department's through the Department's IPC Operation Lead, titled "PPE advice for hotel based healthcare worker (HCW) for contact with COVID-19 quarantine clients".[8] A version of this advice was approved by me and distributed by the EOC to Department staff working on site at the hotels on 22 April.[9] On 1 May 2020, the advice was updated and issued as "PPE Advice for Hotel-based Healthcare Workers Contact with COVID-19 Quarantined Clients". A copy is at **DHS.0001.0001.1358**. The advice set out the requirements for health care workers (that is, nursing and medical staff) working at quarantine hotels, in different situations. This information was, to the best of my knowledge:

        (i) sent by Operation Soteria Health Coordination to the Department's contracted nursing agencies (YNA and Swingshift) to be sent to every nurse ahead of their first shift in a hotel, and to every nurse involved in Day 3/Day 11 COVID-19 testing (where face-to-face contact with quarantine guests occurs) every time they are booked on a shift; and

        (ii) distributed via the team leader packs and available in laminated printed form and paper copies on the Hotel Team Leader's desk on site at each hotel.

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6 Email chain between EOC and team leaders dated 16 May 2020 – 29 May 2020 [DHS.5000.0015.0213]

7 Email from REDACTED to EOC, Merrin Bamert and others dated 30 May 2020 [DHS.5000.0078.2158]

8 A copy of the draft is at **DHS.5000.0027.5115**.

9 Email from Operation Soteria EOC to DHHS staff and quarantine hotels, dated 22 April 2020 [DHS.5000.0029.2253] and attachment PPE advice for hotel health care workers (HCW) for contact with COVID-19 quarantine clients dated 22 April 2020 [DHS.5000.0010.1863].

(b) On 15 April, draft advice was prepared in conjunction with Infection Prevention Australia titled "PPE advice for hotel security personnel for COVID-19 quarantine clients".[10] I received, reviewed and approved the final version of this advice and it was issued as "PPE Advice for Hotel-Based Security Staff & AOs in Contact with Quarantined Clients". A copy is at **DHS.5000.0003.9688**. The advice was distributed via the team leader packs and available in laminated printed form and paper copies on the Hotel Team Leader's desk on site at each hotel. It was also 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**. It directed security staff and AOs to:

(i) wear a mask when physical distancing was not feasible (instructions were included for putting on and taking off a mask);

(ii) maintain hand hygiene and cough etiquette as outlined; gloves were not recommended for security or AO staff.

(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 is at **DHS.5000.0009.1930**. The instructions on the use of PPE were the same as in the earlier version, but further detail was provided about hand hygiene and how to use a mask properly. This version was distributed to staff on 10 June.[11]

25. As set out in paragraph 15(b) above, in the first week of the hotel quarantine program, I personally went to hotel sites (then the Crown Promenade and Metropol) to give Department staff instructions about the use of PPE (donning and doffing). I took printed copies from the Department's website about how to don and doff PPE appropriately. From early May, this information was also provided as part of the onboarding process to Department staff by email when deployed as hotel team leaders.[12]

26. Early on in the program, I emailed the Department's team on the ground to reinforce that it was important that we lead by example with our physical distancing and other infection control and OHS activities, including making sure handovers and team huddles should occur in an appropriate location within each hotel and limiting our movement of teams between hotels.[13] I also instructed that the Department team leaders on site should conduct a shift handover briefing for Department staff (including AOs and nursing staff) and the Dnata team leader if

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10 A copy of the draft advice is at **DHS.5000.0095.9059**.

11 Email from DHHS OpSoteria EOC dated 10 June 2020 [DHS.5000.0008.1681].

12 In late April, a deployment confirmation email was prepared and subsequently used from about 3 May 2020 for staff deployed to Operation Soteria. (DHS.5000.0030.6735) The email contains information about DHHS approved practices regarding social distancing and use of PPE. It also provides as an attachment information about donning and doffing (DHS.5000.0030.6737). This deployment email was sent to new staff as part of the Hotel Team Leader onboarding Process (DHS.5000.0028.6288).

13 Email from Merrin Bamert dated 4 April [DHS.0001.0008.0170].

possible, covering PPE instructions, OHS considerations and physical distancing.[14] I also recommended to the SEMC that a daily huddle continue on site between Department Team Leader and DJPR team leaders to discuss key issues[15] This was subsequently captured in the Operation Soteria Standard Operating Procedures (a guide for team leaders)[16] which provided that at the beginning of each shift, the Team Leader should provide a briefing to all personnel on the floor, which should involve everyone present including the Department, DJPR, nurses, concierge staff, AOs, security representative, hotel representative and any other relevant parties. (In addition, I understood that daily briefings continued between the Department's Operations Leads and DJPR team leaders).

27. In my experience, Department Team Leaders were alert to PPE and social distancing concerns and issues were escalated up the Department's chain of command. Department Team Leaders regularly reminded hotel team leaders at the daily 11am and 4pm team leader briefing about IPC and PPE; this was reiterated by me during my visits to hotels, if I joined teleconferences, and at every EOC briefing I gave. These briefings were in large part intended to reinforce the same messaging to the community at the time about physical distancing and hand hygiene, as well as to provide instruction on the use of PPE when required because social distancing was not achievable (for instance, for nursing staff making face to face contact with guests).

28. Throughout April and May, the Department worked with that IPC consultant from Infection Prevention Australia to develop the policies described in paragraph 24 above, and to conduct onsite reviews and report on IPC and PPE issues and provided on site instruction.[17] As part of that work, I understand that on around 11 April, the Department arranged for a PPE briefing to be provided by the infection prevention control consultant from Infection Prevention Australia for GPs and nurses working at the Rydges hotel.

29. The Department's Workplace Health and Safety Officer for the program also undertook onsite visits to check availability of hand sanitiser and signage, including on 20 May, placing signage on walls and doors relating to social distancing and the maximum number of staff allowed in an area at one time. Examples of that signage is at **DHS.5000.0081.9224** and **DHS.5000.0081.9225.**

30. As part of the Department's outbreak management response following the Rydges outbreak, and later the Stamford outbreak, the Public Health Outbreak Management team observed and provided instruction to staff on site (including security and nursing staff) on a number of occasions in late May and June, including through formal training sessions and a meeting with each of the three security companies to discuss IPC and PPE (with advice provided by the

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14 Emails from Merrin Bamert dated 4 April [DHS.0001.0008.0504/DHS.0001.0008.0170].

15 Email from Merrin Bamert dated 4 April [DHS.5000.0054.0804]

16 Standard Operating Procedures (a guide to Team Leaders), 30 May 2020 [DHS.5000.0003.1053]

17 See email from REDACTED to Worksafe dated 11 June 2020 [DHS.5000.0009.1930]

Outbreak team, and Pam Williams and DJPR in attendance). I was generally kept informed about the training and instruction being provided, and made recommendations including conducting sessions across multiple shifts and providing translated materials for security guards for whom English was not a first language.[18]

Question 5. In your view, was the:

(a) PPE;
(b) directions or instructions about the use of that PPE
provided to people working at quarantine hotels adequate? Why or why not?

Volume and type of PPE

31. In my view, the volume and type of PPE available to people working at quarantine hotels was generally adequate. There were occasional logistical issues; that is, where supplies became short and additional supplies were required at short notice. In the first two weeks or so, supplies, particularly of gowns, were tight (which is why I delivered gowns on site as described in paragraph 15(d) above). During the period I was Deputy Commander – Hotels and Commander, I do not recall being advised of people working at quarantine sites being put in a position where they were not able to access PPE that was required to be used in accordance with the then current public health advice. At the time, the understanding of the virus was that it was droplet only and that physical distancing and hand hygiene were the main lines of defence. Hand sanitiser was always available.

32. There was an issue with nurses on site wanting to use P2/N95 masks for swabbing procedures. Although in my own view, I understood that nurses were nervous, I was advised by Dr Finn Romanes in the Public Health command that such masks were not recommended to be used, and by Braeden Hogan that the advice from the World Health Organisation was that surgical masks were suitable and that we need to ensure the rational use of PPE and minimise use at all times if possible (reflecting the advice referred to in paragraph 19 above and as explained further in my response to Question 6 below).

33. I also note that some security guards and hotel staff used masks in circumstances that were not consistent with the then current public health advice, referred to in paragraph 19 above (i.e. when social distancing was achievable), and in circumstances where there were in the early days of the program concerns about a national shortage of surgical-grade masks. Given the advice at the time, my own view was that the security and hotel staff should not be using masks when present in the foyers without guests, which was in accordance with the guidance given to security as described in paragraph 24(b) above. In addition, I was aware that security

[18] See for example DHS.5000.0019.3535

guards wore gloves in circumstances where glove usage was not recommended (and had the potential to increase transmission risk by creating complacency regarding hand hygiene).

Directions or instructions about the use of PPE

34. In my view, there were not initially adequate directions or instructions for Departmental staff about the use of PPE. For instance, as I set out in paragraph 15(b) above, I personally visited hotel sites to provide instruction about the use of PPE after my Emergency Management staff advised me they had no knowledge of how to don and doff PPE. As set out in paragraph 25 above, by the end of April this information was being provided to team leaders during the onboarding process.

35. Directions about the use of PPE improved over time, particularly after the Department engaged the IPC consultant from Infection Prevention Australia, leading to the development of the policies described in paragraph 24 above, as well as onsite instruction during review of hotel sites, as described in paragraph 28 above. In addition, the appointment of a Workplace Health and Safety Officer (as described in paragraph 29 above) assisted with auditing and improving practical resources on the ground at hotel sites.

36. It was intended that security and hotel staff should have limited face to face interaction with guests (such that the same physical distancing and hand hygiene practices that applied in the community would be the frontline mechanisms to reduce transmission risks, generally without the need for PPE unless physical distancing was not achievable). However, it became apparent following the Rydges and Stamford outbreaks that there had been challenges in embedding understanding of social distancing, hand hygiene and appropriate PPE usage amongst some security and hotel staff. Around the same time, I made recommendations to the Outbreak Management response, including conducting training sessions across multiple shits and providing translated materials for security guards for whom English was not a first language.[19]

Question 6. In the context of the Hotel Quarantine Program, did any person raise concerns or complaints with you in relation to PPE? If so, please provide details, including details about what action (if any) you took in relation to the matter that was the subject of the complaint or concern. Please provide any relevant documents.

37. Within the first several weeks of the program, I became aware of concerns that social distancing and PPE were not clearly understood or adhered to by both departmental and non-

[19] See for example [DHS.5000.0019.3535; DHS.5000.0088.5778]

departmental staff on the ground at hotels. I raised these concerns at the time with Jason Helps and Andrea Spiteri amongst others, with suggestions for improvement.[20]

38. In the first few weeks of the hotel quarantine program, based on my own observations of staff at hotels, I had concerns about the use of surgical masks and gloves by security guards in circumstances where physical distancing was possible and appropriate. I was concerned about mask shortages (as described earlier), as well as improper mask and glove-wearing potentially increasing transmission risk, including through a reduction in compliance with hand hygiene. I was also concerned about the lack of social distancing by nursing staff. I addressed those concerns by emailing staff reminding them of the requirements for social distancing and PPE; I also spoke to nursing and Department staff about this when I visited on site.

39. On around 14 April, I became aware that the IPC consultant from Infection Prevention Australia had raised concerns about significant differences in PPE usage across hotel sites; I had also observed excessive use of gloves by security guards in the foyer when no passengers were present.[21] The use of gloves can increase transmission risk by reducing compliance with hand hygiene measures. This led to:

    (a) the development of the policies for use of PPE described in paragraph 24(a) and 24(b) above;

    (b) the engagement of the IPC consultant to review IPC by clinical staff, training, procedure development and review, and assessment of other agencies' PPE arrangements to identify recommendations that could be made to other agencies.[22]

40. The IPC consultant subsequently conducted checks of hotels and, in a report dated 5 May, noted that while many aspects of the hotel's PPE practices are acceptable, the most obvious area of non-compliance continues to be with the security team overusing PPE and lack of hand hygiene.[23] In response:

    (a) a meeting was held with Unified Security and the advice described in paragraph 24(b) provided directly to them; and

    (b) the Deputy Commander – Hotels contacted the YNA agency to request that they attempt to reduce the movement of staff across hotels, this was to be balanced with ensuring we were able to staff the hotels. The planning team (specifically rostering) to reiterate the model of ensuring continuity of staff.

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20 Email dated 29 March [DHS.5000.0075.1193]

21 Email chain between REDACTED, Merrin Bamert and others dated 14-15 April 2020 [DHS.5000.0052.7822]

22 Email from REDACTED to REDACTED (copying Merrin Bamert and others) dated 17 April 2020 [DHS.5000.0053.1869]

23 Summary of findings – Review of Hotel accommodation for OS travellers in quarantine, REDACTED [DHS.0001.0021.0020]

41. Nurses raised concerns about the use of surgical, rather than P2 masks, during swabbing procedures (as referred to in paragraph 32 above).[24]

    (a) National and State advice provided throughout the pandemic has been that P2 or N95 masks are only recommended for use when aerosol generating procedures are being undertaken or will occur. In all other instances the advice was to wear a surgical face mask for direct client contact. This was reflected in the document "Operation Soteria – PPE Advice for Hotel-based Healthcare Workers Contact with COVID-19 Quarantined Clients" described in paragraph 24(a) above.

    (b) On around 17 April I had a conference with the IPC consultant from Infection Prevention Australia about this, and she was engaged to provide advice and subsequently to consult with nurses on the appropriateness of surgical masks for swabbing. The IPC consultant recommended the use of a P2/ N95 mask for swabbing.

    (c) I found it difficult to obtain consistent advice about whether swabbing was an aerosol generating procedure that required use of a P2 mask, rather than a surgical mask.

    (d) SCV subsequently recommended in a report that nurses be allowed to use P2 masks to alleviate their anxiety about performing the swabbing procedure.

    (e) However, the Deputy Chief Health Officer advised that the state PPE guidance did not require P2/N95 masks for swab taking and that the nursing staff at the hotels should therefore not use P2/N95 masks and as a result nurses were not provided with those masks.

42. DJPR raised concerns with me about the provision of PPE to hotel security staff.

    (a) DJPR raised a concern with me that the Department was not providing PPE to the security staff.

    (b) At the time, I understood it was the responsibility of DJPR under their contracts with security companies, to provide PPE. However, I instructed Department staff to provide PPE to security staff straight away, in an attempt to ensure there was no situation in which PPE should be worn and was not available, and asked for an audit of PPE usage.

    (c) There were also many discussions between DJPR and Operation Soteria Command about the misuse of PPE by security guards and behaviour that resulted in the ceasing of a subcontract at Rydges. This was raised in the investigation at Rydges and

[24] See for example DHS.5000.0027.5106

discussed at the meeting attended by the Deputy Commander – Hotels on 12 May 2020.

43. Concerns were raised with me about the access to gowns by nursing staff at hotels.[25] Following this:

(a) On 1 May I had a teleconference with Professor Euan Wallace of SCV in which we discussed the issue of gown availability. I advised Professor Wallace that there was no longer an issue with tight supply of gowns.

(b) I received from Professor Wallace final reports into two clinical incidents in hotel quarantine. The first report did not raise any concerns about PPE. The second report, dated 17 June, made reference to PPE availability, which had been dealt with during my discussion with Professor Wallace.

44. Following the Rydges Outbreak:

(a) On 29 May, I requested an audit of all hotel sites, to determine the hotel sites at which security companies were accessing Department-supplied PPE, and whether security companies had training in PPE usage. The result of that audit identified that the Department supplied PPE to non-Department staff at 8 hotels and that not all staff were receiving PPE training, mostly because of different shift times when training was conducted. As set out above, in response, the Department's hotel team leaders were advised to provide PPE to all staff onsite, including security and hotel staff.[26]

(b) The Department's Outbreak Management Team identified a range of concerns about adherence to PPE measures amongst hotel and security staff.[27] For instance, some security guards were reluctant to adopt the use of alcohol based hand sanitiser for religious reasons. As a result, as set out in paragraph 30 above, instructions were provided on site and meetings were held with each security company.

Welfare checks

Question 7. What was the procedure and practice for conducting checks on the welfare of people in hotel quarantine? Did that procedure or practice change over time? Please provide details, including any relevant documents.

25 Soteria Review Escalation Points April 2020 [SVC.0001.0002.0356].

26 DHS.5000.0078.2158

27 See for example Email from Claire Harris 28 May 2020, [DHS.5000.0095.1540]

45. There were a number of different aspects to the procedure and practice for conducting checks on the welfare of guests in hotel quarantine. Broadly that can be divided into:

    (a) physical screening by nurses at the airport that screened for COVID and provided the first opportunity for arriving passengers to raise immediate health concerns;

    (b) a self-reported confidential questionnaire to be completed on the bus prior to arrival at the hotel. The document could then be handed to the nurse or AO on arrival at the hotel. I understand the nurses could scan the document for immediate concerns however the priority was for guests to be sent to their rooms to reduce the risk of transmission in the foyer. Nurses would provide care to anyone with immediate needs otherwise calls would be made for further needs;

    (c) daily medical screening conducted by nursing teams located within the hotels via telephone to the guests room to cover basic health and wellbeing needs and specifically COVID symptom checks;

    (d) day 3 and day 9 welfare checks conducted by the offsite welfare check team; and

    (e) checks by the Complex Assessment and Response Team (**CART**);

    (f) physical nurse health screenings and medical assessments, and mental health assessments where issues were escalated.

46. Self-reported screening of arrivals was also conducted via the completion of a form provided to guests arriving at ports of entry for hotel quarantine. A template of the questionnaire is at **DHS.5000.0003.0415**. A food allergy tolerance and screening document was also provided to guests at this time. It was expected that both would be filled out on the bus transport to the hotel and provided on arrival as part of the arrivals screening procedure.

47. Often returning passengers did not complete these forms, however they often escalated concerns to staff on arrival, for example for urgent medical care or pharmaceutical requests.

48. The daily screening checks were conducted via phone calls from agency nurses on site, and then by Alfred Health nursing staff on site from 16 April, to check in with each guest and ask if they had any COVID symptoms and general questions about health and wellbeing. This was to minimise transmission risks associated with face to face assessment. If this screening indicated a clinical need for face to face assessment, a nurse would attend the guest in appropriate PPE. A template of this daily screening form entitled 'COVID-19 Assessment Form' is at **DHS.5000.0003.9706**.

49. Day 3 and Day 9 welfare checks by the welfare check team were provided with the intention of conducting a more comprehensive health and wellbeing assessment. These checks were

conducted by Departmental staff (although not necessarily by clinical staff) under the supervision of the Deputy Commander Welfare.

(a) The day 3 check was a structured survey covering health, safety and wellbeing, including essential information about medications, allergies or health issues currently being treated to ensure they have access to continue their treatment, as well as questions about safety, emergency contacts, coping in quarantine and strategies for wellbeing, and exit planning. A copy of the template used by staff to make these calls is at **DHS.5000.0029.2919**.

(b) The day 9 check was a shorter version of the day 3 check designed to focus on whether needs were being met and providing an opportunity for feedback. A copy of the template used by staff to make these calls is at **DHS.5000.0029.2927**.

50. CART was established on 28 March as an on call roster of Departmental staff to respond to issues arising for guests in hotel quarantine. Over time, it was established as a more enduring team of practitioners to assess, support and refer guests with psychosocial complexity in hotel quarantine. Checks by CART were on the basis of referrals from nurses, the welfare check team, or other staff involved in the hotel quarantine program, such as AOs, Department Team Leaders, hotel staff, DJPR site management or security. CART supported people with complex needs arising from either pre-existing personal, social, health or wellbeing needs, or needs that were likely to be significantly exacerbated by hotel quarantine. Upon referral, CART made phone contact with the guest to discuss strategies and, where necessary, connected guests to specialist supports (e.g. family violence specialist assessment).

51. Physical nurse and medical assessments included general nursing and mental health nursing checks, and complete nursing assessments, medical telehealth and medical visits. These occurred when clinically indicated as a result of:

(a) self-reporting by guests;

(b) reporting by staff on site (whether hotel, security, Departmental or nursing staff or raised via the Government Support Service telephone line organised by DJPR); and

(c) escalation following a daily screening check, day 3 or 9 welfare check, or CART assessment.

52. Arrangements were in place from the commencement of the program for nursing staff on site, with arrangements made for mental health nursing on site from week two of the program.

53. In the first week of the program, the Department provided access to the Compliance Welfare Management System (the **CWMS**). The system evolved over time and included separate “Compliance Application”, “Welfare Application” and ultimately the “nurse health record”. The

CWMS was intended to facilitate the sharing of information (as appropriate, taking into account privacy concerns) through select read/ write permissions to enter and view data across each application. For instance:

(a) The Welfare Application was designed to enable the recording of information from the day 3 and 9 welfare checks and CART referrals, as described in paragraphs 49 and 50 above.

(b) The nurse health record was designed to capture guests' health history, consultation history and results, as well as link to the questionnaire results and CART referrals.

Question 8. Why were welfare checks conducted in the way that they were? If your answer differs for different time periods or locations, please specify.

54. The initial self-reported screening, via the questionnaire, was established to capture guests' immediate health and wellbeing concerns upon arrival (for instance, any required medication, allergies, or immediate mental health concerns).

55. Guests then received a daily call to check symptoms and general wellbeing (discussed at paragraph 48 above). The welfare check calls were initially established in part to satisfy checking and reporting obligations under the *Public Health and Wellbeing Act* (**PHWA**), as well as more generally to check and respond to the safety, health and wellbeing of guests. As I noted in paragraph 13 above, I developed in consultation with Family Safety Victoria and the Mental Health Branch an initial script for a welfare check call at the commencement of the program. At the time, it was intended that guests would receive a daily call, with a longer call on the first day for extensive history taking and the follow up to be shorter. As the volume of guests increased rapidly (from 0 to 1,500 within the first week), it was not possible to achieve a daily welfare check call, although daily screening calls by nursing staff were made. The day 3 and 9 welfare calls were accordingly established on the basis that:

(a) daily nurse screening calls should identify issues that required escalation;

(b) guests arriving from overseas travel were often fatigued and overwhelmed and were better able to articulate their needs after having some time to settle in to the hotel environment.

56. A decision was made in the first weeks of the program to seek to obtain this information on day 3 (and 9), as opposed to on arrival, as returning travellers where increasingly found to be fatigued and in need of rest upon arrival, making thorough assessment on day 1 difficult.

57. The primary reason the daily screening check by nursing staff, day 3 and day 9 welfare screening checks, and CART checks were conducted by telephone was to reduce face to face interaction with guests who were potentially COVID positive (and therefore to reduce

transmission risk). Where issues were escalated which required a physical visit by nursing, mental health nursing, or medical staff, that could then be arranged with appropriate PPE.

Question 9. In your view, was the practice and procedure for undertaking welfare checks adequate and appropriate? Why or why not?

58. In my view, the procedure for welfare checks was adequately and appropriately designed. Hotel quarantine was an alternate location for isolation that was intended to prevent people from interacting with others in the community as a strong public health measure. The majority of guests were well and required a primary care model with escalation points as needed, and diversion to the hospital system for high-acuity concerns. The model was designed to provide COVID symptoms screening to support diagnosis and care as required.

59. When the welfare approach was designed it was also at a time where both the Commonwealth and State public health advice was to reduce face to face interaction. Many health professionals were provided telehealth / videoconferencing access to Medicare reimbursement, promoting this view. Therefore returning passengers were provided appropriate care using technology in the first instance, however face to face assessments would occur and would be supported at the door of a returning passenger's room or inside, if deemed necessary, and PPE was provided in those instances.

60. However, the difficulties with the hotel environment and the sheer volume of returning passengers at times made operationalising the procedures difficult. In particular, the reliance on telephone checks, while appropriate to minimise risk of COVID transmission, could have been improved with a direct line into guest hotel rooms, rather than being restricted by calls having to go through the hotel switchboard. This was an issue for external calls (such as the day 3 and day 9 welfare check conducted by the welfare team) but not an issue for nurses conducting daily telephone checks, as the nurses were located on site (and therefore called internally from the hotel). I raised this issue at the commencement of the program.[28]

61. In addition, uptake and functionality of the COVID Compliance and Welfare Application and nurse health record limited the ability to record and share information (as appropriate, taking into account privacy concerns). For instance:

    (a) There were some issues with onboarding and uptake amongst nursing staff of notarising guest health records in the electronic health records. For instance, in late April, there were administrative challenges in creating user accounts for the nurses because they were not Department employees. In addition, the increasing number of contracted nursing staff created some challenges for establishing training. Other nurses simply preferred using pen and paper. In late May, I arranged for a health

[28] See email from Merrin Bamert dated 30 March [DHS.5000.0001.6368]

coordinator in the EOC to project manage and develop an implementation plan to improve training and uptake for nurses, including on site sessions to encourage uptake. A copy of the implementation report for that project is at **DHS.5000.0084.0699**.

(b) The Department engaged a consulting firm to assist us to develop a reporting process in the electronic health records that was intended to tier people based on their mental, social and physical health needs. However, during my time as Commander, we did not receive a final product from the consulting company.

Question 10. How was information gleaned from welfare checks shared with:
(a) nursing staff;
(b) the department,
(c) anyone conducting 'daily reviews'?

62. Information from the initial self-reported screening was collected by AOs or nurses on arrival at the hotel along with other documents (including information about allergies, past medical history and medications) and provided to the team leader/nurse to review and escalate any concerns.[29]

63. Each hotel commenced a slightly different approach as hotels came on board and became more sophisticated. Initially, nurses kept paper-based records in most cases, either in folders by floor level and room number or in progress books. Medical notes were contained in the relevant medical company's software. The need to create a more systematised and readily accessible record-keeping system led to the development of the electronic nurse health record as part of the COVID Compliance and Welfare Application.

64. In addition to record-keeping for individual guests, handovers between nurses occurred at every shift with known concerns often on a whiteboard with those that required medical review or nursing review again.

65. Nurses conducting the daily screening checks were expected to:

(a) record the contact in the nursing notes kept for each guest onsite at the hotel. This was initially done in paper files (described above) and subsequently in the electronic nurse health record;

(b) share or escalate concerns as necessary, for instance, during handover, or to organise an in-room nursing assessment, specialist mental health assessment or GP assessment if required, or to refer the guest to CART; and

[29] See DHHS Isolation Medical Screening Form [DHS.5000.0003.9706]

(c) escalate any concerns to the DHHS team leader and /or operations phone in the EOC; this would then be escalated to the Deputy Commander – Hotels. Overnight the phone was diverted to the executive on call.

66. The welfare team conducting the day 3 and day 9 welfare checks were expected to:

(a) record the information in the Welfare Application (at the start of the program, this was done by paper, and the Department subsequently loaded previous surveys on to the application); and

(b) share or escalate concerns as necessary, for instance with: the onsite nurse for health or mental health related matters (by calling the nurses); the DHHS Team Leader on site; or the CART team for more complex cases.

67. The CART team were expected to:

(a) record information in their own record-keeping systems;

(b) refer issues as necessary, for instance with the onsite nurse for health or mental health related matters, mental health triage, the GP on call, the Department Team Leader on site or the Quarantine exemptions team; and

(c) escalate issues to Deputy Commander Welfare and ultimately to me or Pam Williams as Commanders if necessary.

68. Nurses conducting in-room checks were expected to:

(a) record the contact in the nursing notes kept for each resident onsite at the hotel. This was initially done in paper files (described above) and subsequently in the electronic nurse health record; and

(b) share or escalate concerns as necessary, including to medical practitioners (for instance, if a guest required review by a doctor or if they needed to attend a hospital), and to the Hotel Team Leader and AO, who could escalate to the EOC and the Deputy Commander – Hotels as necessary.

69. Medical records for doctors were otherwise held separately by medical staff in a medical director type software. That required a verbal handover from doctors to nurses, who were expected to record information in written notes or electronic health record progress notes.

70. I was not aware of information gleaned from those contacts with guests unless an issue was escalated to me if necessary in any particular case. If necessary, I was able to log in to the COVID Compliance and Welfare Application or nurse health record, however there were

limitations in the Application as described in paragraph 61 above, particularly in relation to inconsistent recording of information by nurses in the nurse health record.

71. I am informed by the Department's Business Technology and Information Branch and I believe that:

(a) the Exemptions team have read-only access to certain parts of the Compliance and Welfare Application for the purpose of considering and recording exemptions from hotel quarantine; and

(b) the Intelligence team, previously known as the data analytics team, have read-only access to the Compliance and Welfare Application for the purposes of generating reports based on various data sets.

72. I understand that from early on in the program, given the volume of guests and the public health directions under which guests were detained, the "daily reviews" for the purposes of the PHWA were undertaken by reference to a spreadsheet of guests listed by name, room number, and how many days they had been in quarantine, and not specifically by reference to data gleaned from any of the welfare checks I have described in my answer to Question 8 above.

Complaints and issues

11. Did you have concerns, or raise any issues, about any aspect of the Hotel Quarantine Program, or the way that the program was being delivered? If so, in relation to each, please:
(a) provide the details of each concern or issue;
(b) explain how the concern or issue was dealt with, including any persons to whom it was relayed; and
(c) describe what outcome, if any, was achieved in relation to the concern or issue. Please provide any relevant documents.

73. As set out in response to Question 12 below, the hotel quarantine program was established incredibly quickly through the hard work and dedication of many hardworking and committed colleagues, with processes and procedures continually improving to reflect the evolving public health understanding of COVID-19 and the lessons learned on the ground. This was not – and could not be – perfect. I have included below a range of issues and concerns that I encountered in the three months I was involved in hotel quarantine, some of which highlight scope for improvement on various fronts including:

(a) recruitment of adequate staff to ensure capacity to fulfil leadership roles with suitably experienced and capable staff;

(b) improved efficiency in the development and uptake of IT systems, data collection and reporting;

(c) consistency of advice in outbreak management processes.

74. In addition, as described in my answers to Questions 5 and 6 above, I had concerns and raised various issues in relation to PPE usage and social distancing, which highlighted scope for improvement on embedding compliance with social distancing and PPE practices. Following the Rydges outbreak, I was concerned about IPC, and raised the need for an infection prevention lead from a health service to be embedded in the EOC.

75. Within the first several days of the hotel quarantine program operating, I received feedback from various people on the ground staff at the airport and hotels, including AOs and medical staff, as well as guests, regarding the teething issues with the then current processes and suggested ways in which these needed to be addressed. I raised these concerns and suggested process changes internally with Jason Helps and Andrea Spiteri, amongst others within the Department.[30] Initial teething issues included:

(a) forms for passengers being only available in English;

(b) social distancing and PPE not clearly understood or adhered to by both departmental and non-departmental staff on the ground at hotels (as set out in my answer to Question 6 above); and

(c) the need for regular welfare checks on guests.

76. The steps the Department took to address PPE usage are described in my response to Questions 4 to 6 above, and the steps taken in response to welfare checks are addressed in response to Questions 8 to 10 above.

77. At the start of the program I had concerns about the availability of appropriate health equipment for nurses to do minimum reviews (such as thermometers, blood pressure and oxygen saturation equipment, primary assessment/ observation charts, and equipment for assessment of infants and children). I raised this concern at the time with the SEMC.[31] These items were subsequently supplied for use at the hotels.

78. In early April 2020, I raised concerns about the need to put in place processes for the granting of temporary leave in the context of fresh air breaks for guests in hotels. [32] In response,

30 Email dated 29 March 2020 [DHS.5000.0075.1193];

31 Email dated 31 March 2020 [DHS.5000.0054.5792]

32 Email dated 4 April 2020 [DHS.5000.0054.1812; DHS.5000.0053.6758].

Dr Finn Romanes provided an initial Public Health Command endorsed procedure which set out the process to be followed.[33] Policies were further developed and embedded over time.

79. In mid-April, I raised concerns with DJPR regarding the need for communication and clarity around the roles and responsibilities of the AOs, Department Team leaders and DJPR staff in hotels. I discussed the matter with DJPR and agreed job cards for those roles should be developed and shared across the Department and DJPR.[34] Job cards were subsequently developed.

80. On 17 April 2020, I raised with SCV the need for an incident escalation and sentinel event review process.[35] As a result:

    (a) On 5 May, there was agreement that a clinical governance framework and clinical lead were required. A process for this was established, although there were some delays in recruiting to the position and then implementing the framework. Because of my background in the Department and my nursing background, I assisted with drafting a clinical governance framework, and drafting a clinical lead role but I was not able to fill the position for a clinical governance lead until the second week in June when we recruited a nurse practitioner. Ultimately this issue was resolved by the engagement of Alfred Health on the 27 June who took over the clinical governance and clinical lead.

    (b) I received two reports from SCV in respect of two incidents I had sought to be reviewed by Safer Care Victoria (as referred to in paragraph 43(b) above). A key outcome following the handing down of both reports was to establish a clinical governance review panel. This process was being established when I left the role.

81. In around early May, I had concerns about the capacity to provide suitably skilled Department Team Leaders on the ground at hotels. That concern was addressed in part by implementing twice daily telephone meetings with Department Team Leaders to provide an opportunity to escalate issues on the ground. In addition, team leaders were provided supernumerary shifts with experienced leads when they commenced wherever possible, and a standard operating procedure document was developed for team leaders.

82. In May, DJPR raised concerns with me regarding AOs misinterpreting exit procedures and releasing guests one day prior to the end of their 14 day detention. This was escalated to the Enforcement and Compliance Command. By early June, the Department had made its position clear that guests exiting the program were to do so from 12 noon on the day their

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33 See email from Finn Romanes dated 4 April 2020 [DHS.5000.0095.9277]

34 See email dated 22 April 2020 [DHS.5000.0001.7108]

35 See email dated 17 April 2020 [DHS.0001.0096.0001]

quarantine period concluded, with the exception of families, guests with outgoing flights and others with compelling circumstances.[36]

83. In early June, issues were bought to my attention regarding the approach to the management of temporary leave requests for guests visiting dying family members or attending funerals. I worked with Anita Morris to prepare feedback to DJPR on how to manage such requests.[37]

84. I raised concerns regarding security's failure to check identification of people requesting access to quarantine hotels following an incident at the Grand Chancellor in mid-June. I requested DJPR to remind security of their obligations and I asked my team to engage with DJPR staff on the ground regarding the issue.[38] I also considered whether an alternative workforce model to the use of security was more appropriate.[39]

85. In early May I became aware of concerning behaviour by security guards at Rydges, including in relation to sexual harassment of nursing staff.[40] The complaints were investigated by DJPR with the Department's assistance and the security sub-contractors were stood down.

86. The Chief Operating Officer of Alfred Health raised several concerns with me regarding cleaning, infection control and work health and safety concerns of Alfred Health staff at Brady Hotel. I coordinated with Kevin McEvoy, Deputy Commander Operation Soteria and the Department Team Leader at Brady Hotel, to successfully address the issues raised.[41]

87. I had concerns about the suitability of hotels for quarantine that were originally contracted by DJPR including the provision of fresh air options for guests without the need to leave the hotel. I addressed this concern by developing a set of "must haves" for future contractual engagement of hotels going forward contained in a draft document entitled 'Policy – Hotel Suitability check list'.[42] Ultimately, the Department was able to have more input for future contractual engagement of hotels, including trying to encourage the selection of hotels with fresh air options where possible.

88. On 17 April after several complex situations were experienced at the hotels I raised my concerns to the Director of People and Culture to request the recruitment of a health and wellbeing officer 7 days a week to support staff employed or contracted by the Department in the hotels and for staff working in the EOC. This role was filled by a senior wellbeing officer and was very well received by staff. The role provided information and opportunities for staff to access either the senior wellbeing officer or EAP services as required.

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36 Emails regarding these issues can be found at [DHS.5000.0027.2414; DHS.5000.0016.8437].

37 DHS.5000.0008.8030

38 DHS.5000.0001.5009

39 DHS.5000.0034.6968

40 DHS.5000.0022.8608

41 DHS.5000.0096.3156, DHS.5000.0088.5651 and DHS.5000.0095.0418.

42 DHS.5000.0096.3176

89. Appropriate food for guests (including allergy, dietary and culturally appropriate foods) was frequently raised as an issue by guests. Concerns were raised to DJPR for resolution as the contract manager.

Further Information

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

90. The three months I was involved with hotel quarantine stands as the most intense working experience of my working life. Between the work I did with hotel quarantine, and including my regional responsibilities, I, like many of our colleagues across the public service, was working over 14 hours a day and I was often on call overnight. Having spent many years on the triage desk of Emergency Departments, I felt like I spent every day for three months triaging and prioritising the significant issues and complexities that this program presented for both the returning passengers and the staff involved.

91. I know that the people associated with the operation used every skill, capability and their heart and soul to be the best they could be and worked hard to play their part in fighting the worst pandemic in 100 years. There was no rule book or ready reckoner to how to do hotel quarantine in 4 and 5 star hotels: places that are normally reserved for a vacation, a nice room where you sleep but can venture out to see a city, that in this instance became a person's only space – with one room, limited furniture and in many cases no opening windows and no or limited fresh air for 14 days. A place where these returning Australians had urgently come home due to difficult circumstances, such as job loss in the country of origin or after experiencing complex lockdowns prior to returning.

92. Our role was to operationalise public health, where the outcome was to protect the Australian public and suppress the transmission of a virus for which we still knew very little about, while balancing this with supporting the over 20,000 returning passengers who were detained in the 3 months I was involved in the program. Importantly, their experience and their health and wellbeing – and the health and wellbeing of our all the amazing and committed staff who put their hands up to assist – was always in the forefront of my mind. The commitment from the staff involved – whether on the front line in the hotels, ports, callers and welfare staff, who dealt respectfully with our returning passengers with such compassion to their circumstances, through to the staff in the Emergency Operation Centre (**EOC**) who worked such long and fast-paced hours supporting policy, operations, rosters, logistic, safety and wellbeing – was inspiring.

93. Of the 20,000 guests in the hotel quarantine program until June (on average, approximately 3,000 people in the hotels every night), the majority were able to complete their quarantine with little fuss or interruption. However for many this was not the case: we were dealing with a

microcosm of the community and we had to support people with mild to significant health concerns, the spectrum of mental health disorders, family violence and other family and social issues, as well as people who were home for compassionate reasons to be with a dying parent or family member. My own view, as a health professional, was that the hotel environment was not an optimal location for quarantine, but this was a decision that was beyond my control. My focus, at all times was the health and wellbeing of guests, and their safety, as well as the safety and wellbeing of our staff.

94. Having worked in policy for many years, a program of this size and complexity would ordinarily have taken 6 months to develop with risk strategies in place. In this case, we had less than 48 hours to get the program up and running and in the first week we had five hotels activated and 1,550 returning passengers. Over the three months of my involvement, it was clear that the intelligence and understanding about the disease and its infectiousness changed. This was also occurring while restrictions within the community were easing. We did continually improve all our processes and procedures and worked hard to develop maturity in how we operationalised the service. But as I acknowledge above in my response to Question 11, in retrospect and with the benefit of all the information we have learnt over the course of the program, there are valuable future reflections and learnings that can hopefully guide any future efforts required to establish a complex program of this nature.

Signed at Melbourne

in the State of Victoria

on 9 September 2020

Merrin Bamert