BOARD OF INQUIRY INTO THE COVID-19 HOTEL QUARANTINE PROGRAM

WITNESS STATEMENT OF DR ANNALIESE VAN DIEMEN

Name: Dr Annaliese van Diemen

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Occupation: Deputy Chief Health Officer, Victoria

Date: 9 September 2020

1. I make this statement to the Board of Inquiry in response to **NTP- 136**, the Notice to produce a statement in writing (**Notice**) dated 1 September 2020. This statement has been prepared with the assistance of lawyers assisting the Department of Health and Human Services (**Department**).

ROLES AND RESPONSIBILITIES

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

2. I hold the following qualifications:

   (a) Fellowship of the Australian Faculty of Public Health Medicine (chapter of the Royal Australian College of Physicians);

   (b) Fellowship of the Royal Australian College of General Practitioners (**RACGP**);

   (c) Master of Public Health from James Cook University (Master Public Health, Medicine, Emergency Management and Disaster Preparedness) in 2014;

   (d) Diploma of Child Health, Paediatrics from the University of Sydney in 2011;

   (e) Bachelor of Medicine, Bachelor of Surgery (MBBS), Medicine from Monash University in 2007; and

   (f) Bachelor of Medical Science, Medical Curriculum in the Rural Setting from Monash University in 2007.

3. I have worked for the Department since March 2016.

4. I held the role of Manager, Investigation and Response (2016) followed by Manager, Communicable Disease Prevention and Control from January 2017 until April 2019. My responsibilities in this role are described below in answer to question 2.

5. From April 2019 to November 2019, I was Senior Medical Advisor, Antimicrobial Resistance.

6. I have been the Deputy Chief Health Officer (**DCHO**) since November 2019.

7. Prior to working at the Department, I have held roles as a Public Health Registrar, a General Practitioner, a Resident Medical Officer, an intern and an Admissions assistant.

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

8. I am a DCHO.

9. Prior mid-January 2020, my ordinary role was DCHO – Communicable Diseases in the Health Protection Branch of the Department of Health and Human Services (the **Department**).

10. The Communicable Disease section includes: Communicable Disease Prevention & Control, Communicable Disease Epidemiology and Surveillance, Immunisation, Partner Notification & Support Unit and Public Health Medicine (communicable disease).

11. In that role, I had obligations with respect to the notification, investigation, management, analysis and reporting of cases and outbreaks of approximately 66 notifiable diseases under the *Public Health and Wellbeing Act* 2008 (Vic) (**PHWA**). This includes the provision of a 24-hour notification service and 24-hour staffing of the Human Biosecurity functions of the federal *Human Biosecurity Act* 2015 (Cth). Other areas in the sections remit include infection prevention and control (**IPC**) breaches, such as practitioners failing to sterilise or using equipment inappropriately, the Victorian Arbovirus Disease Control Program (**VADCP**), anti-microbial resistance, lookback exercises (for example the Croydon anaesthetist lookback), pandemic planning and emergency preparedness, funding of Public Health Reference Laboratories and Victorian Tuberculosis Team and supporting people living with HIV who may be putting others at risk. The functions described above are undertaken collaboratively across the Communicable Disease Prevention & Control, Communicable Disease Epidemiology and Surveillance, Partner Notification and Support and Public Health Medicine teams.

12. In that role, the contact tracers responsible for outbreak responses were under my responsibility, primarily in the Communicable Disease Prevention & Control team (for all diseases) and the Partner Notification and Support team (for more targeted contact tracing in cases of HIV, syphilis and drug resistant gonorrhoea).

13. The Communicable Disease section also contains the Immunisation team which is responsible for both policy and program delivery of the State's funded immunisation programs. These programs include all vaccinations funded under the National Immunisation Program and any additional State funded vaccination programs.

14. As Manager, Communicable Disease Prevention & Control (**CDPC**), I managed the two teams responsible for contact tracing (Public Health Officers), which are normally called the Investigation and Response teams. These teams are grouped by profession-based officers, comprising of one team of Environmental Health Officers and one clinical team (mostly nurses) with seven team-members and a manager in each team. These teams followed up notifications of communicable disease, in a prioritised manner (urgent and non-urgent), and managed outbreaks, such as food borne outbreaks, gastroenteritis outbreaks, and respiratory outbreaks. I also managed a small number (4) of project and program officers responsible for; infection prevention & control advice specific to public health issues, the VADCP, pandemic planning and managing the contracts and relationships with the Public Health Reference Laboratories and the Victorian Tuberculosis Program.

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

15. In relation to the State's broader response to COVID-19, I had obligations under the PHWA, the State Health Emergency Response Plan[1] (**SHERP**) and the *Concept of Operations, Department of Health and Human Services as a Control Agency and as a Support Agency in Emergencies*, November 2019, (the **Concept of Operations document**).[2]

16. In all of these roles I reported directly to Professor Brett Sutton, the Chief Health Officer (**CHO**).

17. I am a delegate of the CHO[3] and am also appointed as an authorised officer under the PHWA. It is in my capacity as delegate and authorised officer that I made directions under the PHWA relating to the Hotel Quarantine program, as I explain in more detail below.

18. I was also appointed the Public Health Commander (**PHC**) in mid-February 2020 as part of the incident response to COVID-19.

[1] State Health Emergency Response Plan, Edition 4, DHS.0001.0027.0883.

[2] 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.

[3] Instrument of delegation, 8 November 2019, DHS.0001.0045.0001; Instrument of delegation, 11 December 2019, DHS.0001.0045.0007; and Instrument of authorisation authorising me to exercise emergency powers, 17 March 2020, DHS.0001.0011.0741.

19. The Concept of Operations, that I refer to in paragraph 15, is an overarching guidance document for staff working in the department in emergency-related roles. Under the Concept of Operations Policy v 1.0, the PHC has responsibilities for: command of the public health activities of an emergency response (including the investigation, management of public health risk, and communication of risk); undertaking actions to reduce pressure on the health system through control measures and advice; monitoring the impacts of an emergency on public health; and authorising public health communication to the public. Thus during hotel quarantine operations, I had significant other responsibilities in relation to the State's broader response to COVID-19.

20. Upon the declaration of the state of emergency on 16 March 2020, I became the PHC for the purposes of SHERP. SHERP contemplates that the CHO will usually be the State Controller for class 2 health emergencies, but this is not always the case. It was not the case for the COVID-19 emergency. While SHERP contemplates that the PHC reports to the State Controller, in practice I did not report to the State Controller. I reported to the CHO and filled an advisory role with the State Controller.

21. Under SHERP, where DHHS is the control/lead agency, as it is for the current emergency, the PHC is responsible for commanding the public health functions of a health emergency response (including investigating, eliminating or reducing a serious risk to public health). The hotel quarantine program was not a public health function but an emergency management function and response relating to a health emergency. As such, my functions as PHC in relation to the hotel quarantine program related to the issuing of directions as delegate of the CHO (although that role is not undertaken in the capacity of PHC); and as PHC, issuing guidance and advice relating to COVID-19, and setting policies and procedures to address the health and wellbeing of returned travellers. The State Controller has oversight for the implementation of that advice, guidance, policies and procedures.

22. Under SHERP, the PHC is to liaise directly with the State Health Commander and the State Health Coordinator. In the context of the hotel quarantine program, I did do this but focused on the public health functions of the program, rather than operational matters of running hotels.

23. In relation to hotel quarantine, I was aware that returned travellers in detention were detained because of the direction notice I made as delegate of the CHO. I discuss this further in my answer to question 4.

24. In the early days of the program, the CHO and I were sent many requests on many issues on the operation of the directions and the hotel quarantine program. It took some time to determine how to allocate those issues to the appropriate people and decision-makers and to understand that structure, as it was not always immediately clear to me, but I was able to

work out how to address those requests. In particular, at this time, the welfare of returned travellers and ensuring that there were appropriate pathways for clinical care was a high priority for me. However, I did not have oversight or responsibility for the operational aspects of the program. From about 15 April 2020, there was an arrangement in place that the policy and protocols around health and welfare would be the responsibility of PH-IMT while the implementation of these policies and protocols, including logistics, rostering and others, would be performed by the Emergency Operations Centre (**EOC**).

25. I was motivated to ensure that appropriate and clear policy and public health documents were in place to support the directions and decision that I was required to make as delegate of the CHO and to ensure that these decisions were evidence based. I had the objective of ensuring there was a clear and visible process to support operationalising the directions being issued, and that there was oversight over the decisions being made by those operating the hotels. At the end of March 2020, as PHC I required that there be a clear plan for the whole detention process including clear exemptions protocols and pathways, and a centralised record for detainee information.

26. I asked the Physical Distancing Lead and Deputy Public Health Commander – Planning, Dr Romanes, to advance the preparation of this single policy. In early April, he produced a draft plan which contained the policies and procedures relating to mandatory detention including those to address health and wellbeing of returned travellers.

27. The draft plan reflected our approach at that time and it was updated and further plans created for specific topics. Collectively, the plans are the:

    (a) Draft COVID-19 – DHHS Physical Distancing and Public Health Compliance and Enforcement Plan dated 4 April 2020[4] (**Physical Distancing Plan**);

    (b) Draft COVID-19 Policy and Procedures – Mandatory Quarantine (Direction and Detention Notice) v1 dated 8 April 2020;[5]

    (c) Annex 1 COVID-19 Compliance Policy and Procedures – Detention Authorisation (v1) dated 30 April 2020;[6]

    (d) Annex 1 COVID-19 Compliance Policy and Procedures – Detention Authorisation (v2) dated 25 May 2020;[7]

[4] COVID-19 – DHHS Physical Distancing and Public Health Compliance and Enforcement Plan, 4 April 2020, DHS.0001.0001.0729.
[5] draft COVID-19 Policy and Procedures – Mandatory Quarantine (Direction and Detention Notice) v1 dated 8 April 2020, DHS.5000.0075.0010.

[6] Annex 1 COVID-19 Compliance Policy and Procedures – Detention Authorisation (v1) dated 30 April 2020 DHS.5000.0025.4759. I approved this plan on 30 April 2020.

[7] Annex 1 COVID-19 Compliance Policy and Procedures – Detention Authorisation (v2) dated 25 May 2020, DHS.0001.0013.0006.

(e) Annex 1 – Detention Compliance and Enforcement (c2) dated 1 June 2020.[8]

28. The policies documented in these protocols were those used by me in making decisions to grant exemptions and grant approvals. Under Operation Soteria Plan v 3 (approved 26 May 2020), as PHC, I was responsible for approving and granting approvals to alter the way in which mandatory quarantine applied. Approvals could be made by the Emergency Coordination Centre Commander in accordance with the relevant policy.

29. I also had responsibilities under the Operation Soteria Plan. Under Operation Soteria Plan v 2 (approved 26 April 2020),[9] v 2.1 (approved 8 May 2020)[10] and v 3 (approved 26 May 2020)[11], I:

(a) was responsible for reviewing the Operation Soteria Plan (through the Deputy Public Health Commander/delegate), in consultation with the Enforcement and Compliance Commander, DHHS Commander COVID-19 Accommodation, the State Health Coordinator and the State Controller. Final authorisation for distribution of the Plan sat with the Emergency Management Commissioner;

(b) approved section 5 of the Plan relevant to Health Standards. I explain this further in answer to question 5 below;

(c) (or my delegate) was authorised to access any record within the authorised information management systems (Public Health Event Surveillance System (**PHESS**), Dynamic CRM Database, Best Practice general practice software, paper records) to enable oversight of the health and welfare of persons in detention; and

(d) received incident reports verified and endorsed by COVID-19 Accommodation Commander.

30. As I explain in answer to question 4 below, I also signed the Direction and Detention Notices under sections 199(2)(a) and 200 of the PHWA relevant to Operation Soteria.

[8] Annex 1 – Detention Compliance and Enforcement (c2) dated 1 June 2020, DHS.0001.0001.1053.

[9] Operation Soteria Plan v 2, DHS.5000.0074.2583.

[10] Operation Soteria Plan v 2.1, DHS.0001.0008.0517.

[11] Operation Soteria Plan v 3.0, DHS.0001.0001.1053.

APPLICATION OF THE HOTEL QUARANTINE PROGRAM

Question 4. Who made the decision that quarantine would apply to <u>all</u> returned travellers (even those with drug or alcohol dependencies, pre-existing physical or mental health conditions, and complex needs)?

31. On 26 March 2020, the Prime Minister announced that National Cabinet had decided that all travellers arriving in Australia would be required to undertake their mandatory 14 day self-isolation at designated facilities. I recall the CHO informed me that the decision would be given effect to in Victoria by directions under the PHWA on the evening of Friday, 27 March 2020.

32. In Victoria, before this announcement and by a direction under the PHWA made 16 March 2020 made by the CHO, all overseas returning travellers were required to self-quarantine at a suitable premises for 14 days. From 16 March 2020 to 26 March 2020, I made further directions relevant to measures to limit the spread of COVID-19 in Victoria.[12] This included the quarantine direction on 18 March 2020 (the **Airport Arrivals Direction**), to replace that made by the CHO on 16 March 2020.[13] Thus at the time of National Cabinet's announcement, there was already a system in Victoria for the quarantining of returning travellers as part of measures to limit the spread of COVID-19.

33. The Airport Arrivals Direction required a person who arrived in Victoria from outside of Australia to self-quarantine at a suitable premises for a 14 day period. This generally resulted in home or residential quarantine. 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.[14]

Direction and Detention Notice requiring hotel quarantine under the PHWA

34. Following National Cabinet's announcement, I made the Direction and Detention Notice as an Authorised Officer authorised to exercise emergency powers under the PHWA pursuant to s 200(1)(a). I was required to consider whether to make this direction to require returning travellers to be quarantine in a hotel room. After careful consideration (as I discuss further below), I made the Direction and Detention Notice, and in so doing revoked the Airport Arrivals Direction that was in force at that time. This gave effect to National Cabinet's announcement but was a decision I took pursuant to s 200(1)(a) of the PHWA. The direction was extended and I made a number of subsequent directions.

[12] From about 15 July 2020, Dr Romanes assumed the role of PHC and made directions under the PHWA.

[13] Which replaced that made 16 March 2020.

[14] I made a further direction to apply to those disembarking from a cruise ship on 19 March 2020.

35. The directions are referred to as “Detention Authorisations”. 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.”

36. In making the Direction and Detention Notice, I was cognisant of the magnitude of the decision and the seriousness of detaining people. At the time, it was clear to me that it was necessary to issue notices to balance the risks to public health but I was also very aware of the significance of the human rights issues engaged by the making of the Notice.

37. In making the decision, I took advice about my obligations under the *Charter of Human Rights and Responsibilities Act* 2006 (Vic) (**Charter**) and undertook a consideration of the effect of the Direction and Detention Notice on human rights. While the Directions curtailed rights of returned travellers, those rights needed to be weighed and considered in the context of the outbreak of a highly infectious viral pandemic in which there was (and is) no vaccine. At the relevant time, overseas travellers were by far the largest source of infections in Victoria. I was acutely aware of the susceptibility of all Victorians to being infected with the virus if this source was not strictly controlled, and further that a failure to control this source of the virus would have a disproportionately severe effect on certain people (namely, elderly persons and those with poor immune systems). In my view, although I accepted that the limits on rights was a serious matter, I considered those limits to be necessary to protect the health of large numbers of Victorians and prevent significant loss of life.

38. The Direction and Detention Notice was given to each person arriving in Victoria from outside Australia, 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. This was the standard period and was based on advice from the Australian Health Protection Principal Committee (**AHPPC**) and Communicable Diseases Network of Australia (**CDNA**) that 14 days was the incubation period.

Exemptions and permissions to leave

39. While the Physical Distancing Plan was being used, in light of the Direction and Detention Notice and when other measures were adopted, the Plan was amended to reflect the restrictions in place in Victoria to manage and reduce the risk of transmission.

40. For example, in response to the Directions and Detention Order, the Physical Distancing Plan set out the early position on how requests for permission to leave detention from people in

hotel quarantine should be made and determined and expressed that exceptional circumstances were required for people seeking not to be ordered into hotel quarantine.[15]

41. In paragraph 27 I identify the policies I am aware of which related to detention of returned travellers. While the draft Physical Distancing Plan and later iterations were amended, the content of the policy applied by me in making decisions is recorded in the documents I have identified at paragraph 27.

42. Early on I had to consider the difficult question of the circumstances in which exemptions would be granted. The CHO and I discussed this and formed the view that the starting point was a presumption that exemptions to mandatory quarantine would only be granted in limited circumstances. As the program matured defined categories were identified and documented in the COVID-10 Compliance Policy and Procedures – Detention Authorisation.[16]

43. As I explain above, under the Physical Distancing Plan and subsequent protocols, identified in paragraph 27, as the PHC and DCHO, I was responsible for assessing:

    (a) whether persons should be excused from the Direction and Detention Notice (in that they would not be served with one) (**exemptions**);

    (b) if returned travellers in quarantine, after having been served with a notice requiring them to quarantine in hotel, could be given a temporary permission to leave quarantine (**permission to leave**).[17] These requests came to me from the Deputy Public Health Commander – Planning.

44. In broad terms, the first set of categories of circumstances in which a returned traveller could be permitted to leave the hotel room were:

    (a) for the purposes of attending a medical facility to receive medical care;

    (b) where it was reasonable necessary for physical or mental health;

    (c) on compassionate grounds; and

    (d) in case of emergencies.

45. As the PHC, I, or the Compliance Lead (who was also an authorised officer) could grant permission to release a person from quarantine or from their room in certain circumstances. I

[15] Physical Distancing Plan, p 15.

[16] Annex 1 COVID-19 Compliance Policy and Procedures – Detention Authorisation (v1) dated 29 April 2020, DHS.5000.0025.4759. Up until 29 April 2020, the policy was in draft but being observed – see draft COVID-19 Policy and Procedures – Mandatory Quarantine (Direction and Detention Notice) v1 dated 8 April 2020, DHS.5000.0075.0010. See Annex 1 COVID-19 Compliance Policy and Procedures – Detention Authorisation (v2) dated 25 May 2020, DHS.0001.0013.0006 from 29 May 2020 and Annex 1 – Detention Compliance and Enforcement (c2) dated 1 June 2020, DHS.0001.0001.1053.

[17] Physical Distancing Plan, page 22.

could also determine that the quarantine should occur in an alternative location, where that occurred by way of alternative direction under the PHWA.

46. I gave a policy direction that is noted in the Physical Distancing Plan, at p 22, that permissions to leave hotel quarantine should be exceptional and always based on an individual review of circumstances.

47. Under the Physical Distancing Plan, an application for permission to leave may be granted in the following circumstances:

    (a) a person who has medical treatment in a hospital (the CHO or I would consider the relevant circumstances, if relevant, an on-site nurse would also consider the matter, including any urgency);

    (b) a person who has recovered from confirmed COVID-19 infection and is released from isolation;

    (c) an unaccompanied minor; and

    (d) instances where a person has a reasonably necessary requirement for physical or mental health or compassionate grounds to leave the room, as per the Detention Notice.

48. The Physical Distancing Plan asked that the procedure allow for authorised officers to "be nimble and able to respond to differing and dynamic circumstances impacting people who are detained, so that the detention does not become arbitrary. The process outlined here reflects their ability to make critical decisions impacting people in a timely manner." That is, the broad categories in paragraph 44 also remained.

49. Relevant considerations for approval were required to meet public health and human rights requirements. Authorised officers were to balance the needs of the person and public health risk. The Physical Distancing Plan states, "For example, if the person needs immediate medical care, public health risks need to be managed appropriately, but the expectation is that the leave would automatically be granted. This would be more nuanced and complex when the request is made on compassionate grounds where there is a question about how public health risks might be managed. However, again, human rights need to be considered closely."

50. The Physical Distancing Plan also states, "Requests in relation to the mandatory quarantine (detention) orders or permission to leave (for people in detention) should be rapidly reviewed by staff in the call centre function, and should always be funnelled through the COVID Directions inbox." This process aimed to result in a complete repository of all categories of

requests for permission, exceptional circumstances requests and advice / exemption requests. The requests were considered high priority.

51. If a person was given a temporary leave, they were given a new notice. This procedure is set out on p 23 of the Physical Distancing Plan. If a permission were granted, then there would be conditions for that permission, for example, that the person be able to safely quarantine elsewhere and would not enter other buildings or premises. Where the permission related to medical treatment, the person was to be accompanied by an on-site nurse, an Authorised Officer, security or a Victoria Police member, with social distancing principles applying.

52. The less common process applied in relation to a person not yet in quarantine. Members of the public could request that detention not be applied. These applications were also to be submitted to the COVID-19 Directions email inbox, to have a complete funnel for handling these requests. Again, exceptional circumstances were required for a decision to not issue a detention notice to a person. Any decisions were made in writing.

53. I recall one example of a returned traveller in hotel quarantine who had a family member dying in hospital at the time being permitted to visit that family member. The relevant hospital agreed to allow that person to visit, wearing personal protective equipment (**PPE**) and with an IPC regime in place.

54. At the end of April 2020, the following circumstances were generally recognised as justifying an exemption from detention (that is, a notice would not be served):[18]

    (a) Unaccompanied minors in transit to another state;

    (b) Unaccompanied minors where a parent or guardian is unable to come into the hotel;

    (c) Foreign diplomats coming into the country;

    (d) People with a terminal illness;

    (e) People whose health and welfare cannot be accommodated in a hotel environment (e.g. mental health or requirements for in-facility health treatment);

    (f) People who are transiting directly to another country (and who do not need to travel domestically first);

    (g) Air crew;[19]

[18] Annex 1 COVID-19 Compliance Policy and Procedures – Detention Authorisation (v1) dated 29 April 2020, DHS.5000.0025.4759 (page 25).

[19] Australian Government Department of Health, Coronavirus exemptions, DHS.0001.0107.0001.

(h) Maritime workers who have come off a boat and will be leaving by boat depending on their particular movements; and

(i) Maritime workers who have come off a plane and will be leaving by boat within the quarantine period, depending on their particular movements.

55. By mid-May, the Enforcement and Compliance Commander (who was also an Authorised Officer), who was responsible for compliance and enforcement activity including authorised officer workforce as well as issuing and reissuing detention orders, could to grant exemptions on certain conditions, without seeking my approval for non-complex cases involving:

(a) Unaccompanied minors in transit to another state;

(b) Unaccompanied minors where a parent or guardian does not agree to come into the hotel;

(c) Foreign diplomats coming into the country – The diplomatic status that Australian citizens have in other countries does not apply in Australia, so Australians with diplomatic status must undertake mandatory detention for 14 days in a designated hotel;

(d) People with a terminal illness;

(e) People whose health and welfare cannot be accommodated in a hotel environment (e.g. mental health or requirements for in-facility health treatment);

(f) People who are transiting directly to another country (and who do not need to travel domestically first);

(g) Air crew including medevac crew;[20]

(h) Maritime workers who have come off a boat and would be leaving by boat, depending on their particular movements; and

(i) Maritime workers who have come off a plane and would be leaving by boat within the quarantine period, depending on their particular movements.

Supporting evidence, such as a report from a medical practitioner, may have been needed to be provided before an exemption request would be considered.[21]

56. Complex cases were escalated to me, or the person filling the Public Health Commander role on the given day. In making these decisions, I had regard to balancing the risks of

[20] Ibid.

[21] Annex 1 COVID-19 Compliance Policy and Procedures – Detention Authorisation (v2) dated 25 May 2020, DHS.0001.0013.0006, page 28.

transmission of COVID-19 with the rights in the Charter. I took into account personal circumstances, including a person's pre-existing medical or mental condition, including complex needs (such as alcohol or drug addiction, or due to a person's disability and a hotel room's inappropriateness for their needs).

57. I do not recall exemptions from detention being granted due to alcohol or drug addiction, but that does not mean that such exemptions may not have been granted by the Compliance Lead.

Question 5. What consideration, if any, was given to exempting certain returned travellers from the Hotel Quarantine Program? What factors were taken into account?

58. I have partly answered this question in my response to question 4.

59. Exemption requests were made generally either:

    (a) prior to the arrival of a returned traveller; and

    (b) during the course of mandatory quarantine.

60. The range of circumstances varied and each case needed to be considered individually on its own merit. An example of an exemption I granted was for an individual being treated for cancer and travelling regularly from New Zealand to Melbourne for that cancer treatment.

61. The decision to grant an exemption requires a balancing of risk to the public against personal circumstances and human rights.

62. The Charter of Human Rights considerations relevant to the decision making process generally those set out on page 21 of the Physical Distancing Plan applicable to the decision to make a detention notice, namely:

> **"*Right to life*** *– This includes a duty to take appropriate steps to protect the right to life and steps to ensure that the person in detention is in a safe environment and has access to services that protect their right to life*
>
> ***Right to protection from torture and cruel, inhuman or degrading treatment –*** *This includes protecting detainees from humiliation and not subjecting detainees to medical treatments without their consent*
>
> ***Right to freedom of movement –*** *While detention limits this right, it is done to minimise the serious risk to public health as a result of people travelling to Victoria from overseas*

Right to privacy and reputation *– This includes protecting the personal information of detainees and storing it securely*

Right to protection of families and children – *This includes taking steps to protect facility and children and providing supports services to parents, children and those with a disability*

Property rights – *This includes ensuring a detainee's property is protected*

Right to liberty and security of person – *this includes only be detained in accordance with the PHWA and ensuring steps are taken to ensure physical safety of people, such as threats from violence*

Rights to humane treatment when deprived of liberty *- This includes treating detainees with humanity*"

63. I have discussed above the categories that became defined in the policy and procedure documents. Some of those categories aligned with the Commonwealth's guidance published by the Australian Government, Department of Health entitled 'Exceptions to the 14 day mandatory quarantine period for international travellers'.[22]

WELFARE CHECKS

Question 6. What was the procedure and practice for conducting checks on the welfare of people in hotel quarantine? Did that procedure or practice change over time? Please provide details, including any relevant documents.

64. The health and welfare of detainees was in square focus for me and my Public Health Colleagues but I was not involved directly in conducting checks on the welfare of people in hotel quarantine.

65. I was also aware of the separate requirements of s 200(6) of the PHWA requiring a review of detention every 24 hours. This review differed from the welfare and other checks.

66. Early on in the program, the arrangements were unsettled and there were multiple checks being undertaken by different people for different reasons. All returned travellers were to receive a nursing check every day and a separate welfare check. The AOs undertook checks and then there was a longer form health check after a few days with the objective of

[22] Australian Government Department of Health, Coronavirus exemptions, DHS.0001.0107.0001 and Annex 1 COVID-19 Compliance Policy and Procedures – Detention Authorisation (v2) dated 25 May 2020, DHS.0001.0013.0006, Appendix 7, page 57-8.

addressing any health needs. These checks were all undertaken by separate individuals and the process was not clearly documented nor were the records centrally managed.

67. The Operation Soteria Plan version 1[23] referred to the provision of regular welfare calls to all quarantined passengers, which is what I understood was taking place, but did not otherwise prescribe the practice or procedure for those matters.

68. In consultation with the CHO, on 9 April 2020, I made a request to the State Controller for a more complete operations plan, and also for a plan to be produced to address arrangements for the provision of health and welfare to people in mandatory quarantine.[24] As an immediate response to that request, the State Controller advised that a new Public Health Liaison Officer reporting to me as PHC would be established to work across operational leads and to facilitate appropriate connection and support the PHC in relation to the operation.[25] I was also provided with a draft of version of the Operation Soteria Plan which included the provision of regular welfare calls to all quarantined passengers and support to meet identified needs.[26]

69. Over the Easter long weekend, following incidents at hotels, there was a push to finalise the improvements in the paperwork in relation to welfare and recording welfare checks and escalation processes. As PHC, I had no oversight over the operations side of the hotel quarantine program. By considering the incidents and the response to them, I had an opportunity to understand in more detail how the program was operating at a granular level. The steps I then took in response are set out here.

70. That Easter weekend and into the following week, I was also involved in a number of meetings with the State Control Centre and emergency operations to reach an agreement on the policy and procedure for health and welfare, as well as the responsibility for implementing it.

71. By 15 April 2020, I agreed with the State Controller that the PH-IMT would be responsible for the creation of policy and associated procedures for health and welfare of passengers while the EOC would be responsible for the operationalising of all policy and procedures – including logistics and rostering at hotels.[27]

[23] Operation Soteria Operations Plan, 28 March 2020, DHS.0001.0001.1475 (Page 8).

[24] Email from Dr Romanes, 9 April 2020, DHS.5000.0053.6652.

[25] Email from State Controller, 10 April 2020, DHS.5000.0053.6652.

[26] Email from State Control Centre, 10 April 2020, DHS.5000.0053.6652 attaching DHS.5000.0053.6655.

[27] Email from me, 15 April 2020, DHS.0001.0012.2104.

72. As at 15 April 2020, the PH-IMT had prepared an Interim Healthcare and Welfare Plan for mandatory quarantine dated 11 April 2020.[28] I reviewed it and provided my comments on it on 15 April 2020, in light of the arrangement agreed with the State Control Centre. I requested the plan be reviewed to, in effect, remove operational details, as this was the responsibility of the EOC and focus on healthcare and wellbeing standards.

73. The interim plan provided that hotel residents would be triaged into three tiers of risk and the welfare check they received would depend on their risk tier, with flexibility for a resident to be moved between tiers as necessary. The welfare checks under the interim plan were:

Risk Tier	**Risk factors**	**Welfare check type**
Tier 1	Residents with suspected or confirmed COVID-19 Families with children < 18 years Passengers aged > 65 years Aboriginal and Torres Strait Islander peoples Residents with underlying comorbidities (e.g. respiratory or cardiac conditions) Residents with a history of mental illness	Daily phone call
Tier 2	Those who indicate they require a phone call but do not have any other risk factors. Residents who are by themselves.	Phone call every second day
Tier 3	Low risk – everyone else.	Daily text message (via Whispir)

74. The procedure for undertaking a welfare check addressed particular concerns within a framework including that:[29]

> ***Welfare and health service provision***
>
> *Welfare checks are being undertaken on residents. The welfare checking process includes phoning a subset of residents each day and conducting long and short surveys. Referrals to the nurse, social supports, the concierge and the department's*

[28] Interim Healthcare and Welfare Plan for mandatory quarantine dated 11 April 2020, DHS.5000.0126.1658.

[29] Ibid, Pages 19-21.

Authorised Officers are taking place as a result. An on-call Complex Care Team is also in place to support residents with more complex needs.

- *Residents will have a welfare check (as specified below) each day.*
- *DHHS welfare officers conducting welfare checks phone and email covid-19.vicpol@dhhs.vic.gov.au and authorised officer individually to alert authorised officers of medical and welfare issues.*
- *Residents will be provided with a resident satisfaction survey to complete each week. Any concerns raised on the survey will be escalated and managed as appropriate.*
- *Residents can seek review by the nurse 24 hours a day if required.*
- *24 hour on-call medical support will be available to detainees at all sites. This will initially be provided by a Field Emergency Medical Officer (FEMO), and subsequently through a locum general practice service.*

…

Conduct of a welfare check

A welfare check will allow passengers to be assessed for medical and social issues, and concerns flagged and responded to. These issues include but are not limited to health, mental health, safety and family violence concerns. A welfare check will be conducted by a DHHS officer which is included as a script at **Appendix 4.** Welfare checks are made from the DHHS welfare call centre.

75. A Deputy Commander Welfare was responsible for managing the operation of a welfare checking team and the CART team, and coordinated the facilitation of meeting the welfare needs of those in hotel quarantine, working with nursing and mental health nursing staff on site.

76. A welfare checking team conducted two telephone welfare checks during the quarantine period: a comprehensive health and wellbeing assessment, typically on day 3; and a shorter health and wellbeing assessment on day 9.

77. The first check verified health information provided by guests upon hotel arrival to ensure essential information about medications, allergies or health issues have been identified in order that it be managed appropriately. The check could also identify issues such as family violence and drug and alcohol dependencies, and wellbeing strategies.

78. The second check focused on ensuring needs were being addressed and provided an opportunity for feedback.

79. The Interim Healthcare and Welfare Plan was updated and became the Mandatory Quarantine Health and Welfare Plan. On 17 April 2020, the Deputy PHC sent me an email, which was also sent to the CHO and State Controller with a draft of the Mandatory Quarantine Health and Welfare Plan.[30] I had approved this draft and asked that it be disseminated as a working plan. For this reason, on 18 April 2020, the DPHC – Planning sent the State Controller the Mandatory Quarantine Health and Welfare Plan for endorsement.[31]

80. This plan continued to evolve. Between 18 April 2020 and 30 April 2020, the Health Standards, which I endorsed, became part of Mandatory Quarantine Health and Welfare Plan. It was considered a working document and for that reason what not attached to the Operation Soteria Plan. The decision to articulate health standards was made for multiple reasons, firstly in order to be consistent with the nomenclature used in the health and wellbeing standards of care that the RACGP had developed for caring for people in immigration detention,[32] and secondly as it enabled a clearer separation of the policy from the operational aspects.

81. By 30 April 2020, the plan had a new name: 'Annex 3 – Health & Wellbeing Standards for healthcare and welfare provision'. I endorsed Annex 3 on 30 April 2020.[33]

82. Subsequently, from time to time, Annex 3 was updated and I endorsed updated copies. However, the core of the policy remained substantially as set out in the Interim Healthcare and Welfare Plan which I discuss above.

83. I also advocated with the State Control centre to have a clinical lead or liaison appointed to have this oversight and I made this recommendation in late April. A job card was created by the Physical Distancing team on 6 May 2020. The Deputy Secretary, Regulation, Health Protection and Emergency Management approved a revised version of this job card on 14 May 2020. I am unsure if this position was progressed or appointed.

[30] Email to me, 17 April 2020, DHS.5000.0111.4902 attaching 'Protocol for AO -Direction and Detention notice' DHS.5000.0111.4903 and Draft Mandatory Quarantine Health and Welfare Plan DHS.5000.0111.4966.

[31] Email from Dr Romanes, 18 April 2020, DHS.5000.0110.7942 attaching DHS.5000.0110.7943.

[32] RACGP, The Standards for health services in Australian immigration detention centres, DHS.0001.0106.0028.
[33] Email to me, 30 April 2020, DHS.5000.0118.2851 attaching DHS.5000.0118.2852.

Question 7. Who undertook welfare checks on people in quarantine? If your answer differs for different time periods or locations, please specify.

84. There were multiple groups undertaking checks on people in quarantine, whilst not all of these were specifically titled 'welfare checks'. Prior to about the Easter long weekend, I did not know how welfare checks were practically being undertaken but understood the procedure to be followed, which I have discussed above in my answer to question 6. Since the mandatory quarantine program was stood up, the CHO, the DPHC – Planning and I had frequently discussed and I had sought more involvement and oversight over the program. I recall being aware at this time that if there were concerns these were escalated to the relevant shift manager:

    (a) Specific daily health welfare checks were being undertaken by nurses on site aimed at determining if a person was developing symptoms of COVID19 and required testing. I understood from conversations with Operation Soteria that these staff were engaged by the Department. I am no longer certain but believe that these daily checks frequently resulted in other requests for medical care or people revealing they had other medical symptoms.

    (b) Longer form welfare surveys were undertaken in the first few days of hotel quarantine to determine if people had greater health or welfare needs that required addressing during their quarantine period. Further checks were undertaken if there were complex needs identified in the initial welfare check. The nurses did not report to me and I was not initially aware of the content of the welfare checks or health surveys.

    (c) Additionally there were daily compliance checks from the Authorised Officers.

    (d) People in quarantine also had multiple dial out options to seek care – both for medical services and concierge services.

85. I saw copies of the health checks and welfare checks after the welfare incident at Easter. The process above is my recollection of what was explained to me after the welfare incident.

86. While the overall content and frequency of the checks appeared to be appropriate at the time, I was concerned about the fragmented and paper based documentation system (which had evolved out of necessity in the rapid set up of the program) and that there was potential for people to 'fall through the cracks' if there was not an overarching system which could document and monitor the health and wellbeing interactions for each person in hotel quarantine.

87. I also wanted to ensure that there were appropriate standards that would be applied to the making of welfare checks and the overall provision of healthcare and that there were

escalation processes in place for issues identified through the welfare checks or health assessments.

88. My objective was to create an electronic record that was as streamlined as possible. While this would avoid some duplication that was occurring (and which there had been anecdotal reports that some quarantined people were frustrated with), the primary goal from my perspective was to ensure that any red flags or identified issues were all documented in a single place and reviewed regularly. Ultimately, that record was reflected in Part 5 of the Operation Soteria Plan v 3 and in standards 2 and 3 of that part (screening and follow up of health and welfare risk factors and provision of health and welfare services respectively).

89. As discussed above, these standards are an adaptation of the RACGP standards for health services in Australian immigration detention centres.[34]

90. Subsequently, an electronic platform called the Quarantine and Welfare System was established and became the central platform for us to record welfare screening and follow up for people in mandatory quarantine. I did not receive reports on the health and welfare check process and was not responsible for monitoring its implementation, however a number of staff from the Intelligence team in the Public Health Command were deployed to assist with the development of reporting processes.

Question 8. How frequently were welfare checks undertaken? If your answer differs for different time periods or locations, please specify.

91. I have addressed this above.

Question 9. Why were welfare checks conducted in the way that they were? If your answer differs for different time periods or locations, please specify.

92. Again, I have explained this above.

Question 10. In your view, was the practice and procedure for undertaking welfare checks adequate and appropriate? Why or why not?

93. The welfare process that was described to me overall appeared adequate. However as above I was concerned that the documentation and coordination process left potential for

[34] RACGP, The Standards for health services in Australian immigration detention centres, DHS.0001.0106.0028.

people to fall through the gaps. I am unable to comment about operational aspects of the policies but to the extent the practice reflected the policies prepared by the PH-IMT as discussed in my answer to question 6, I consider that they were adequate. In preparing the health standards, the PH-IMT drafters were informed by the national standards set out in the Immigration Detention Standards.[35] I cannot comment on the of the overall standard of welfare checks as I was not involved in the daily oversight of the procedure or practice of these. I cannot comment on the implementation outside of the system that was described and initial surveys that I saw in early April.

INFECTION CONTROL

Question 11. What measures did the Department take to ensure that:

(a) hotel properties utilised; and

(b) staff working,

within the Hotel Quarantine Program had adequate infection control measures in place? What were those measures?

94. The AHPPC is a decision-making committee for national health emergencies comprising all state and territory chief health officers[36] and is chaired by the Australian Chief Medical Officer. It provides advice relevant to COVID-19 and produces statements that articulate its public health advice on the relevant issues.[37] In late January or early February, AHPPC appointed an expert advisory group to provide nationally consistent infection prevention and control guidance. This group reported directly to AHPPC, however some of its members attended CDNA, a sub-committee of the AHPPC, semi-regularly. I am aware of the AHPPC advice, including because I assisted the CHO on preparing briefings and recommendations for the AHPPC on matters related to COVID-19. I also sat on the CDNA.

95. All infection prevention and control advice provided in Victoria by the IPC cell was in line with advice from this national group.

96. I am not able to speak for the Department generally. Neither I nor the PH-IMT were responsible for operational matters relating to the hotel quarantine program.

[35] Ibid.

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

[37] 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**). I sat on CDNA and the CHO sits on AHPPC.

97. In late March 2020, I formed a view as PHC that the Department's expert guidance in IPC and PPE policy needed to be more coordinated and systematised. As part of the PH-IMT, I established a cell lead by a Public Health Physician comprised of infection control consultants to coordinate and consolidate the policy and advice on IPC and PPE so that there was a single resource available. The function of the newly formed IPC cell fell within the delegation of the DPHC – Pathology and IPC reporting to me as PHC through to the CHO.[38]

98. The IPC consultant seconded to the Department prepared general advice in relation to IPC and PPE that applied to COVID-19 from the beginning of the incident. This advice was prepared having regard to national and international guidance and was available for both healthcare and non-healthcare settings on the departmental website at the time that Operation Soteria commenced. For example, I am aware that advice about the particular sequence for doffing PPE was prepared based on NHMRC Australian Guidelines for the Prevention and Control of Infection in Healthcare (2019).

99. We then provided this advice to Operation Soteria, for implementation in the hotels. At the same time, we were providing state-wide infection prevention control advice.

100. I am aware that in early April 2020, Operation Soteria sought further, specialised advice, including in the context of establishing Rydges as a COVID-19 hotel, in addition to what I identify here. At the time, our IPC cell did not have capacity to provide that additional advice as it was providing COVID-19 IPC advice to settings across the state, including to aged care facilities. We recommended that Operation Soteria engage Infection Prevention Australia and I understand that occurred.

101. I understand at that time the independent IPC consultant developed bespoke PPE guidance for the Hotel Quarantine program, which was reviewed and endorsed by the IPC cell within the PHIMT. In so doing, the IPC cell had regard to relevant standards from the AHPPC advisory group and the World Health Organisation (**WHO**), available at the time.

102. Cleaning and disinfection advice was provided in the form of both general advice for non-healthcare settings (in line with the national infection prevention and control advisory group advice) and through the Case and Contact management guide for healthcare providers providing care to suspected or confirmed cases of COVID19.

103. In terms of responsibility for the implementation of IPC measures in hotels, I understood that I had responsibility for the availability of IPC advice and guidance but did not have accountability for its appropriate implementation.

[38] Email from me, 27 March 2020, DHS.5000.0122.0601.

104. From February 2020 to now, the knowledge of COVID-19, how it is transmitted and the appropriate IPC measures that should be used has evolved. In addition, the IPC measures that are appropriate depend on both the user and the setting. For example, much advice is prepared for healthcare workers, given their heightened risk but also taking into account their greater health literary and expertise in appropriately using PPE and awareness of IPC.

105. I understand that further specific training resources were developed for security guards after the Rydges and Stamford outbreaks. These resources were developed as a collaborative effort by the IPC cell, which by then had increased staffing, and the training was undertaken by an independent contractor.[39]

106. In addition to this, the outbreak squads visited several hotels as part of their program of outreach work to assess the IPC practices being undertaken. I was aware at a high level of the protocols under which the squad were to operate. They had a two pronged remit: to address IPC in a proactive way to address high risk settings and then to respond to outbreaks by visiting premises where outbreaks occurred and assisting with the review and implementation of appropriate IPC procedures at the premise.

Incident Action Plan

107. I was involved in drafting the "2019-nCov public health incident" (**Incident Action Plan**), along with the Deputy Public Health Commander, with version 1 in use from 2 February 2020.[40] The Incident Action Plan articulated overarching strategies and principles for a response to COVID-19 and how to minimise the impact of COVID-19 on the health and wellbeing of Victorians. The Incident Action Plan was intended to be a living document, that would record COVID-19 cases and strategies to be used in response and who was responsible for that response. The Incident Action Plan addresses IPC, as at 2 February 2020, as follows:

> • *The department recommends droplet and contact precautions for healthcare workers assessing suspected cases and confirmed cases of 2019-nCoV infection. If available, airborne precautions can also be used.*
>
> • *This advice extends to family members, visitors, other health care workers and any other individuals in contact with the suspected or confirmed case.*

[39] I approved the engagement of the independent contractor on 10 June 2020, DHS.5000.0122.2526.

[40] 2020 Novel CoV Incident Action Plan - 2 February 2020, DHS.5000.0056.3655.

• The department, through Primary Health Networks, has distributed P2 face masks to general practitioners

108. Droplet or contact precautions have standard definitions in infection prevention and control terminology, and these definitions were set out in the Guide for healthcare providers, which was released as version 1 on 24 January 2020. As the pandemic unfolded, the Incident Action Plan was no longer used and was replaced by the documents I explain below, in particular the Outbreak Management Plan.

Operation Soteria Plan

109. As Public Health Commander, I was required to approve parts of the three versions of the Operation Soteria Plan, the plan by which the hotel quarantine program was to be governed and managed.

110. The first version of the Operation Soteria Plan dated 28 March 2020[41] provided that the Department would provide and conduct health screening, and other wellbeing services (including psycho-social support) and PPE for persons arriving from overseas by air and being detained in hotel quarantine. I was not involved in the drafting or approval of this version.

111. The second version of the Operation Soteria Plan (v 2.0) was approved by the Emergency Management Commissioner on 26 April 2020, also addresses infection prevention and control as relevant operation standard, in standard 5, which addressed: PPE (criterion 5.1), cleaning and waste disposal (criterion 5.2), laundry (criterion 5.3) and isolation protocols (criterion 5.4). This information was available to those working in Operation Soteria as material relevant to their operations. I was involved in settling and approving this content.

112. This material is also found in the next version of the Plan, approved on 8 May 2020, Operation Soteria Plan v 2.1.[42] The amended Plan continues to address PPE and IPC and refers to the Public Health Standards for care of returned travellers in mandatory quarantine. Standard 5 relates to Infection Control. The Plan also addresses incident reporting and includes a flowchart for issue escalation and incident reporting.

113. On 26 May 2020, version 3 of the Operation Soteria Plan was approved.[43] The version addresses IPC and PPE focused on DHHS team leaders and support officers and nurses. Annexure 2 discusses Health and Wellbeing and includes Standards for Healthcare and

[41] Operation Soteria Plan v1, 28 March 2020, DHS.0001.0001.1475.

[42] Operation Soteria Plan v2.0, DHS.5000.0074.2583.

[43] Operation Soteria Plan v3.0 with annexes v2.0, 1 June 2020, DHS.0001.0001.1053.

Welfare provisions. Standard 5 – Infection Control at page 97: Criterion 5.1 – Personal Protective Equipment; Criterion 5.2 – Cleaning and Waste Disposal; Criterion 5.3 – Laundry and Criterion 5.4 – Isolation Protocols. And at page 109 there is also a policy for COVID-19 testing in Hotel Quarantine.

Cleaning

114. Cleaning is an IPC measure. I am aware that the Department's IPC consultant prepared cleaning advice, *Cleaning and disinfecting to reduce COVID-19 transmission: Tips for non-healthcare settings*,[44] that was publicly available on the Department's website on 20 March 2020. The purpose of the guide was to provide advice on cleaning and disinfecting to reduce the risk of COVID-19 transmission in all non-healthcare settings in Victoria.

115. I am aware that on 29 May 2020, Dr McGuinness sent Operation Soteria a version of the cleaning guide, for the purposes of the Rydges Hotel. Dr McGuinness recommended, for example, at least once daily cleaning plus disinfection (using a disinfectant for which the manufacturer claims antiviral activity) of all common areas including all high touch surfaces and lifts.[45]

116. In addition, the COVID-19 Case and Contact Management Guidelines for Health Services and General Practitioners (**CCOM Guidelines**)[46] is publicly available and provides for general infection prevention and control,[47] based on the CDNA Series of National Guidelines – COVID-19 and the WHO guideline, *Infection prevent and control during health care when novel coronavirus (nCoV) infection is suspected: Interim guidance January 2020*. It is the Department's key resource for clinicians and health services. It is regularly updated to ensure that it aligns with the national CDNA Australia guidelines and international best practice.

117. The CCOM Guidelines thus reflects nationally consistent advice regarding the management of COVID-19 suspected and confirmed cases had evolved as further information regarding the specific risks of transmission became known. The Guidelines noted that as that further knowledge or advice became available, it was incorporated into the Guideline[48] and I am aware that such changes were made.

[44]Cleaning and disinfecting to reduce COVID-19 transmission - 20 March 2020, DHS.0001.0015.0323.

[45] Email 29 May 2020, DHS.5000.0105.5941 attaching Cleaning and disinfecting to reduce COVID-19, DHS.5000.0105.5942.

[46] DHS.0001.0060.0034, version 17 dated 5 April 2020. This document was continuously updated.

[47] CCOM Guidelines, p 18.

[48] CCOM Guideline, p 19.

118. On 16 June 2020, the *Hotel Quarantine Response: Advice for cleaning requirements for hotels who are accommodating quarantined, close contacts and confirmed COVID-19 guests*[49] was published (the **June Cleaning Guide**). The June Cleaning Guide was specifically tailored for cleaning in hotel quarantine.

119. The content in the March and the June Cleaning Guides is very similar: the definition of cleaning is the same in both documents and the steps for cleaning ("How to Clean") is substantially the same, but the content is found in different parts of the document. The only substantive difference is the June Cleaning Guide identifies three different spheres of cleaning:

    (a) daily cleaning - common areas cleaning to be twice daily cleaned and with daily floor surfaces cleaning;

    (b) exit deep cleaning – clean and disinfection of hotel rooms that have accommodated COVID-19 positive guests and close contacts; and

    (c) exit hotel quarantine program cleaning.

120. The nature of each of these cleans is explained. However, the substance of this advice is largely found in the March Cleaning Guide. The management of linen is also addressed in the June Cleaning Guide. The June Cleaning Guide refers to a number of resources, including the March Cleaning Guide.

The Outbreak Management Plan

121. The Outbreak Management Plan addresses IPC in the context of an outbreak, including processes for reviewing IPC processes in place at a site at the time of an outbreak, inspecting to determine adherence to those processes and making recommendations for any necessary improvements.

PPE Guidance to AOs and Security Guards

122. I am aware that the IPC consultant engaged by the Department prepared advice on PPE to be worn by authorised officers or security guards.

123. A first version of this advice was found in the first version of the Operation Soteria Plan.

124. This table was extracted from the Plan and put in a separate document, *'Operation Soteria – PPE Advice for Hotel Security Staff and AO's in Contact with Quarantined Individuals'* (**PPE Advice for AOs and Security Staff**).

[49] Hotel Quarantine Response: Advice for cleaning requirements for hotels who are accommodating quarantined, close contacts and confirmed COVID-19 guests, DHS.0001.0001.0720.

125. The Advice for AOs and Security Staff was based on evidence available at the time in relation to COVID-19 and that it was primarily transmitted via droplet and contact transmission. The national and WHO guidance regarding PPE, at that time, was to wear a mask if within 1.5m of suspected/confirmed cases; a mask would not be required if physical distancing could be maintained.[50]

126. This advice was on the understanding that security guards would be present when guests arrived at a hotel and would escort guests to and from their rooms for fresh air breaks, and that this was the limit of their duties and interactions, including that they would not be required to touch people (in performing security duties) or provide any hands on care. The PPE recommendations were based on National guidance and the above 'job description'. For this reason, we determined that masks were to be used when escorting guests if physical distancing could not be maintained.

127. Glove use was discouraged with an emphasis to be placed on hand hygiene instead. We understood that security staff were to open all doors and push lift buttons etc, not guests.

128. The other issues that were considered when making this advice included:

    (a) security guards are not a health workforce and would not be as familiar with use of masks or other PPE as health care workers would be;

    (b) masks could provide a false sense of security, when the emphasis was to try and maintain physical distancing at all times;

    (c) use of masks in these circumstances without adequate training could increase instances of staff touching their face and thereby increase risk of contamination and transmission;

    (d) glove use can lead to poor hand hygiene compliance particularly with untrained workers as they feel they are protected then touch lots of surfaces potentially contaminating them;

    (e) masks are better for source control rather than protecting wearers from infection; and

    (f) a risk benefit analysis needs to be taken for any advice that is given based on the best available evidence at that time.

129. The IPC team formed the view that this advice was consistent with advice they received at the time from the Clinical Excellence Commission of New South Wales, a body that provides

[50] WHO guidance, 27 February 2020, Rational use of PPE, DHS.0001.0106.0134.

IPC standards. That advice meant that the security guards in their hotel quarantine facilities were only to wear masks when within 1.5 m. I understand this is their current advice.

130. In my view, it would not have been appropriate to ask security guards to, for example, wear full PPE (including eyewear and a gown) when escorting guests on fresh air breaks. The advice provided that masks could be worn should staff be unable to physically distance. This would include the circumstance where unexpected events were likely to occur. It is still the case that full PPE is not recommended in these circumstances and is not recommended by national advice.

Question 12. Were you involved in deciding upon or implementing decisions about those measures?

131. I approved the recommendations set out by my team, with the knowledge that they were consistent with national and international recommendations.

132. I was not involved in the implementation of these recommendations on the ground at the hotels used for quarantine.

Question 13. Did those measures change over time? If so, how, when and why?

133. Yes. I have set this out above.

DECISION TO DESIGNATE COVID POSITIVE HOTELS

RYDGES HOTEL, CARLTON

14. Why was the Rydges Hotel in Carlton designated as a COVID positive (or 'Hot') hotel? Who made that decision, and on what factors was it based?

134. I first became aware that the Rydges Hotel would be designated as a hotel for COVID-19 positive guests in the context of the repatriation of passengers from the Greg Mortimer cruise ship out of Uruguay. I did not make that decision. I was informed that Rydges had been selected as the designated hotel by Deputy Secretary, Regulation, Health Protection and

Emergency Management on 9 April 2020. As far as I am aware, the decision to contract with the Rydges was a decision made by the Emergency Operations Management Centre.[51]

135. The decision was consistent with my recommendation to have a dedicated COVID-19 positive hotel, which was endorsed by the CHO and communicated to Merrin Bamert and Meena Naidu by the Deputy Public Health Commander on 31 March 2020 by email. The implementation of this occurred between March 31 and the first week of April – with Rydges being in place as a designated hotel by April 9th as above.

136. The recommendation that cohorting of positive COVID-19 cases, and preferably in a single location (in this case a hotel) is a recognised public health preventative measure. This practice was implemented in at least one other jurisdiction (New South Wales) prior to Victoria implementing it.

    (a) Cohorting patients with a single communicable disease creates less risk across the 'system' (in this case the hotel quarantine system, but frequently this occurs across a health care system and in aged care settings) as it separates unwell/infectious people from susceptible people and therefore decreases the number of susceptible people to whom the infection can spread.

    (b) Cohorting also decreases the number of staff who are potentially exposed to infectious people.

    (c) Cohorting allows for a higher concentration of medical/support staff to be placed together as the cohorted group have a higher risk of deteriorating and requiring medical attention.

Question 15. What additional infection control measures were implemented at the Rydges Hotel in Carlton upon it being designated a COVID positive (or 'Hot') hotel? When were they implemented and why?

137. I am not aware of the infection control measures that were implemented at the Rydges Hotel. The implementation of IPC measures in the hotel quarantine program was not within the role of PHC. As discussed above I am aware that further advice was sought, and that the IPC team in the Public Health Command did not have capacity to provide this advice, and as such recommended that an independent IPC consultant be engaged through Infection Prevention Australia, which occurred.

[51] Email, 9 April 2020, DHS.0001.0013.2566.

Question 16. Do you believe that the infection control measures implemented at the Rydges Hotel in Carlton were adequate:
(a) in general; or
(b) in light of its designation as a COVID positive (or 'Hot') hotel?
Why or why not?

138. I believe that the guidance that was given was appropriate for the time, and in line with national and international expert advice around infection control for COVID19.

139. In terms of the adequacy of the implementation of that advice, I am aware from the Rydges Outbreak response and updates I received from the DPHC Case, Contacts and Outbreak Management that there were shortcomings in behaviours of staff working at hotels relating to hand hygiene and PPE practices were identified and addressed by the Outbreak Management Team and that efforts were made to address these shortcomings. I am cognisant that our understanding of the transmission dynamics of COVID19 has changed in the time since the infection control measures were recommended and implemented and that recommended practices are different.

BRADY HOTEL

Question 17. Why was the Brady hotel designated as a COVID positive (or 'Hot') hotel? Who made that decision, and on what factors was it based?

140. I was not involved in the decision to designate Brady hotel as a COVID positive hotel and not aware of who made that decision. I believe one of the factors was the Rydges withdrawing from the program after the outbreak there, and that one of the considerations was that Brady Hotel had balconies so would require fewer fresh air breaks for detainees.

Question 18. What additional infection control measures were implemented at the Brady Hotel upon it being designated a COVID positive (or 'Hot') hotel? When were they implemented and why?

141. I am aware that on 17 June 2020, arrangements were made for two groups of IPC nurses to attend the Brady Hotel to complete security guard hand hygiene training and to make other arrangements relating for swabbing.[52] At the time, I understood that the attendance to train security contractors in hand hygiene was because of learnings from the Rydges outbreak.

[52] Email copied to me, 17 June 2020, DHS.5000.0120.4867.

Question 19. Do you believe the infection control measures implemented at the Brady Hotel were adequate:
(a) in general; or
(b) in light of its designation as a COVID-positive (or 'Hot') hotel?
Why or why not?

142. I have not been involved in overseeing the implementation of the infection control measures at the Brady Hotel.

RESERVATIONS ABOUT THE HOTEL QUARANTINE PROGRAM

Question 20. Did you have reservations about:
(a) the governance;
(b) any other aspect,
of the Hotel Quarantine Program? If so, what were those reservations and when were they held?

143. I had reservations about the fragmentation of service delivery within the hotel quarantine program. This fragmentation was demonstrated after an adverse guest event over the Easter weekend (that was referred to Safer Care Victoria), where it became clear that the various medical, welfare, support and concierge systems were all separate and there was no single source of truth for guest health and welfare services. This concerned me as it meant that there could be multiple risk signals that were expressed across these services but not viewed in a holistic manner. Whilst these systems were created with extreme haste, I felt it was important to consolidate as much as possible in order to ensure maximum health and wellbeing functions for detainees. I advocated for changes to be made to address this as I discuss above. As far as I am aware, this happened.

Question 21. To whom did you express those reservations and what, if anything, was done to address them? In your view, were those responses:
(a) appropriate?
(b) adequate?

144. I expressed these reservations to the State Controller and the State Health Coordinator during multiple meetings in the weeks following the incident at Easter. There was a concerted effort across the three groups to ensure that both the Health and Welfare

standards were improved, and that the coordination between the various groups involved in the delivery of the hotel quarantine program was improved. These responses were appropriate but some items took longer to action that was ideal, in particular the appointment of a clinical lead role into the hotel quarantine emergency operations team. An electronic system was created improve the quality and transparency of healthcare documentation in the hotel quarantine program as a result of this effort.

REFLECTIONS ON THE HOTEL QUARANTINE PROGRAM

Question 22. What, if anything, do you consider that:
(a) the Department;
(b) other government departments or private organisations;
(c) you,
should have done differently, in relation to the Hotel Quarantine Program?

145. As hotel quarantine was devised from National Cabinet, there was minimal discussion of the operational aspects of the various State and Territory programs through the CDNA group. While there are nationally standard protocols for the management of cases and contacts (Series of National Guidelines), I am not aware of national standards or guidance for the operation of hotel quarantine programs. Nor am I aware that there was any ongoing national discussion regarding the implementation and management of hotel quarantine. In retrospect, I think a dedicated national group to discuss, collaborate and work through issues collectively and learn from each other's experiences would have been appropriate.

146. I think that the fragmented responsibilities identified in my answers above were indicative of some inconsistencies in understandings between different staff and departments as to who was considered to be ultimately responsible for certain aspects of the program, including oversight of operations on the ground.

147. I think we all could have treated the hotel quarantine program more as a health program than a logistics or compliance exercise and viewed the overarching principals more from a health lens than occurred at the time, including standards of care and infection control. As such, we could have considered the importance of oversight from clinically trained personnel as a higher order of priority, both in the governance system and on the ground at the hotel sites and ensure this occurred earlier than it did.

148. In line with increasing the health lens over the program, there could have been regular external auditing and reporting on adherence to the standards set out in the overall Operation Soteria Plan (or equivalent).

FURTHER INFORMATION

Question 23. If you wish to include any additional information in your witness statement, please set it out below.

149. I think it would be worth considering having additional legislative or reportable requirements for exercising the various elements of the emergency powers and responses specifically for health emergencies, including requirements that those exercises are appropriately resourced and done in a great level of detail, in a similar way to occurs in Singapore. Whilst desktop exercises are useful, I think deeper dives into exactly how certain scenarios might play out, including more operational exercises across various scenarios would be helpful into the future.

150. I am certain there is no single cause of the current second wave, and that there were hundreds of micro-decisions and actions that resulted in the second wave, none of which would have individually been enough to cause the end result. I hope that the Inquiry continues to focus on systemic and sustainable opportunities for improvements that will be beneficial to both the hotel quarantine system going forward and to future health emergencies and system challenges.

Signed at Melbourne

in the State of Victoria

on 9 September 2020

Dr Annaliese van Diemen