BOARD OF INQUIRY INTO THE COVID-19 HOTEL QUARANTINE PROGRAM

WITNESS STATEMENT OF BRETT SUTTON

1. I make this statement in response to notice to produce from the Board of Inquiry into the COVID-19 Hotel Quarantine Program, dated 2 August 2020.

2. I am the Victorian Chief Health Officer and the Victorian Chief Human Biosecurity Officer, Regulation, Health Protection & Emergency Management Division in the Department of Health & Human Services (**the Department**). I was appointed Chief Health Officer in March 2019.

3. Except where I otherwise indicate, I make this statement from my own knowledge and, wholly or substantially, from my area of expertise (communicable disease and public health).

4. To the extent that I express opinions in this statement, I set out the assumptions on which my opinions are based. I have also identified the documents that I have had regard to in making this statement.

BACKGROUND, ROLES AND RESPONSIBILITIES

1. What are your relevant qualifications, professional background and work history?

5. I have a Bachelor of Medicine and Bachelor of Surgery (MBBS) in 1993 from the University of Melbourne and a Master of Public Health and Tropical Medicine (MPHTM) in 2007 from James Cook University.

6. I am a fellow of the Australasian Faculty of Public Health Medicine (FAFPHM), since 2017; the Royal Society for Public Health (FRSPH), since 2016; and the Australasian College of Tropical Medicine (FACTM), since 2016.

7. I am an Adjunct Clinical Professor in Preventive Medicine Alfred Hospital, Monash and a member of the Faculty of Travel Medicine (MFTM), since 2016.

8. My post-graduate appointments and professional affiliations include:

   (a) 2017 - 2018 Chair of AFPHM Policy and Advocacy Committee;

   (b) 2017- 2019 Board Director at East Timor Hearts Fund;

(c) 2014-2019 Co-founder and co-chair of PalCHASE (Palliative Care in Humanitarian Settings & Emergencies);

(d) 2010 to 2012 Co-convenor of Australian National Immunisation Special Interest Group;

(e) 2009 -current Associate of Burnet Institute, Centre for International Health.

9. My work experience includes:

(a) Acting Chief Health Officer, Victorian Department of Health and Human Services, October 2018 – March 2019;

(b) Deputy Chief Health Officer (Communicable Disease), Victorian Department of Health and Human Services, November 2016 – October 2018;

(c) Specialist Public Health Trainee, Burnet Institute, February 2016-November 2016;

(d) Public Health Medical Officer, Office of the Chief Health Officer, Victorian Department of Health, April 2014- February 2016;

(e) Team Leader and Senior Public Health Officer, Communicable Disease Prevention and Control Section, Victorian Department of Health, May 2011- April 2014;

(f) Deputy Chief of Party, USAID bilateral child health project (TAIS), John Snow Inc. (JSI), Timor-Leste August 2009-April 2011;

(g) Field Support Coordinator, USAID bilateral child health project (TAIS), Timor-Leste November 2008-July 2009;

(h) Regional Disease Surveillance Coordinator, IRC, Ethiopia & Kenya April 2007-September 2008;

(i) Senior Emergency Doctor, Sandringham and Sunshine Hospitals August 2004-August 2006;

(j) Director, Emergency Department, NWRH, Tasmania, 2004;

(k) Project Doctor, MSF, Afghanistan, February-August 2003;

(l) Deputy Director, Emergency Department, NWRH, Tasmania, 1999-2003;

(m) Project Doctor, MSF, Afghanistan, February-August 1997.

2. What is your title and what are your key roles and responsibilities within the Department of Health and Human Services (the Department)?

10. My title is Chief Health Officer (**CHO**) and Victorian Chief Human Biosecurity Officer, Regulation, Health Protection & Emergency Management Division in the Department of Health & Human Services.

11. As CHO, my key roles and responsibilities within the Department include performing a range of functions. These include:

    (a) providing high level, expert public health medical, technical and strategic advice and lead policy development, review and reporting on significant public health issues;

    (b) providing high level leadership, and guidance across government and the broader public health sector;

    (c) performing the statutory role and undertake the responsibilities of the Chief Health Officer under the *Public Health and Wellbeing Act 2008* (Vic) (**PHWA**) and other relevant legislation;

    (d) rapidly identify and analyse public health risks to enable interpretation of implications for policy and practice to appropriately undertake associated research, preparedness planning and response;

    (e) overseeing the development of public health standards, procedures, guidelines and policies using consultative processes with stakeholders across government at state and national levels;

    (f) where appropriate, being a government spokesperson on public health matters, in particular during public health incidents and emergencies;

    (g) coordinating the prevention and response to public health incidents and emergencies;

    (h) representing the department on intergovernmental advisory and research committees and community based forums.

12. Under the PHWA, I also have some specific powers which arise in the context of public health emergencies:

    (a) authority to make decisions on matters of public health and to exercise management, control and emergency powers in health emergency situations;

    (b) coercive powers where there is a risk to public health, including the power to authorise appointed officers to exercise public health risk powers (s 189). The public

health risk powers are set out in s 190 (including closing premises, inspecting premises, enforcement powers);

(c) provision of advice to the Minister about a State of Emergency arising out of any circumstances causing a serious risk to public health (s 198(1));

(d) coercive emergency powers (s 200) where a State of Emergency exists, which include:

(i) authorising an authorised officer (orally or in writing) to exercise emergency powers (s 199(2)(a)), including powers to detain persons;

(ii) detaining persons within an emergency area for a period reasonably necessary to eliminate or reduce a serious risk to public health (s 200(1)(a));

(iii) restricting the movement of persons within or into an emergency area (ss 200(1)(b) and 200(1)(c));

(e) must notify the Minister of any detention notice issued under s 200(7): s 200(9); and

(f) may issue examination and testing orders if they believe a person has been exposed to and is likely to transmit an infectious disease which would result in a serious risk to public health (s 113 – a statutory threshold needs to be satisfied to use this power).

13. Relevantly to the COVID-19 response, the Secretary had and continued to delegate the following powers in the Act to me:

(a) sections 30(1) and 30(3)(b), the power to appoint a person employed under Part 3 of the *Public Administration Act* as an authorised officer, including subject to conditions I consider appropriate;

(b) section 30(6), the power to direct an authorised officer in relation to the performance of their functions or duties or the exercise of their powers under the Act or the *Public Health and Wellbeing Regulations.*[1]

14. One of my key areas of focus during the COVID-19 pandemic response has been in relation to my membership of the Australian Health Protection Principal Committee (the **AHPPC**).

[1] Instrument of Delegation by the Secretary to me, dated 15 January 2019, continued in effect by delegations dated 20 April 2020, 18 June 2020 and 6 July 2020.

15. The AHPPC is a decision-making committee for national health emergencies comprising all state and territory chief health officers[2] and is chaired by the Australian Chief Medical Officer. It provides advice to whole-of-government bodies, the National Cabinet and the National Coordination Mechanism.[3] The AHPPC also produces statements that articulates its public advice on the relevant issues.

16. As I discuss further below, I have participated in AHPPC meetings on an almost daily basis since mid-February 2020, and with my team have prepared and provided briefings and recommendations to be considered by the AHPPC in its nationwide response.

17. During the pandemic response, my other areas of focus have been:

    (a) playing a leading role in public communications in relation to the government-controlled measures (the directions and the enforceable requirements);

    (b) providing advice, taking into account AHPPC recommendations, on COVID-19 and appropriate mitigation measures and the matters they address in their public statements and Victoria, by advising the Minister for Health, the Premier and the Crisis Council of Cabinet on policy settings for key public health issues; and

    (c) making decisions on critical matters, normally raised with me by the Deputy Chief Health Officers, usually where something is of high consequence, high importance, contentious or sensitive and therefore escalated to me.

18. In addition to matters being escalated to me, I receive updates from my team about current COVID-19 data and the public health response efforts, including by:

    (a) morning intelligence briefing emails (that are often sent daily), which addressed state-wide numbers and other information relating to the prevailing circumstances at the relevant time;

    (b) an outbreak summary email, which provides a general, high-level overview on an outbreak status, for example, numbers of people that had been swabbed and numbers for the day.

19. These summaries do not contain granular detail about all actions that are taking place.

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[2] In some states, also referred to as Chief Public Health Officers or Directors of Public Health.

[3] Most COVID public health directions originate out of AHPPC, with some coming up to AHPPC from its sub-committee the Communicable Diseases Network Australia (**CDNA**). Senior public medical officials from the department sit on CDNA and I sit on AHPPC

3. What advisory functions do you have as Chief Health Officer?

20. As noted above, in my role as Chief Health Officer, I provide advice as described in paragraphs 11 and 14 above.

21. I have also advised or made decisions in relation to the necessary restrictions to be imposed, in the form of directions under the PHWA.

22. I have provided advice in relation to strategic and policy settings to mitigate or control the COVID-19 pandemic in Victoria, including with regard to communication and engagement; testing; case management and contact tracing; and outbreak or cluster management.

23. Under s 198(1) of the PHWA, I also have a role in advising the Minister with respect to the existence of any circumstances causing a serious risk to public health, for the purposes of the declaration of a state of emergency by the Minister.

24. In relation to Hotel Quarantine, my team provided some public health advice as answered in question 16.

4. Which officers of the Department, if any, are required to report to you as Chief Health Officer? To whom are you, as Chief Health Officer, required to report?

25. Generally, I report to a Department Deputy Secretary who, in turn, reports to the Secretary of the Department, Kym Peake. During the COVID-19 response, the size and structure of the Department's public health team has changed.

26. Up to April 2020, I reported to the Deputy Secretary, Regulation, Health Protection and Emergency Management, Melissa Skilbeck, who reported to the Secretary of the Department, Kym Peake.

27. On 7 April 2020, the Secretary appointed Jacinda De Witts, Deputy Secretary, COVID-19 Public Health Emergency Operations and Coordination, who reports to the Secretary. At the time, the new position was described to me as providing support to me and the Public Health Commander, in managing the growing public health team and departmental staff involved in managing the public health emergency. It then became formalised that I was to report to the Deputy Secretary, COVID-19 Public Health Emergency Operations and Coordination.

28. The Deputy Chief Health Officers report to me. Prior to COVID-19, I had two Deputy Chief Health Officers, one with duties in relation to communicable diseases and the other focussing on the environment and food safety. The Deputy Chief Health Officer (Communicable Disease), Dr van Diemen was placed in the Public Health Incident

Management Team (**PH-IMT**) role to be exclusively focused on COVID-19 and her substantive position was backfilled by others who continued with non-COVID related communicable disease work.

29. On or about 22 July 2020, an additional Deputy CHO, Prof Allen Cheng, was appointed to have specific duties with respect to COVID-19, including acting as Chief Health Officer during my leave days.

30. Prior to the COVID-19 response, the branch I managed was called the Health Protection Branch. The Health Protection Branch is part of the Regulation Health Protection and Emergency Management Division in the Department. I now have a focused role in the new COVID-19 Division, which is explained below.

31. Due to the COVID-19 response, the structure of the Health Protection Branch has expanded and changed since January 2020. The ordinary reporting lines and those that have developed in response to the COVID-19 Public Health Incident Management response are as follows.

32. The ordinary functions of the Health Protection Branch are split into three streams: Communicable Diseases, Environment; and Business and Strategy. As at March 2020, officers in the Department that reported to me in that ordinary structure were:

    (a) Deputy Chief Health Officer (Communicable Disease).[4] Under the Deputy Chief Health Officer (Communicable Disease) sit a number of Public Health Physicians, managers and their respective teams. The teams include Communicable Disease Prevention & Control Unit; Communicable Disease Epidemiology & Surveillance (including epidemiologist Dr Charles Alpren); Immunisation, HIV Policy & Partner Notification and Support; Public Health Medicine Unit (Communicable Disease) (including Dr Finn Romanes and Dr Simon Crouch twinned with Dr Clare Looker[5]); and Antimicrobial Resistance. There were normally approximately 79 employees reporting through to the Deputy Chief Health Officer (Communicable Disease).

    (b) Deputy Chief Health Officer (Environment),[6] who receives reports from a Senior Medical Advisor and managers responsible for the following teams: Environmental Health Policy & Risk Management; Food Safety; Water; Environment Health

[4] Dr Annaliese van Diemen.

[5] As explained below, Dr Romanes, Dr Crouch and Dr Looker have all been seconded from these usual positions to the COVID-19 Division.

[6] Dr Angie Bone.

Regulation and Compliance. There are approximately 71 employees reporting through to the Deputy Chief Health Officer (Environment).

(c) Director, Health Protection Branch, the Strategy and Business Unit – who supervises teams in the Strategic and Business function, namely the Strategic Projects & Regulator Policy Unit; Health Protection Business Unit; and Technology & Systems. There are approximately 20 people working in the strategic and business functions of the health protection branch.

33. As noted above, under this ordinary structure, I report to the Deputy Secretary, Regulation, Health Protection and Emergency Management.

34. On or about 4 April 2020, the PH-IMT was formed to respond to COVID-19. That team comprises a structure intended to address the needs of the COVID-19 response.

35. Reporting to me in the PH-IMT structure is the Public Health Commander.[7] Under the PH-IMT, reporting to the Public Health Commander are four Deputy Public Health Commanders (**DPHC**) each with his or her own team:

(a) Pathology and Infection Prevention and Control;

(b) Case, Contact and Outbreak Management;

(c) Strategy and Implementation; and

(d) Intelligence.

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

37. Under the State Governance arrangements put in place for COVID-19, I was a member of the State Coordination Team which oversaw the coordination functions for the emergency response and set the strategic context of the readiness, response, relief and recovery phases. My role on that committee was largely to report in the daily numbers and provide advice on how the various stages were being implemented across Victoria.

38. Since the end of July, I have been in the State Control Team. The State Control Team is chaired by the Emergency Management Commissioner and comprises Secretaries from relevant departments, the Chief Commissioner of Police and me. It will aim to ensure that government actions are appropriately coordinated; that intelligence is driving and informing

[7] Presently, Dr Finn Romanes.

decision making and that government strategic decisions are operationalised in responding to the COVID-19 pandemic.

DELEGATIONS BY YOU AS THE CHIEF HEALTH OFFICER

5. Since the declaration of a state of emergency in Victoria on 16 March 2020 which of your powers as Chief Health Officer have you delegated and to whom did you delegate them?

39. Under section 22 of the PHWA, I can delegate any of my powers, duties or functions. My power to delegate is limited and must be to a registered medical practitioner who is also an executive officer or a senior medical advisor employed under Part 3 of the *Public Administration Act.*

40. On 8 November 2019 and 11 December 2019, I signed instruments of delegation, delegating several powers to the Deputy Chief Health Officer (Environment) and the Deputy Chief Health Officer (Communicable Diseases).[8] Both instruments of delegation were in force on 16 March 2020 and remain in force, by virtue of a further instrument of delegation dated 19 June 2020 and 6 July 2020.

41. By these instruments, I delegated the powers in the Act to both the DCHO (Environment) and DCHO (Communicable Diseases)[9] in: s 113(1), the power to make an examination and testing order; s 113(3), the power to include specified items in an order or make the order subject to any conditions; s 117(1), the power to make a public health order; s 188(1), the power to direct a person to provide information in relation to a direction to provide information; s 188(4)(a), the duty to warn a person; s 188(4)(b), the duty to inform a person in relation to a direction to provide information.[10]

42. As explained later in this statement, under the PHWA I also appointed persons as authorised officers and authorised some of those officers to exercise public health risk powers and emergency powers. This is not a delegation but an authorisation of the exercise of certain powers.

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[8] Public Health and Wellbeing Act 2008 Chief Health Officer - Instrument of delegation, 8 November 2019, DHS.0001.0045.0001 and Public Health and Wellbeing Regulations 2019 - Chief Health Officer - Instrument of delegation, 11 December 2019, DHS.0001.0045.0007.

[9] As a matter of practice, while Dr van Diemen remained in the role of DCHO (Communicable Diseases), as I explain above, she was in an exclusive COVID-19 role as Public Health Commander. Mihaela Ivan was also acting DCHO (Communicable Diseases).

[10] fn 8 above.

6. Why did you delegate those powers?

43. I delegated the powers referred to in question 5 so that the DCHOs could exercise those powers, in particular to make public health orders and testing orders.

44. Until early this year, I often made all of these decisions myself, but given the scale of the pandemic, delegating these powers enabled those officers to assist in that work.

PANDEMIC PRE-PLANNING

7. Before 16 March 2020, did Victoria have any documented plan for responding to an infectious disease pandemic? If so, please identify any such document.

45. Prior to 16 March 2020, Victoria had two pandemic response plans. It had the Victorian Health Management Plan for Pandemic Influenza 2014 (the **VHMPPI**, or the **Health Pandemic Management Plan**) and the Victorian Action Plan for Pandemic Influenza 2015 (the **EMV pandemic plan**).

46. The aim of the Health Pandemic Management Plan is to provide a health response framework to minimise transmissibility, morbidity and mortality associated with an influenza pandemic.[11] The EMV pandemic plan articulates Victoria's approach to minimising the social and economic impacts and consequences of pandemic influenza on communities.[12]" Both plans were prepared in the context of the national response to the preparation and planning for an infectious disease pandemic.

47. The Health Plan Pandemic Management Plan was originally written in 2007 and updated in 2014 in response to lessons from the H1N1 pandemic. When it was developed in 2007 it reflected the Australian Health Management Plan for Pandemic Influenza (**AHMPPI**). It was updated once the AHMPPI was updated following the 2009 pandemic. I believe similar plans would be developed in other jurisdictions to reflect the AHMPPI.

48. With the onset of COVID-19 infections in Victoria, the Health Pandemic Management Plan was amended in February 2020, once the Department assessed the seriousness of its potential impact for Victoria. That amended plan was the State's COVID-19 Pandemic Plan for the Health Sector, published on the Department's website on 10 March 2020. The EMV pandemic plan and the arrangements pursuant to the Emergency Act and the SHERP remained in place.

49. The COVID-19 Pandemic Plan for the Health Sector and related protocols are prepared with regard to the Series of National Guidelines (**SoNGs**). The SoNGs have been

[11] Health Pandemic Management Plan, Department of Health, October 2014, p 4.

[12] Victorian Action Plan for Pandemic Influenza 2015, p 6.

developed in consultation with the CDNA and are endorsed by the AHPPC. Their purpose is to provide nationally consistent advice and guidance to public health units in responding to a notifiable disease event. The SoNGs are updated regularly and ascribed version numbers.

50. The Department also regularly undertakes emergency incident exercises where the emergency management regime and the SHERP are performed. These exercises are undertaken on a regular basis and also often include other agencies.

51. Some of those exercises have included infectious disease scenarios, however, it is recognised in emergency management that being able to predict the exact emergency that will need to be responded to is unlikely. Instead, the key benefit is the practice of responding to a plan and the engagement of all areas and agencies.

52. There are two national-state committees relevant to preparedness in relation to communicable diseases. First, the AHPPC, on which I sit and which I discuss below. Second, the CDNA, which is a subcommittee of the AHPPC and on which one of my Deputy CHOs sits. Both committees also commission ongoing pandemic research and modelling. The AHPPC has other relevant subcommittees, including the National Health Emergency Management subcommittee and the Public Health Laboratory Network.

53. This includes the establishment and funding of the Australian Partnership for Preparedness Research on Infectious Disease Emergencies (**APPRISE**) based at the Doherty Institute here in Melbourne. The Department has a close working relationship with the APPRISE secretariat. Discussions were underway in October 2019 between APPRISE and the Department about the planning of a Victorian pandemic exercise early in 2020.

Concept of Operations, DHHS

54. In November 2019, Andrea Spiteri, the Director, Emergency Management Branch (and State Health Coordinator) and I prepared a joint document, the *"Concept of Operations, Department of Health and Human Services as a Control Agency and as a Support Agency in Emergencies"*[13] (the **Concept of Operations document***),* which is an overarching guidance document for staff working in the department in emergency-related roles.

55. It is relevant to a number of public health emergencies including communicable disease such as an infectious disease pandemic. The document articulates the key functions of

[13] Concept of Operations, Department of Health and Human Services as a Control Agency and as a Support Agency in Emergencies, DHHS, 25 November 2019, DHS.0001.0001.0004.

Public Health Command; Departmental Command; Health Coordination and Relief and Recovery Coordination and services.[14]

56. The Concept of Operations document recognises that communicable diseases "can build over day weeks or months… [to be] eventually recognised as a pandemic."[15] It is intended to set out the Department's "operational functions, roles, key activities and deliverables at the state and regional tiers across all types of emergencies…[and] describes the Concept of Operations for public health emergencies where the department is a support and/or coordination agency."[16] These roles, activities and deliverables are largely tested and practised by the department in regular exercises in preparation for public health emergencies.

57. I am aware of some but not all of the exercises the Department has been involved in.

58. I am aware that the Department worked with Emergency Management Victoria in the *Alchemy Exercise* in August 2018. Emergency Management Victoria ran the exercise to assess state level communications processes relevant during a Biosecurity Emergency that transitions to a Pandemic Emergency. I was not involved in that exercise.

59. On 10 September 2019 the Health Protection Branch, with the Emergency Management Branch of the department, led an exercise called 'Exercise Teapot'. This was a discussion exercise attended by representatives of the department and multiple agencies, which explored a complex multiagency emergency involving widespread outbreaks including of Middle Eastern Respiratory Syndrome coronavirus (MERS-CoV).

8. If there was a documented plan for responding to an infectious disease pandemic, did that plan provide for or envisage either a small or large-scale detention of people arriving in Victoria from interstate or overseas? If it did, please identify any relevant part of the plan which provided for or envisaged such detention.

60. The Health Pandemic Management Plan did not envisage the mandatory detention of people in large-scale detention. Insofar as the plan addressed isolation or quarantine, it focused on the voluntary isolation of people in their own homes. This was the initial response in Victoria and throughout Australia. Large-scale mandatory detention would not be a consideration in an influenza pandemic and had not previously been conceptualised

[14] Ibid.

[15] Ibid., p3

[16] Ibid., p2.

(e.g. by the World Health Organization) as a routine response to a potential coronavirus pandemic.

61. I understand that the Office of Health Protection in the then Department of Health and Ageing developed the National Pandemic Influenza Airport Border Operations Plan (**Fluborderplan**), with contributions from AHPPC and CDNA. The Victorian Health Pandemic Management Plan took this plan into account.[17] The Fluborderplan recognises the possibility of quarantining. However, even at that level, I am not aware that there was an in-depth consideration of the potential for a large-scale detention based quarantine program, to the extent that has been necessary in response to the COVID-19 pandemic.

9. To what extent, if any, were the plans that Victoria had in place for responding to an infectious disease pandemic prior to 16 March 2020 informed by the experiences in Victoria or elsewhere in dealing with:

(a) the Middle East Respiratory Syndrome (MERS) pandemic;

(b) the Sudden Acute Respiratory Syndrome (SARS) pandemic;

(c) the H1N1 Pandemic (Swine Flu); and/or

(d) any other pandemic or epidemic.

62. As explained, the Health Pandemic Management Plan was updated as a direct result of lessons from recent pandemics. The infectious disease pandemics that informed the Health Management Pandemic Plan) were primarily the H1N1 (swine flu) pandemic, the H5N1 (bird flu) pandemic that was circulating internationally as well as the H7N9 (avian influenza) virus that was emerging from China in 2013.[18] Pandemics that occurred prior to the 2007, such as SARS (2003) and the avian influenza (H5N1) first reported in Hong Kong in 1997, would have informed that plan and therefore, as a legacy, also informed the updated 2014 plan.

63. Listed Human Diseases under the *Biosecurity Act* 2015 (Cth) include diseases that are communicable and may cause significant harm to human health. The list includes MERS, SARS and 'human coronavirus with pandemic potential'. This is in recognition of the pandemic potential of certain human coronaviruses. SARS (2003) and MERS are notifiable diseases under the PHWA. The previous CHO, Prof Charles Guest, prepared a protocol in 2016 in relation to MERS and the Department continues to monitor those diseases.

[18] Health Pandemic Management Plan, Department of Health, October 2014, p 1.

[18] Health Pandemic Management Plan, Department of Health, October 2014, p 1.

64. The Health Pandemic Management Plan does not specifically refer to being informed by the MERS-CoV (2012) or SARS (2003), however given when the plan was approved and also as it was reflective of World Health Organization plans and information, it is likely that it was at the very least informed by SARS and MERS-CoV to the extent that the WHO was also informed by those epidemics.

65. The Plan had also been informed by the extensive lessons and understanding of the three major influenza pandemics of the 20th century: the 1918-19 influenza pandemic estimated to have caused 20-50 million deaths worldwide, as well as pandemics in 1957 (2-3 million estimated deaths) and in 1968-1969 (1 million estimated deaths). Pandemics are a known and planned-for activity by health departments across Australia and the world.

66. The SHERP was also substantially amended in 2017 following thunderstorm asthma events that occurred in November 2016. Whilst not directly related to influenza, it led to changes to the SHERP relating to rapid-onset demand of the health service which are relevant to a pandemic response.

10. In your view, were any plans that Victoria had in place prior to 16 March 2020 for responding to an infectious disease pandemic:

(a) appropriate;

(b) adequate;

(c) sufficiently considered; and

(d) sufficiently resourced,

to cope with the COVID-19 Pandemic. Please explain your reasons for each answer.

67. As outlined above, the State had plans in place to deal with known pandemic risks and also more general plans to respond to an infectious disease pandemic. These plans were appropriate and contemporary but were only supported by a single policy officer. Additional resourcing for pandemic planning would have likely allowed for greater plan development, training, stakeholder engagement and adaptation to COVID-19 planning challenges.

68. The scale of the COVID-19 pandemic has also had unique elements with regard to the global response, including significant clinical severity of illness; an extremely protracted period of response; and significant potential for control (including local elimination) through behavioural and other interventions. State challenges included the ability to scale up quickly, constrained access to the levels of authorised officers needed to manage the hotel quarantine operation and scaling up contract, case and outbreak management processes.

69. In my view, the planning efforts that had been undertaken enabled us to quickly adapt, as best we could, to take into account COVID-19, noting that our responses adapted to our increasing understanding about the disease as more information became available to us about its epidemiological and clinical characteristics.

INITIAL PLANNING

11. Were you aware, in advance of 16 March 2020, of the potential for a State of Emergency to be declared in Victoria? If so, state how you became so aware.

70. From my role and past experiences, I have a general awareness of the circumstances in which a State of Emergency could be declared in Victoria.

71. Before the State of Emergency declaration on 16 March 2020 in Victoria, I was aware of the following key events, relevant to that decision.

72. On 10 January 2020, I issued an alert for patients[19] who had travelled from Wuhan, China who experienced the onset of fever and respiratory symptoms within 14 days of their return.

73. In the following weeks, the risk of the COVID-19 outbreak increased in Victoria (and across the world), particularly in late January 2020 after the Chinese New Year holiday migration within and to China.

74. As noted above, I am a member of AHPPC. By late January 2020, the AHPPC had met to consider a national response to COVID-19. I attended this meeting. I was already conscious of the potential need for an emergency response to be invoked, and the possibility of such a response was discussed in the meeting.

75. On 29 January 2020, I issued a CHO Alert for clinicians in relation to COVID-19. At the time there were two confirmed cases and the alert advised clinicians wear masks when dealing with patients coming from Hubei province.[20]

76. On 30 January 2020, the World Health Organisation (**WHO**) declared COVID-19 a public health emergency of international concern (PHIEC).

77. On 1 February 2020, the AHPPC recommended that entry to Australia should be denied for people who have left or transited through mainland China. I had strongly supported this

[19] CHO Alert, Pneumonia cluster in Wuhan China, 10 January 2020, DHS.5000.0057.9657.

[20] CHO Alert – 2019 Novel Coronavirus (2019-nCoV), 29 January 2020, DHS.5000.0057.0480.

measure and advocated that it should have no exceptions, as had been a consideration at that time.

78. On 23 February 2020, I publicly expressed my view that a pandemic was very likely, if not inevitable. I tweeted the following:

> *"Victoria has been working on its #pandemic preparedness for #COVID19 for some weeks. It's clear that with local transmission in several countries that a pandemic is very likely, if not inevitable. We are working rapidly on planning and surge with our health sector. (1/6)*
>
> *We've provided guidance to practitioners and many communications materials but are now focused on the models of care that will need to be in place - clinics, phone triage, home care, right through to ICU and aged care. There are dozens focused on this across the sector. (2/6)*
>
> *Victoria and Australia nonetheless remain completely in containment mode - identifying any possible case; isolating those who are infectious; and quarantining contacts. Regardless of developments internationally, this gives all of us time and space to plan and prepare. (3/6)*
>
> *I'm speaking to my CHO counterparts daily and briefing the sector - and indeed all sectors - through our emergency management arrangements, under @CommissionerEMV . This is critical - pandemics challenge all sectors with effects on supply, workforce and business continuity. (4/6)*
>
> *Australia absolutely has world-class healthcare but even the best healthcare in the world is challenged during pandemics, so everyone will need to work together to ensure that should a pandemic eventuate, our services can function as effectively as possible. (5/6)*
>
> *We've got some of the brightest minds in the world in our health services, laboratories, research sector and emergency management sector. I'm confident we're well placed to meet the challenges ahead, whatever they might be. Hoping for the best, and planning for the worst. (6/6)"*

79. On 27 February 2020, the Commonwealth Government announced that Australia is treating COVID-19 as a pandemic and that it had activated an Australian Health Sector Emergency Response Plan.

80. On 11 March 2020, WHO announced that in their view, COVID-19 should be characterised as a pandemic.

81. By mid-March I had considered whether the COVID-19 pandemic constituted a serious risk to public health for the purposes of the exercise of the Minister's power under the PHWA to declare a state of emergency and had concluded that the COVID-19 pandemic constituted a serious and potentially catastrophic risk to public health and that the declaration of a state of emergency could assist in reducing that risk. I provided this advice formally to the Minister on 15 March 2020.

12. What, if any, functions in relation to Victoria's COVID-19 response were allocated to you when the State of Emergency was declared on 16 March 2020?

82. When the state of emergency was declared on 16 March 2020, I was then able to authorise the exercise of public health risk powers and emergency powers if I believed it necessary to eliminate or reduce a serious risk to public health.[21]

83. The emergency powers included the power to detain individuals in the emergency area for a reasonably necessary period.[22]

84. On or before 17 March 2020, I authorised the DCHO, Dr van Diemen as an Authorised Officer.[23] Dr van Diemen made a number of the directions relevant to hotel quarantine.

85. On 18 March 2020, Dr van Diemen made the Airport Arrivals Direction and, on 28 March 2020, she made the Direction and Detention Notice. Dr van Diemen was able to make these directions due to the powers vested in her as an Authorised Officer as a result of the State of Emergency. In so doing, she had to be satisfied of the relevant criteria in s 200 of the Act and that making the directions was consistent with the principles of the PHWA and the Charter.

86. However, other Authorised Officers also exercised relevant emergency powers, specifically, making and serving the individual detention notices on returning travellers at airports.

87. Since the declaration of a state of emergency in Victoria on 16 March 2020, I have made and extended many authorisations under Division 3 of Part 10 of the Act to authorise specified authorised officers to exercise public health risk powers and emergency powers. On each occasion, I made an authorisation because I believed that it was necessary for the purpose of eliminating or reducing a serious risk to public health.

88. On 16 March 2020[24] and again on 29 March 2020[25], I also sought the assistance from the Chief Commissioner of Police that police officers provide assistance to authorised officers to enforce compliance with directions made under s 200 of the Act.

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[21] PHWA, s 199.

[22] PHWA, s 200(1)(a).

[23] Public Health and Wellbeing Act 2008 - Instrument of authorisation, 17 March 2020, DHS.0001.0011.0741.

[24] Request for assistance from Chief Health Officer to Chief Commissioner of Police under s 202 of the Public Health and Wellbeing Act 2008, 16 March 2020, DHS.5000.0055.3884.

[25] Request for assistance from Chief Health Officer to Chief Commissioner of Police, 29 March 2020, DHS.0001.0012.1504.

89. When exercising the powers in the PHWA, the DCHO and I, along with all authorised officers, needed to consider the principles of the PHWA and the Victorian *Charter of Human Rights and Responsibilities Act 2006* (**Charter**).

13. Did you play any role in the National Cabinet, including by way of briefings or information gathering, for the assistance of those attending the National Cabinet? If so, what was that role?

90. I am not a member of National Cabinet and have not participated in National Cabinet deliberations.

91. The AHPPC, of which I am a member, advises National Cabinet on COVID-19 treatments, modelling, strategies and actions. For example, most of the COVID public health directions originate out of AHPPC, with some coming up to AHPPC from its sub-committee the CDNA. One of my senior medical advisors sits on CDNA as my representative.

92. As representatives for Victoria on the AHPPC and CDNA, from time to time papers, research, information and other documents are prepared by my staff for use by AHPPC and CDNA sessions. However, it is the single voice of AHPPC that provides advice to National Cabinet.

93. In my role as Chief Health Officer, I have also provided advice in relation to the COVID-19 response to the Premier, who is a member of National Cabinet.

14. Prior to 27 March 2020 did you have a role in planning for the possibility of any form of quarantine for returned travellers?

94. Prior to January 2020, as discussed in answer to questions 8 and 9, I have been involved in general pandemic planning.

95. In relation to the quarantining of returning travellers in Victoria in order to reduce transmission of COVID-19, in my role as CHO, I have advised the Victorian government and sat on the AHPPC to consider the key mitigation strategies that could be implemented. Thus the decision to quarantine returning travellers might be considered in the context of the anterior steps taken to reduce transmission risks. These steps began with isolation and social distancing.

96. On 29 January 2020, the AHPPC, met to consider a national response to COVID-10. Australia had declared COVID-19 a communicable disease incident of national significance on 21 January 2020. After the AHPPC's meeting, on 29 January 2020, the Australian Chief

Medical Officer recommended that anyone travelling from Hubei province should isolate for 14 days. The Department implemented this decision in Victoria.

97. At the same time, in Victoria, the *Public Health and Wellbeing Regulations* 2019 were amended to require that the Department be notified of positive COVID-19 test results.[26] This enabled the department to collect data on COVID-19 cases in Victoria in order to consider how to reduce the spread of the virus.

98. On about 2 February 2020, SoNG v1.2 was released by the CDNA. It recommended that "*Returned travellers who have left or transited through China in the last 14 days who are unwell with respiratory symptoms, with or without fever, or other symptoms consistent with 2019-nCoV should be isolated and managed as per the current recommendations for suspected case*."

99. Countries were progressively added the list. By 5 March 2020, SoNG 1.17 released by the CDNA provided that returned travellers from China, Iran, South Korea should self-quarantine at home for 14 days. This was a recommendation and self-quarantine was not legally mandated. Italy was added to this list on 13 March 2020.[27]

100. On 15 March 2020, the Australian National Security Committee (**ANSC**) decided that there should be a universal, precautionary self-isolation requirement on all international arrivals to Australia effective from midnight on 15 March 2020. In addition, cruise ships departing from foreign ports would be banned from arriving at Australian ports after an initial 30 days. The ANSC also decided that all people travelling to Australia from overseas should be required to self-isolate for 14 days.

101. On 15 March 2020, the National Cabinet instituted a consistent, national response to COVID-19, on the above advice of AHPPC.

102. As noted in response to question 11, on 16 March 2020, the Victorian Minister for Health, declared a state of emergency under s198 of the PHWA throughout Victoria for a period of 4 weeks in response to the serious risk to public health presented by COVID-19. The state of emergency has been extended on numerous occasions and applies until 16 August 2020.[28]

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[26] *Public Health and Wellbeing Amendment (Coronavirus) Regulations* 2020, commenced 29 January 2020, regs 3 and 4 inserts item 15A into Schedule 3 and 4, being "regulation 15A Novel coronavirus 2019 (2019-nCoV)".

[27] SoNG, v2.0, dated 13 March 2020.

[28] It was extended on 12 April 2020 (effective midnight on 13 April 2020); 11 May 2020 (effective midnight on 11 May 2020); 31 May 2020 (effective at 11:59 pm on 31 May 2020); 21 June 2020 (effective at 11:59 pm on 21 June 2020); 19 July 2020 (effective 11:59 pm on 19 July 2020) until 16 August 2020.

103. In March 2020, the DCHO (Dr van Diemen) and I began to make orders and directions under the PHWA relevant to COVID-19, including in relation to social distancing and ultimately, in relation to quarantining returning travellers.

104. In the first four weeks of a state of emergency, the DCHO and I issued 20 sets of legal directions, usually within 24 hours of National Cabinet decisions

Residential quarantine

105. On 16 March 2020, I issued a direction under the PHWA requiring overseas travellers to self-quarantine.[29] The direction also banned non-essential mass gatherings (500 people or more).[30] On 18 March 2020, the DCHO (Annaliese van Diemen) made a further direction, referred to as the Airport Arrivals Direction, which replaced the direction I made on 16 March 2020.[31] In circumstances where a person did not have access to suitable premises in Victoria, this may have been a hotel, although this is not expressly stated in the direction.

106. The self-quarantine requirements in the directions were that any person arriving in Victoria on an overseas flight (even if connecting through another Australian state) to travel from the airport to a premises suitable for the person to reside in for 14 days. The person was then required to reside in that premises, except in identified, exceptional circumstances, for 14 days. The period ended at midnight on the 14th day after arrival. The person was not to leave the premises other than for the purposes of obtaining medical care or medical supplies, in any other emergency situation and in circumstances where it was possible for the person to avoid close contact with other people. In addition, the person was not permitted to allow other persons to enter the premises, unless that other person usually lived at the premises and also complied with the 14 day requirement (or entered for medical or emergency purposes).

107. Failure to comply with the requirements was an offence.

Hotel quarantine

108. My role as relevant to the implementation of hotel quarantine is addressed in answer to question 15.

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[29] This was consistent with the SoNG 2.1, dated 20 March 2020 that provided that All returned travellers who have undertaken international travel and returned on or after 16 March 2020 should self-quarantine at home for 14 days after arrival in Australia.

[30] Direction from the Chief Health Officer in accordance with emergency powers arising from declared state of emergency, 16 March 2020. DHS.5000.0055.3880.

[31] Direction from Deputy Chief Health Officer, Airport Arrivals, 18 March 2020, DHS.5000.0084.0648.

109. Over 26 and 27 March 2020, National Cabinet met and agreed to reduce a major source of transmission risk and growth in COVID-19 cases by requiring all travellers arriving in Australia to undertake their mandatory 14 day self-isolation at designated facilities (for example, a hotel).

110. The Department led the drafting of model directions for other states and territories to give effect to this decision. The DCHO signed off on the Charter assessment and form of the Direction and Detention notice, and mandatory detention of international arrivals was introduced from 11.59pm on 28 March 2020.

111. While hotel quarantine was required to give effect to the decision of National Cabinet, it was necessary, given that the detention of travellers would require the exercise of powers under the PHWA, for me to consider whether that measure was open in terms of these statutory powers, and noting that in exercising powers under the PHWA, I and authorised officers are regarded as public authorities with obligations under s 38 of the Charter.

112. The DCHO (Dr van Diemen) and I came to a common view about how best to take forward the necessary intervention to prevent cases of community transmission. We formed the view that balancing the constraint on liberty, other human rights and other considerations, hotel quarantine was seen as the least restrictive means reasonably available to stem the spread and effect of the COVID-19 virus. At that time, more than 60% of cases in Australia were attributable to international arrivals and quarantine was the most robust way of implementing an effective intervention.

113. On 28 March 2020, to give effect to the National Cabinet's decision and hotel quarantine, the DCHO made a direction, titled the Direction and Detention Notice.[32] The Direction and Detention Notice was given to each person arriving in Victoria from outside Australia (for example at Victoria's two airports), requiring them to be detained in a specified hotel room, for a period of 14 days. The Direction and Detention Notice facilitated and underpinned the hotel quarantine program in Victoria.

114. The directions have been referred to as "Detention Authorisations" as they were made pursuant to s 200(1)(a) of the PHWA, which provides for the power to "detain any person or group of persons in the emergence area for the period reasonably necessary to eliminate or reduce a serious risk to public health."

[32] Direction and Detention Notice, 28 March 2020, DHS.0001.0004.1695.

115. There have been seven versions of the Direction and Detention Notice[33], made between 28 March 2020 and 19 July 2020. There have been no material changes between these versions, except as follows:

(a) Direction and Detention Notice (No 5) includes an amendment which permits a person in quarantine to leave quarantine to visit a patient in hospital where they are permitted to do so under the *Hospital Visitor Directions (No 6)*; and

(b) Direction and Detention Notice (No 6) includes amendments which state that a person in hotel quarantine will be detained for a further period of 10 days from the end of their detention period if they refuse to be tested for COVID-19 on the request of an Authorised Officer while in hotel quarantine. This was in response to the policy on testing, as discussed below.

116. I **attach** a chronology of the legal directions which have been issued under the PHWA in relation to COVID-19 up to 3 August 2020.

15. Did you have any role in the decision to change course from directing international arrivals into Victoria into self-isolation at home, to directing arrivals into the Victorian Hotel Quarantine Program? If so, what role did you have?

117. After New Zealand began using hotel quarantine for international arrivals, on 14 March 2020, I raised the issue of mandatory emergency accommodation for returning international travellers with the AHPPC in the third week of March 2020, based on the New Zealand model. The idea was not progressed at that time.

118. The National Cabinet made the decision to introduce mandatory quarantine, on 27 March 2020, for implementation by 11.59pm on 28 March 2020.

[34] Concept of Operations, above fn 13.,

THE VICTORIAN HOTEL QUARANTINE PROGRAM AND OPERATION SOTERIA

16. What was your involvement (if any) in the:

(a) planning;

(b) approving;

(c) running,

of the Victorian Hotel Quarantine Program?

119. I was not directly involved in the operational planning, approving or running of the Victorian hotel quarantine program. However I was involved in elements of the framework supporting the programs, including the oversight of directions issued under the PHWA in relation to implementation of the mandatory 14 day quarantine requirement, the appointment of AOs to perform roles required in relation to persons in hotel quarantine, and the oversight of some of the health and welfare considerations relating to the population in quarantine.

120. I was involved in providing supportive guidance and advice that was available to Operation Soteria through the PH-IMT.

121. PH-IMT articulated relevant public health principles and provided general public health advice relevant to COVID-19, in relation to, for example, hand hygiene, social distancing, PPE and testing.

17. Were you or any of your staff consulted at any stage during the Victorian Hotel Quarantine Program as to the necessary infection control processes and procedures that should be embedded into hotel quarantine sites? If so, what was that advice?

122. I had no personal involvement in implementing the IPC arrangements in Hotel Quarantine. As outlined above, I was responsible for providing general advice that could then be tailored to specific circumstances.

123. For example, I was involved in developing the Concept of Operations policy, dated 25 November 2019.[34] It outlined key functions and activities in relation to 'Emergency Accommodation Coordination' provided to persons required to quarantine or isolate.

[34] Concept of Operations, above fn 13.,

124. The Public Health Commanders and the IPC team, reporting to a Deputy Public Health Commander, were asked to provide information on best evidence-based approaches to managing cases in hotel quarantine.

125. I understand that Dr van Diemen and Dr Finn Romanes were involved in the preparation of the Incident Action Plan. On 2 February 2020, version 1 of the Department's for "2019-nCov public health incident" (**Incident Action Plan**) was in use.[35] It articulated overarching strategies and principles. It addresses the objectives and strategies to respond to and minimise the impact of COVID-19 on the health and wellbeing of Victorians including objectives and strategies for the incident management team structure and governance and case and contact management.

126. The IAP was intended to be an overview of the public health response. It applied in the way we went about managing the epidemic. The Outbreak Management Plan, by contrast, addressed how specific outbreaks would be managed. As the scale of the COVID-19 response grew, the document ceased to be used.

127. On 5 June 2020, I approved the final COVID-19 Outbreak Management Plan.[36] Prior to this, including at the time of the Rydges and Stamford outbreaks, earlier versions of the document were in existence and were being used. I reviewed a number of earlier drafts.

128. On occasion, I raised specific issues, if they had been escalated to me. For example, in early April 2020, I raised PPE in a State Health Incident Management Team meeting to advise that health care workers should wear basic PPE and that high levels of PPE should be reserved for higher risk cohorts.[37] At this time, hospitals were consuming PPE quickly. This followed AHPPC advice to the Communicable Disease Network of Australia (**CDNA**), on 30 March 2020, that correction and detention and group residential settings are higher risk of outbreaks of COVID and recommendations about managing vulnerable workers. As it had been raised at AHPPC, I then passed it on.

18. What did you understand to be the relationship between the Victorian Hotel Quarantine Program and Operation Soteria?

129. I understood Operation Soteria as providing the logistical and operational framework to provide the health, human services and wellbeing functions required by the quarantining of

[35] 2020 Novel CoV Incident Action Plan - 2 February 2020, DHS.5000.0056.3655.

[36] Outbreak Management Plan, 5 June 2020, DHS.0001.0006.0531.

[37] State Health Incident Management Team Minutes, 1 April 2020, DHS.0001.0004.1362.

returned travellers, as required by the decision of National Cabinet on 27 March that people returning to Australia from overseas should be required to quarantine for 14 days.

19. What did you understand to be the objective(s) of:

(a) the Victorian Hotel Quarantine Program;

(b) Operation Soteria?

130. Quarantining is the separation of potentially well people, that may have been exposed to an infectious disease, from other parts of the population to prevent the spread of that disease.

131. The objectives of the Victorian Hotel Quarantine Program were to reduce a major source of infection and growth in COVID-19 cases by preventing a high-risk cohort from potentially passing the virus on to others. This was done by quarantining returning travellers for 14 days to allow any persons that had been exposed to COVID-19 while overseas to develop symptoms and be tested.

132. The Program aimed to prevent the transmission of COVID-19 from returning travellers to the broader Victorian population. In March 2020, the major form of transmission of COVID-19 in Australia was from returned travellers.

133. To the extent that I was aware of Operation Soteria, my understanding is that it aimed to provide the logistical and operational support to meet the aims of the Hotel Quarantine Program.

20. When did Operation Soteria first commence?

134. I am informed that Operation Soteria commenced on 28 March 2020.

21. As at the date Operation Soteria first commenced, did you consider that its structure was the best available option for achieving the described objectives of:

(a) Operation Soteria; and/or

(b) the Victorian Hotel Quarantine Program?

Please give reasons for your answers to (a) and (b) above.

135. When Operation Soteria commenced, I was not sufficiently aware of the details of its structure to form a view about whether it was the best available option for achieving the desired objectives.

136. In my view the quarantining of persons in hotels was a robust mitigation measure for the prevention of transmission of COVID-19 in the community from returning travellers.

137. When it was commenced, I was not aware of the detail of the program in order to form a view about whether that structure was best suited to meet the program's objectives.

22. At any time since its commencement did you form a view about the appropriateness of the following elements of Operation Soteria

(a) the quarantining of persons in hotels;

(b) the use of private security companies to enforce or assist in the enforcement of quarantine requirements in hotels;

(c) whether the appropriate infection control personnel and processes were in place at each hotel contracted into the program?

(d) whether identified cases of people testing positive to COVID-19 in hotel quarantine should be moved from their original hotel into a hotel clustering positive cases together?

a) the quarantining of persons in hotels

138. As discussed above, in my view, quarantining in hotels was a robust mitigation strategy against the spread of infection.

b) the use of private security companies to enforce or assist in the enforcement of quarantine requirements in hotels

139. At the time of its commencement, I did not have a view about the use of security companies in hotel quarantine. I did not know that security guards were used until after the outbreaks.

140. Following the outbreaks, in June 2020, I raised with the COVID-19 Accommodation Commander whether there were alternatives to using security contractors as they posed some transmission risk. I also raised the idea of routine symptomatic testing.[38] In reply,[39] I was informed that alternative workforce models were being considered in addition to increased training of security guards, which I understand happened.

141. This is an example of where I might raise something if it was a new or discrete matter in respect of which I thought Operation Soteria might not be aware. I did not otherwise, as a

[38] Email dated 21 June 2020, DHS.5000.0034.6968.

[39] Ibid.

matter of course, discuss routine IPC matters with Operation Soteria command or reflections from Public Health Commanders.

142. With the benefit of hindsight, I can see that using a highly casualised workforce, generally from a lower socio-economic background, where that means that poor leave provisions limit how one can care for and financially support one's family if unwell. In addition, where many of these staff might combine multiple, piecemeal jobs across different industries to maintain an adequate income, creating transmission risk. In addition, the security guard workforce is often represented by people with relatively larger families and larger networks of friends, which creates additional transmission risks should they become unwell.

c) whether the appropriate infection control personnel and processes were in place at each hotel contracted into the program?

143. My team and I did not have oversight in relation to infection, prevention and control personnel and processes in place at each hotel. The infection prevention control consultant in the PH-IMT provided overarching, state-wide guidance in relation to IPC and PPE that all workplaces and settings were to implement and was available to Operation Soteria for troubleshooting when requested.

144. Until the outbreaks at the Rydges and the Stamford Plaza Hotels, I was not aware of the sufficiency of the infection control processes in place. The IPC arrangements were being managed by Operation Soteria with an independent consultant.

145. From my review of the outbreak management reports in respect of both hotels, I can see that there were challenges in how IPC was being managed and that this increased transmission risks.

d) whether identified cases of people testing positive to COVID-19 in hotel quarantine should be moved from their original hotel into a hotel clustering positive cases together?

146. I was not consulted about moving positive cases into one hotel floor or to a specific hotel.

147. I understand that in Operation Soteria meetings, of which I was not a part, the concept of identifying a smaller hotel that could be used for COVID-19 positive people was raised in early April.

148. At the time, COVID-19 positive travellers were occupying floors of a hotel (leaving empty rooms that were not able to be used by persons that were not COVID-19 positive).

149. Creating a COVID-19 positive hotel, or a "hot hotel", was intended to mitigate the current circumstance where COVID-19 positive people occupy a floor of each hotel, so that other rooms cannot be used for persons not COVID-19 positive. It would also allow specific IPC measures to be adopted to take into account the increased risk.

150. The specific question of whether a "hot hotel" should be used became particularly significant in the context of a flight arriving from Uruguay with 70 passengers on board that were COVID-19 positive.

151. In my view, combining positive cases into one location is generally a sound approach from an IPC perspective as it minimises the risk of transmission created by positive cases being accommodated with people who have not been exposed.

23. If so, what were your views, when did you form them, and did you express them to any other and which person holding an official position?

152. Including for the reasons expressed in answer to question 22, following the outbreaks at the Stamford and Rydges Hotels, I formed the view that these settings clearly represented a risk of transmission from quarantined individuals to contracted staff.

153. I expressed these views to the Public Health Commander, noting that she was a point of liaison with the commander of Operation Soteria and noting that review of the circumstances of transmission were being investigated with the support of the outbreak management teams for those outbreaks.

24. Save as provided for in answer to the preceding question, did you have any other reservations about any aspect of:

(a) Operation Soteria;

(b) the Victorian Hotel Quarantine Program at any time?

154. Until there were outbreaks, I did not have reservations about the hotel quarantine program.

155. Prior to the outbreaks, in April 2020, I had been made aware of some issues relating to coordination of data, coordination of welfare support from medical and nursing staff and challenges raised by subcontracting health services. These issues seemed to me to relate in part to the speed with which the operation was stood up. When these issues came to me, I raised them with the Operation Soteria command to be addressed.

156. As stated, after the outbreaks, I heard of the allegations about security in the media and considering the issue now, I can see the risks created by the use of that workforce. I was not involved in the making of that decision. Until there were outbreaks, I was not in fact aware that they were using security guards.

157. In the course of the Stamford outbreak, I was informed that a family outbreak in [redacted] was associated with that outbreak, and that it was discovered separately and incidentally. In

investigating that outbreak, it was discovered that a family member (who had been interviewed multiple times) was in fact a member of security staff, yet had repeatedly denied working and did not declare [redacted] presence at the Stamford.

158. This was illustrative of the potential pressures of casual labour to work when unwell and to 'hide' such work from departmental officials. This information was – again – known to the outbreak management team and Public Health Commander who I assumed liaised with Operation Soteria Command on such information.

159. I did have some reservations about the lack of involvement of Public Health Command in Operation Soteria, given that the detention of individuals was pursuant to directions issued under the authority of the CHO, through authorisation of AOs, and I felt an ethical responsibility for the welfare of those detained in quarantine.

160. For this reason, through my DCHOs, in the development of the Operation Soteria governance, we sought Public Health involvement in Operation Soteria command, which was not, initially, adequately identified. The amended Operation Soteria Plan did then address health and welfare in more detail and resulted in a liaison position between public health command and Operation Soteria. However, this liaison not an optimal way of getting line of sight into the operation of the program with respect to health and welfare.

25. If yes to any part of the preceding question, what were your reservations, when did you form them, and did you express them to any, and if so which other person holding an official position

161. After outbreaks, it became clear to me that there were risks associated with using a subcontracted and casualised workforce for security, as I address in answer to question 24. I referred matters on when they came to me.

RELATIONSHIP TO OTHER VICTORIAN OFFICIALS

26. In relation to the Victorian Hotel Quarantine Program what is the relationship between the Chief Health Officer and:

(a) the Emergency Management Commissioner;

(b) the State Controller (Operation Soteria);

(c) the Public Health Commander; and

(d) the Deputy Chief Health Officer(s)?

162. The Victorian Hotel Quarantine Program was established under the emergency management frame work for a class 2 heath emergency. COVID-19 is a class 2 health emergency.

Emergency Management Commissioner

163. Section 32 of the *Emergency Management Act* 2013 sets out the functions of the Emergency Management Commissioner (**EMC**) during a Class 2 emergency, including ensuring that the control arrangements are in place and therefore the ultimate approval of any operational plan.

164. There was no direct reporting relationship between me and the EMC, however I was a member of the State Coordination Team, which was chaired by the EMC. (The State Coordination Team has been replaced by the State Control Team, on which I continue to sit).

State Controller (Operation Soteria)

165. The Emergency Management Manual Victoria (**EMMV**) made under the *Emergency Management Act* 2013 designates the Department as the 'control agency' for class 2 health emergencies. The State Health Emergency Response Plan – Edition 4 (**SHERP**) outlines the arrangements for management of health emergencies in Victoria.

166. On the declaration of the State of Emergency on 16 March 2020, Andrea Spiteri, the Director of Emergency Management, was appointed as State Controller by the Deputy Secretary, Regulation, Health Protection and Emergency Management. In class 2 health emergencies the Chief Health Officer can be the State Controller, but this is not always the case[40] and whether or not I am does not affect my powers under the PHWA.

167. There was no direct reporting relationship between me and the State Controller – Health.

168. Under the governance structure of Operation Soteria, the State Controller ultimately reported through to the EMC. The State Controller did not have powers under the PHWA. I — together with my Public Health team — provided public health advice to Operation Soteria as required. The State Controller and I were both members of the State Coordination Team, which had regular state co-ordination meetings.

Public Health Commander

169. Under the SHERP, the Public Health Commander is the Chief Health Officer or delegate.

[40] Concept of Operations, above fn 13.

170. The Public Health Commander reports to the State Controller and is responsible for commanding the public health functions of a health emergency response. The Public Health Commander also leads PH-IMT. I provide further information about the PH-IMT above in my answer to question 4.

171. I did not fulfil the Public Health Commander role. Rather, my delegate and the Deputy Chief Health Officer, Dr van Diemen, performed it until on or around 18 July 2020. That role is now being fulfilled by Dr Finn Romanes, among others, who also performed the role early on in Dr van Diemen's absence.[41] Both Dr van Diemen and Dr Romanes report to me in the PH-IMT structure. In the emergency management framework they separately have a reporting line to the State Controller under SHERP.

172. While the Public Health Commander was involved in Operation Soteria, this role is not something I was involved in or can give specific detail about. The Operation Soteria Plan envisaged that the role of Public Health Commander could be a separate role, reporting to the Deputy Chief Health Officer. In practice, the role of Public Health Commander was not separated from the Deputy Chief Health Officer, except very early on.

Deputy Chief Health Officers

173. The Deputy Chief Health Officers report directly to me in the Public Health Command structure and most of my powers are delegated to the Deputy Chief Health Officer. I refer to my answer to question 5 above.

174. Relating to the Victorian Hotel Quarantine Program, my interactions with my Deputy Chief Health Officer (Communicable Disease), Dr van Diemen and in her absence Dr Romanes was in the context of Outbreak Management following the Rydges and Stamford Outbreaks.

[41] It was also filled by Dr Crouch on some days.

AUSTRALIAN HEALTH PROTECTION PRINCIPAL COMMITTEE (THE 'COMMITTEE')

27. During March or April 2020 did the Committee agree or resolve that it was advisable to require all travellers arriving in Australia to undertake 14 days isolation at designated facilities?

(a) If so, on what bases and with regard to what information was that resolution or agreement reached?

(b) Unless already included in your answer to part (a) hereof please state the rationale for fixing the period at 14 days.

(c) If not, what resolution or agreement, if any, did the Committee reach regarding the advisable course(s) to adopt so as to reduce the risk of transmission and growth in COVID-19 cases posed by travellers returning to Australia from overseas?

175. I have partly answered this question in response to questions 14 and 15.

176. As discussed, prior to National Cabinet's announcement on 26 March 2020, the AHPPC did not endorse the idea of quarantining travellers at hotels (or other designated facilities).

177. Following the National Cabinet's announcement of these requirements, the Committee met to consider a national response to COVID-19, but did not agree or resolve to advise returning travellers to undertake a 14 day quarantine at a designated faculty.

178. On 26 March 2020, the AHPPC recommended to governments that the single most important thing that could be done was to stop the capacity for any returning traveller transmitting the virus.[42]

179. Prior to 26 March 2020, the AHPPC made statements about measures to minimise the risk of transmission. These included:

(a) on 18 March 2020, that following a recommendation from CDNA, it strongly supported the continuation of a 14 day quarantine requirement for all returning travellers, as the most important public health measure in relation to case importation;[43]

(b) on 21 March 2020[44], in relation to when confirmed cases could be released from isolation; and

[42] Transcript of Press Conference with the Australian Prime Minister and the Chief Medical Officer, Professor Murphy summarising the recommendations and views of the AHPPC, 27 March 2020.

[43] AHPPC Statement, 18 March 2020.

[44] AHPPC Statement, 21 March 2020.

(c) on 22 March 2020,[45] in response to continued growth in cases from cruise ships, the AHPPC recommended stronger action on enforcement of quarantine and isolation of returning travellers, including to case contacts in quarantine.

180. Following 26 March 2020, the AHPPC made a statement on 26 June 2020,[46] that the AHPPC continued to agree with the requirement that returning travellers should isolate for 14 days (discussed below).

b) Unless already included in your answer to part (a) hereof please state the rationale for fixing the period at 14 days.

181. The AHPPC determined the 14 day period on the basis that most people would exhibit symptoms or become infected (including without symptoms) within that period. The period commences with when a person may have first been in contact with the virus and ends in 14 days, on the understanding most people will exhibit symptoms for COVID-19 within 14 days. The median incubation period for the virus is 4.9-7 days.[47]

182. On 26 June 2020, the AHPPC made a statement:

> "Since 28 March, Australia has required all incoming travellers to undertake 14 days quarantine in a hotel. AHPPC notes that this measure has been a key part of Australia's successful response to COVID-19.
>
> AHPPC recommends that all international travellers must continue to quarantine for 14 days after entry into Australia. The risk of COVID-19 in travellers returning from many countries is increasing, reinforcing the importance of quarantine as a protection measure. On the advice of the Communicable Diseases Network Australia (CDNA), AHPPC considered two options:
>
> 1.Reducing the time of quarantine in a hotel for international travellers. This includes most spending part of the time in home quarantine; or
>
> 2.Continuing the current model of 14 day quarantine in a hotel.
>
> AHPPC considered that there is not enough data to justify reducing the current need for hotel quarantine. AHPPC recommends that all international travellers continue to undertake 14 days quarantine in a supervised hotel."
>
> (my emphasis added)

[45] AHPPC Statement, 22 March 2020.

[46] AHPPC Statement, 26 June 2020.

[47] AHPPC Statement, 14 May 2020.

(c) If not, what resolution or agreement, if any, did the Committee reach regarding the advisable course(s) to adopt so as to reduce the risk of transmission and growth in COVID-19 cases posed by travellers returning to Australia from overseas?

183. Before the National Cabinet's decision, the AHPPC's statements that I refer to in answer to question 27(b) articulated the Committee's views on measures to reduce transmission.

184. Throughout the relevant period, the AHPPC has also made statements in relation to testing, monitoring and enforcement, which is addressed below in answer to question 28.

28. In addition to any resolution or agreement reached by the Committee in March or April 2020 as addressed in answer to the preceding question(s), at any time, did the Committee agree or resolve that it was advisable to require any, and if so what:

(a) testing;

(b) monitoring; and/or

(c) observation,

of travellers returning to Australia from overseas so as to reduce the risk of transmission and growth in COVID-19 cases posed by that cohort of people.

185. I can only comment on the public statements made by the AHPPC as to these matters.

a) testing

186. Also in the 26 June 2020 statement, referred to above, the AHPPC stated:

> Based on available data, AHPPC recommends that jurisdictions improve testing arrangements during hotel quarantine. States and Territories will arrange to test people in hotel quarantine for COVID-19. They will do this in the first 48 hours and then on day 10-12 of hotel quarantine. Exact arrangements will depend on states and territories.
>
> AHPPC acknowledges that hotel quarantine may not be sustainable in the long term and will explore alternative models in the future.

b) monitoring; c) observation

187. As to the other matters, the AHPPC provided general public health advice over the time, including in relation to monitoring COVID-19 patients in hospital settings or elsewhere. For example, on 7 April 2020,[48] the AHPPC provided a statement in relation to caring for clinically well people in their homes with appropriate care to minimising the impact on the

[48] AHPPC Statement, 7 April 2020.

health system and free up beds for more severe cases. These applied generally and were not specific to travellers returning to Australia from overseas.

29. At any time, did the Committee agree or resolve that it was advisable to require any, and if so what:

(a) testing;

(b) monitoring; and/or

(c) observation,

of travellers during, before and after their release from any period of isolation or quarantine. If so, what was agreed or resolved, and when was that agreed or resolved?

188. I refer to paragraph 186. I do not recall the AHPPC otherwise addressing this specific question.

189. SoNGs have addressed these issues from February 2020 to now. There is now a SoNG modelled paper on day 2 and day 13 testing in hotel quarantine.[49]

30. Are you aware what directions were put in place in Victoria as to the testing of those in hotel quarantine during their detention in quarantine, prior to and after their release?

190. The approach to testing those in quarantine changed over the relevant period.

191. Throughout the program, testing was always offered to symptomatic guests as soon as they exhibit COVID-19 symptoms. In May, as described below, testing was offered on day 3 and 11 of a person's quarantine.

192. When the hotel quarantine program commenced on 28 March 2020, consistent with the public health advice and position at that time, COVID-19 testing was not carried out on returning travellers on a routine basis. Rather, guests were offered a test for COVID-19 if they were symptomatic. This position not only reflected the position in the wider community, but also reflected the reasoning behind travellers returning from overseas being required to quarantine – the quarantine period of 14 days was identified because it would be enough time for symptoms of the virus to become apparent, on the basis of what was known about the incubation period for the virus. That meant both that the person would be

[49] SoNG, version 2.11, 22 May 2020.

in quarantine during this period of high infectivity, (being the onset of symptoms) and that they could be tested if symptoms emerged and instructed to self-isolate.

193. In April 2020, testing criteria in the community expanded first to persons at higher risk of exposure and then to anyone displaying clinical symptoms of COVID-19. At this time, this testing criteria for Victoria was the broadest in Australia.

194. From 27 April 2020 – 11 May 2020, Victoria commenced a 'testing blitz' in an attempt to understand the spread of COVID-19 in the community. As part of the testing blitz, persons in Quarantine Hotels (asymptomatic) were offered COVID-19 tests on day 3 and 11 of their quarantine (and day 10 in the case of certain religious exemptions).

195. Victoria was the first state to introduce this routine asymptotic testing in hotel quarantine.

196. Those who received positive test results were transferred to the COVID-19 positive hotel.

197. On 16 May 2020, the AHPPC released guidance stating that testing in quarantine cannot be relied upon to reduce the duration of quarantine, and that asymptomatic testing should only be carried out in limited circumstances to ensure that resources are being used appropriately.

198. I understand that persons who tested positive to COVID-19 either following a test on Day 3 or a symptomatic test were transferred to Rydges, the COVID-19 positive hotel. Persons who tested positive after a day 11 test, were supported to return to the community after the conclusion of their 14 day quarantine, and to self-isolate in accordance with the relevant directions in force at the time. Those who did not have a situation in which they could adequately self isolate were supported with alternative emergency accommodation.

199. On 1 July 2020, Victoria implemented the Detention and Direction Order (No. 6). Although the Direction does not require mandatory COVID-19 tests in Hotel Quarantine, it contains the requirement that if a person refuses to receive a COVID-19 test, they will be required to undergo an additional 10 days of quarantine. None of the prior versions of the Directions required mandatory COVID-19 testing and while the testing was still not mandatory, a refusal to undergo a test resulted in an extension of the quarantine period.

31. Do you know whether people who were still testing positive to COVID-19 at the end of their 14 day hotel quarantine period were being released home to self isolate?

200. Yes, consistent with the requirements in place for members of the Victorian public generally, people in hotel quarantine who, by the end of the 14 day period of quarantine which was authorised by the Direction and Detention orders, had tested positive were released and required to self isolate at home. They were provided with an end of quarantine notice

pursuant to s 200 of the PHWA on the requirements that applied in relation to isolating when positive.

201. At the beginning of Operation Soteria, the approach was that the quarantine period was fixed at 14 days and that at the end of that period, the returning travellers would be released. If a person was known to be COVID-19 positive at the end of their quarantine period, they would be required to self-isolate, along with the approach taken for members of the community. As noted above any case where the person did not have accommodation to return to where they could self-isolate, other accommodation arrangements were made.

202. In April, in advance of the first travellers being due for release the Public Health Commander, Dr Romanes prepared documentation, to guide such persons as to the requirements for isolation at home or in the community should they test positive for COVID-19.

203. As outlined below in relation to testing (question 32), the testing regime offered to returning travellers aimed to assist in identifying whether persons were COVID-19 positive so that on their release, it was clear whether they were required to self-isolate at home or were not so required.

32. Please state the rationale for the Direction and Detention Notice (No 6) issued on 1 July 2020 which provided for the possibility of a further 10-day period of detention for those in hotel quarantine.

204. Prior to 1 July 2020, all travellers were released from quarantine after 14 days.

205. On 1 July 2020, Victoria implemented the Detention and Direction Notice (No. 6).[50] It contained the requirement that if a person refused to receive a COVID-19 test, they were required to undergo an additional 10 days of quarantine.

206. The rationale for this was to prevent or minimise people who were COVID-19 positive from being released from quarantine without being aware of that status. It was a public health understanding that if a person became infected on the last days of quarantine, they would likely be no longer infectious within 10 days. It was an objective measure to ensure that we are aware of all positive cases as they were released from quarantine, so it was clear how they would be managed following their release.

[50] Detention and Direction Notice (No. 6), 1 July 2020, DHS.2000.0003.0001.

207. I am not aware of any case of a person being released from quarantine and testing positive in the community.

33. Between 29 March and 1 July 2020 what requirements did the Department have in place for persons completing the 14-day quarantine period? Please state in your answer:

(a) whether and how any such scheme significantly changed over the period enquired after; and

(b) where such persons were subject to different treatment, the criteria for determining the different treatment.

208. In the course of the 14 day quarantine period quarantined people were not allowed to leave their hotel room, being the place of detention under the relevant order, unless granted a permission for temporary leave or exemption from hotel quarantine by an Authorised Officer.

209. A person could seek permission from an Authorised Officer for a temporary leave from their room, for example, for a fresh air break, or for the purpose of attending a medical facility, to receive medical care, where it was reasonably necessary for physical or mental health, on compassionate grounds or in emergency situations. In these cases, the person would then return to quarantine following their leave.

210. Exemptions from hotel quarantine were also considered for unaccompanied minors, foreign diplomats or people whose health could not be accommodated in hotel quarantine.

211. This was managed by Enforcement and Compliance with the final approval being given by the Public Health Commander.

212. Because of the broad range of people in hotel quarantine, particularly when the profile of the quarantined population moved from returning holiday or business travellers to repatriating families, there were a very wide range of needs to different people including health care requirements, mental health needs, special needs relating to children and the elderly. As I understand it these needs were addressed and met to the extent possible by medical and other staff working within the Enforcement and Compliance part of the Operation Soteria framework.

REVIEW AND FEEDBACK MECHANISMS

34. During the months of:

(a) April 2020;

(b) May 2020;

(c) June 2020; and

(d) July 2020,

were you made aware of any information or allegations indicating that private security contractors or their subcontractors involved in the Victorian Hotel Quarantine Program were performing their duties unsatisfactorily or were engaging in behaviours likely to increase the risk of being involved in COVID-19 transmission? If so, please provide details of that information or those allegations for each month referenced.

213. While there have been rumours, reports and allegations in the media about the conduct of security contractors and subcontractors involved in the Victorian Hotel Quarantine Program I do not recall anyone making me aware of such allegations before those allegations were made publicly.

214. I do not recall being made aware during April 2020 of information or allegations indicating that private security contractors or their subcontractors were performing their duties unsatisfactorily or were engaging in behaviours likely to increase the risk of being involved in COVID-19 transmission.

215. On 26 May 2020, I was informed about COVID-19 cases in staff members at the Rydges Hotel by Dr Simon Crouch, who is the Deputy Public Health Commander – Case, Contacts and Outbreak Management (**CCOM**), who jointly shares that position with Dr Clare Looker.[51]

216. On 27 May 2020, Dr Crouch informed me that a security guard working at Rydges had tested positive to COVID-19.

217. On 29 May 2020, I received an email from Dr Looker which, as far as I am now aware, was the first report to me that there may have been a risk associated with security guard PPE practices including that masks and gloves used by security staff were non-standard and they lacked adequate training in hand hygiene and PPE use.

218. Dr Looker's email also outlines the steps taken to address that risk including that ongoing support and education of security staff regarding hand hygiene, infection control pressures

[51] Email from Dr Crouch to Prof. Sutton and others, 26 March 2020, DHS.5000.0125.0355.

and PPE use.[52] At the time, there was nothing remarkable or special about this information or the proposed response. The approach taken by CCOM was as I expected it should have been, and the actions to address the risk appropriate actions.

219. In the context of the Rydges response, at the end of May 2020, I recall Dr Crouch informing me that smoking breaks and shared sleeping accommodation were being investigated as a possible cause of transmission. This was in the context of a close contact that had been a roommate of one of the security guards who had tested positive for COVID-19. The positive case had not informed the department of his roommate as a close contact, and had not informed his roommate of the positive test. The non-disclosure of this information is a behaviour that increased the risk of transmission because the close contact was unable to be identified by the CCOM. I then raised with Dr Crouch that we could offer support to people who could not isolate by ensuring that they were aware of the alternative accommodation options which were made available by the department so people who were unable to isolate in their home could have accommodation in which to do so.

220. Throughout June 2020, the issue of poor infection prevention control, hand hygiene and PPE practices by security contractors, first identified to me by Dr Looker on 29 May 2020, continued to be identified to the CCOM team by the outbreak squad nurses attending the Rydges and other hotels as an ongoing risk.

221. On 16 June 2020, I was notified by Dr Crouch of a new case connected to Stamford Plaza involving a security guard and that the outbreak control squad had attended the site and raised concerns about the use of PPE when escorting residents outside. I was also informed that there was an incident that a large number of security guards were undertaking shift handover in a small room with poor physical distancing.[53]

222. On 18 June 2020, I received further information that the first case in the Stamford Outbreak was a security guard who had worked while infectious for six days, with two pre-symptomatic days and four symptomatic days. Attending a place of employment while symptomatic with COVID-19 symptoms is a behaviour that is likely to increase the risk of COVID-19 transmission. It is a behaviour that is not localised to security contractors.[54]

223. I otherwise do not recall being made aware of any new information or allegations indicating that private security contractors or their subcontractors were performing their duties unsatisfactorily or were engaging in behaviours likely to increase the risk of being involved in COVID-19 transmission during July 2020.

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[52] Email from Dr Looker to Prof. Sutton and others, 29 May 2020, DHS.5000.0114.7238.

[53] Email from Dr Crouch to Dr. van Diemen, copied to Prof. Sutton and others, 16 June 2020, DHS.5000.0036.3558.

[54] Email form Dr van Diemen to Dr. Sutton and others, 18 June 2020, DHS.5000.0036.6031.

35. If you were so made aware, what actions did you take in response? Why?

224. The actions taken by me to respond to the matters discussed in response to answer 34 are the actions of the PH-IMT which I ultimately am responsible for. The actions undertaken in response are actions that were taken in the context of the specific outbreaks being addressed, and in the context of a number of other outbreaks being dealt with by the PH-IMT at the same time. I am not involved in the day-to-day operations of the Outbreak Management Team, I receive outbreak summary reports which relate primarily to the status of outbreaks (numbers and key actions taken), usually daily.

225. The outbreak response actions as they relate to security guards focussed on training and addressing shortcomings in the IPC and PPE conduct of guards. I understand that the response was primarily an education response, with the outbreak squad providing training and also observations and recommendations to Operation Soteria personnel and command.

226. I am informed that on 27 May 2020, at the direction of CCOM, two outbreak squad nurses attended Rydges and carried out a review.

227. I understand that very quickly, on 28 May 2020, the Outbreak Management Team resolved to have the outbreak squad team prepare materials (video and written) on proper hygiene and use of PPE to be distributed to security via Operation Soteria. I understand a qualified IPC nurse was to provide instruction to hotel and security staff each shift about IPC. I understand that those corrective measures were subsequently provided at Rydges and then other hotels by infection protection and control nurses from the outbreak squad throughout June and July.

228. I was informed that the Outbreak Management Team continued to monitor the training being provided to hotel and security staff, based on reports of the outbreak squad nurses providing that training.[55]

229. In addition, on 29 May 2020, members of my team, including those specialising in infection and prevention control, reviewed IPC advice material provided to security at hotels. The review finalised within 24 hours.

230. The issue of non-disclosure of close contacts and shared accommodation was addressed by ensuring that the CCOM messaging to close contacts was clear about there being support available for people who are unable to effectively self-isolate in their usual accommodation.

[55] See email from Dr Crouch to Prof. Sutton and others, 3 June 2020, DHS.0001.0012.1125.

231. I am aware that in early June 2020, Dr van Diemen as Deputy Chief Health Officer provided her approval to a proposal by Dr Katherine Ong in the PH-IMT of the Department that a Department contracted education consultant being engaged to provide security contractors with IPC and PPE training. I understand that training was subsequently provided from about late June to security contractors working across the hotel quarantine program including at the Stamford.

232. On 18 June 2020, the Infection Control Cell also engaged to review PPE Advice for Hotel Security Staff and AOs in contact with quarantined individuals, documents used and made available to security contractors and others operation at quarantine hotels.

233. Also in June, I provided advice to the AHPPC (in advance of its 26 June 2020 statement, referred to above). In that advice, I acknowledged that issues with security guards included poor adherence to infection prevention and control measures including physical distancing, hand hygiene, and, that we had been advised from case and contacting tracing team that security guards have been presenting for work when unwell (for fear of losing their employment and then unable to support their family).

234. I also acknowledged that living and working conditions of contracted security staff presented a challenge; as a result of the outbreak. The Emergency Accommodation Operations team (Operation Soteria) had identified that many security staff lived and worked together and worked over multiple sites and for multiple employers. As a mitigation strategy Operation Soteria was working with security contractors to require individual security guards be rostered to one site only and that this was underway.

235. The fact that security guards had been presenting for work when unwell (for fear of losing their employment and then unable to support their family), which was to be mitigated by the introduction of temperature and symptom testing (by on-site nurses) for all staff on every shift.

236. Finally, there had been some instances where security staff did not appear to trust the information provided to them by authority, in particular about how to wear PPE gear, and the use of hand sanitiser (in particular, noting concerns about using an alcohol-based sanitiser). Operation Soteria was working with the Behavioural Insights Unit at DPC to develop opportunities to drive behavioural change within the security workforce.

36. To your knowledge did the Department conduct any and what reviews, formal or otherwise, into:

(a) the Victorian Hotel Quarantine Program;

(b) Operation Soteria?

Please identify any document(s) which contain(s) the outcome of such reviews.

237. I was not involved in decisions the Department made with respect to reviews into Operation Soteria or the Hotel Quarantine Program.

238. I am aware that as part of the Outbreak Response into the outbreaks at the Rydges on Swanston and the Stamford Plaza Hotels, the outbreak squad, at the request of the Outbreak Management Team, was sent to review and make recommendations as to IPC procedures at Rydges and Stamford.

239. I understand that the findings of the Outbreak Squad nurses resulted in the CCOM team instigating the training and education of security and other hotel staff, as I explain in my answer to question 35 above.

240. I am aware that the Secretary of the Department asked Safer Care Victoria to undertake reviews into two clinical incidents in relation to travellers in quarantine. Safer Care Victoria undertook a review in May 2020 and provided a confidential report to the Department.

AUTHORISED OFFICERS

37. Have you, as Chief Health Officer, been involved in the formulation or giving of directions, instructions or guidance to:

(a) Authorised Officers; and/or

(b) private security contractors,

in relation to the Victorian Hotel Quarantine Program? If so, what were the directions, instructions or guidance and how were you so involved?

(a) Authorised Officers

241. I appointed Authorised Officers (**AOs**) under the PHWA.[56] On 30 March 2020, there were approximately 70 AOs under s 30 of the PHWA. I made additional appointments from 2

[56] The Secretary had delegated to me the power to appoint an authorised officer under s 30 of the Act.

April 2020, to support the hotel quarantine program. These authorisations included empowering authorised officers to exercise public health risk and emergency powers.[57]

242. The DCHO then sent the AOs the Directions requiring persons to be detained in hotels for them to serve them on international travellers arriving at Melbourne airports.[58]

243. I considered the draft 'COVID-19 – DHHS Physical Distancing and Public Health Compliance and Enforcement Plan in April 2020[59], which explained the role of AOs in respect of hotel quarantine and provided guidance for how AOs were to exercise powers under the PHWA.

244. Enforcement and Compliance, as part of Operation Soteria managed AOs. Members of my team was also involved in overseeing the Enforcement and Compliance function carried out by AOs, including in writing or providing advice about detention orders, exemptions from detention orders, and some temporary permissions for leave.

245. The Deputy Public Health Commander Planning provided advice to the Deputy Chief Health Officer / Public Health Commander on requests where a decision is needed whether to grant leave from detention (permission). Following this initial advice, the Director of Health Regulation and Compliance was responsible for determining whether to grant these exemptions. I was not involved in this process.

246. In addition to general authorised officer appointments, on 29 March 2020, I signed a request for assistance to the Chief Commissioner of Police under s 200 of the PHWA. By that request, I asked that police officers provide assistance to authorised officers exercising their powers for the purpose of eliminating or reducing the serious risk to public health during the state of emergency, including all reasonable steps to enforce compliance with directions made under section 200 of the Act. This was to enable Victoria Police to assist AOs in the enforcement of the directions. The request covered actions that police officers needed to take to monitor compliance with the directions, investigate and respond to alleged breaches of the directions and, where it is determined that persons have failed to comply with the directions without lawful excuse, take any necessary enforcement action, by taking steps to compel compliance and or by issuing of fines or charging people for breaching s203 of the Act or any other steps lawfully available to them.

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[57] See for example, Instrument of Authorisation dated 11 May 2020, DHS.0001.0004.1888.

[59] COVID-19 – DHHS Physical Distancing and Public Health Compliance and Enforcement Plan, 4 April 2020, DHS.0001.0001.0729.

[59] COVID-19 – DHHS Physical Distancing and Public Health Compliance and Enforcement Plan, 4 April 2020, DHS.0001.0001.0729.

(b) Private security contractors

247. I have not been involved in giving directions, instructions or guidance to private security contractors. As explained, prior to the outbreaks I was not aware that security guards were being used. I oversaw the provision of general IPC / PPE advice that could apply across Victorian workplaces and settings, but did not provide Operation Soteria with advice specific to security guards.

248. Prior to the outbreaks, I was generally aware that the Department engaged Infection Protection Australia, as discussed in answer to question 36. I was also aware that the Public Health Branch Infection Control Consultant referred Operation Soteria Command to Infection Prevention Control Australia and subsequently worked collaboratively on drafting PPE advice for hotel workers.

249. Following the outbreaks, the Public Health Branch responded to the concerns in relation to security guards as part of its response to the outbreak. This included the 'Operation Soteria: PPE Advice for Hotel-based Security Staff & AOs in contact with quarantined clients'.

38. Do you know whether Authorised Officers involved in the Victorian Hotel Quarantine Program were directed to undertake a daily review of the appropriateness of ongoing detention? If so, what did this involve, and did you have any involvement in any of those daily reviews?

250. Section 200(6) of the PHWA requires that an authorised officer review, every 24 hours, whether the continued detention of a person is reasonably necessary to eliminate or reduce a serious risk to public health.

251. I understand this obligation was met by a Senior AO undertaking a daily review as against the criteria of the mandatory 14 day quarantine period, noting how many days individuals had been in quarantine. I am informed that these were sent to the DCHO, however I did not review them.

39. Are you aware of the duties of Authorised Officers at hotels being used to quarantine travellers arriving from overseas or interstate?

252. In broad terms, the role of the AOs was to ensure that the directions under the PHWA were complied with, including provision of detention notices under s 200 of the PHWA. The key duties of AOs at hotels were to require detention of travellers (via issuing detention notices), to grant 'permissions' for travellers to leave their rooms where necessary (for fresh air

breaks, medical appointments, funerals and the like), and to facilitate travellers exiting hotel quarantine at the end of their detention period.

OUTBREAKS ATTRIBUTABLE TO HOTEL QUARANTINE

40. As at the date of receiving these questions, what is your understanding as to the percentage of current COVID-19 infections in Victoria can be linked to transmission events at the:

(a) Rydges Hotel in Carlton; and

(b) Stamford Plaza Hotel in Melbourne, CBD.

253. Based on the information currently available to me, a very substantial proportion of current COVID-19 infections in Victoria can be linked to transmissions events at the Rydges Hotel, on Swanston Street in Carlton and, a smaller proportion is associated with the Stamford Plaza Hotel in Melbourne.

254. My view is based on the genomic reports prepared by the Doherty Institute and the epidemiological analysis produced by the relevant teams within Public Health Command. Those reports show that, of the cases that have been sequenced, a very substantial proportion are associated with the Rydges-associated genomic clusters and a much smaller proportion are associated with the Stamford-associated genomic cluster. The sample of cases that has been able to be sequenced is substantial, but a large number of cases have not been sampled and sequenced, because the virus has not been able to be grown for the purpose of sequencing in all cases. However, the remaining proportion are the sequences from returned travellers with a handful of other cases not linking to Stamford or Rydges.

255. Again, based on the information available to me it is unlikely that large transmission networks are present in Victoria that have not been identified through genomic sequences.

41. To the extent that you can do so without identifying any particular individual(s), please state what understanding, if any, you have in respect of the precise circumstances in which each of the transmission event(s) occurred.

256. I have read the outbreak management reports[60] prepared in response to both the outbreak at the Rydges Hotel and at the Stamford Plaza Hotel.

257. I do not know the precise circumstances of the transmission events. There are hypothesised sequences of transmission for both these outbreaks, but the exact mechanism or mechanisms of transmission are almost impossible to know through indirect evidence and observation after the transmission has occurred.

POWER TO GIVE SPECIFIC DIRECTIONS

42. As far as you are aware, have any of the powers in section 113, 117, 188 and/or 200(1)(d) of the Public Health and Wellbeing Act 2008 (Vic) been exercised since a State of Emergency was declared in Victoria on 16 March 2020? If so, please describe the circumstances in which the powers were exercised and what the exercise of the power(s) involved.

258. I have not exercised powers in sections 113, 117 or 188 since the declaration of the State of Emergency on 16 March 2020.

259. Powers under section 200(1)(d) have been exercised. Attached is a table of the directions that have been made since 16 March 2020, and the source of the power for the stated declaration.

43. If "no" to the above question, as far as you are aware, has any consideration been given to the exercise of those powers, since a State of Emergency was declared in Victoria on 16 March 2020? Why or why not?

260. This is not applicable.

[60] COVID-19 Outbreak Management Report Rydges on Swanston, 13 July 2020; DHS.0001.0036.0145; Outbreak Management Report - Stamford Plaza Outbreak 19 July 2020, DHS.0001.0036.0203.

Public Health Framework

44. As a person with considerable experience as a qualified medical professional, and as Chief Health Officer, in your view, has the current public health framework (legislative or otherwise) created difficulties and highlighted issues that made the delivery of the Victorian Hotel Quarantine Program more difficult than may have otherwise been the case? If so, in what way has this occurred and how do you suggest it be addressed?

261. The requirement under the PHWA that Authorised Officers review the returning travellers' detention every 24 hours, and the requirement that they authorise any change in the conditions of detention created some significant staff demands. We struggled to find the numbers of Authorised Officers the program required and had resulting problems with rostering and officers being overworked.

262. This also presented difficulties in identifying appropriately qualified Authorised Officers who were employed under the *Public Administration Act* or appointed under the *Local Government Act* as required by the PHWA.

45. Given your participation in the Australian Health Protection Principal Committee and your knowledge of the structure and delivery of the Victorian Hotel Quarantine Program in other states and territories, are you able to identify relevant differences between Victoria and the other states and territories which may have contributed to the outbreaks in Victoria?

263. I am aware that in NSW, the hotel quarantine program has been able to use NSW Police in a more involved way. I am not otherwise aware of relevant operational differences.

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

Signed at Melbourne

in the State of Victoria

on 13 August 2020

Adjunct Clinical Professor Brett Sutton