BOARD OF INQUIRY INTO THE COVID-19 HOTEL QUARANTINE PROGRAM

WITNESS STATEMENT OF KYM LEE-ANNE PEAKE

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Occupation:	Secretary, Department of Health and Human Services
Date:	14 August 2020

1. I make this statement to the Board of Inquiry in response to **NTP-030,** the Notice to produce a statement in writing (**Notice**). This statement has been prepared with the assistance of lawyers and Departmental officers.
2. I am the Secretary of the Department of Health and Human Services, Victoria (**Department**). I have held this position since 16 November 2015.
3. I make this statement on behalf of the Department.
4. This statement is true and correct to the best of my knowledge and belief. I make this statement based on matters within my knowledge, and documents and records of the Department. I have also used and relied upon data and information produced or provided to me by officers within the Department.

Professional background

5. I commenced as Secretary of the Department in November 2015. I have held a range of senior public service roles, including:
   5.1. Executive Director, Productivity and Inclusion at the Department of the Prime Minister and Cabinet (September 2008-January 2010);
   5.2. Deputy Secretary, Higher Education and Skills Group at the Victorian Department of Education and Training (January 2010-November 2014);
   5.3. Lead Deputy Secretary, Strategy and Planning at the Department of Economic Development, Jobs, Transport and Resources, (November 2014-March 2015); and
   5.4. Deputy Secretary, Governance Policy and Coordination at the Victorian Department of Premier and Cabinet (March 2015-November 2015).

5.5. Prior to this, I held several positions in government, including in the Victorian Department of Premier and Cabinet within Human Services, and as a consultant at KPMG.

6. I am the President of the Institute of Public Administration Australia (Victoria).

7. I have an Executive Master of Public Administration, a Bachelor of Arts (Hons) and a Bachelor of Laws, all from the University of Melbourne.

QUESTIONS

Roles and Responsibilities

1. What is the role and function of the Department of Health and Human Services?

8. The Department supports five Ministers across the portfolios of Health, Ambulance Services, Housing, Disability, Ageing and Carers, Mental Health, Child Protection, and the Prevention of Family Violence.

9. The Department is primarily organised on a portfolio basis to provide policy advice to government and to fund, regulate and deliver programs to enhance the safety, health and wellbeing of Victorians.

10. Key responsibilities of the Department and its administrative offices include:

10.1. Stewardship, funding, performance monitoring, strategic asset management and system planning of public health, mental health and aged care services and ambulance services.

10.2. Stewardship and commissioning of healthcare delivered by non-government organisations (for example maternal and child health services, community health, dental health, community mental health and Alcohol and other drug services).

10.3. Direct delivery of child protection and public housing services and disability services for Victorians who are not eligible for the National Disability Insurance Scheme, alongside direct administration of programs for carers and concession-card holders.

10.4. Stewardship and commissioning of social housing and support services delivered by non-government organisations to vulnerable people. This involves collaboration across Victorian government to better integrate investments and services for vulnerable people and communities with complex and chronic needs.

10.5. Community engagement and collaboration with Aboriginal organisations to provide funding and support for Aboriginal-led health and human services and initiatives to lift health and wellbeing outcomes.

10.6. Regulatory and health promotion functions, including regulation of health and human service organisations, workforces, environmental hazards, preventing the spread of communicable diseases and promoting health communities and behaviours.

10.7. Emergency management functions, including contributing to whole-of-government actions to build community resilience and support social recovery in disaster-impacted communities,

10.8. Planning, delivery and oversight of public health, mental health, aged care and social services infrastructure.

11. Further, the Department has four portfolio agencies – Safer Care Victoria, the Victorian Agency for Health Information, Family Safety Victoria and Mental Health Reform Victoria – with a focus on driving quality and safety improvements across our health services, strengthening specialist service responses to women, children and perpetrators of family violence and implementing interim recommendations from the Royal Commission into Victoria's Mental Health System.

2. What is your role and what are your key accountabilities within the Department?

12. Pursuant to the *Public Administration Act*, as Secretary of the Department I am responsible to the relevant portfolio Ministers for the general conduct and the effective, efficient and economical management of the functions of the Department and its Administrative Offices.

13. In general, my key accountabilities are to provide strategic leadership and stewardship of the Department and associated service systems, to ensure compliance with our legislative and regulatory responsibilities, and to advise portfolio Ministers on policy and service improvements to raise health and wellbeing outcomes.

14. At the start of April 2020, new governance arrangements were put in place to address critical missions required in response to the unprecedented range of economic, social and health issues raised by the coronavirus (**COVID-19**) pandemic.

15. Pursuant to these arrangements a Crisis Council of Cabinet (**CCC**) was established to determine all significant matters of policy, administration, budget and legislation required to respond to the crisis, and portfolio Ministers were appointed to act as "Minister for the Coordination of" the COVID-19 response.

16. Departmental Secretaries were given Mission Lead roles that reported directly to the Premier. I was appointed the Mission Lead Secretary – Health Emergency. This involved leading the public health and health system response to COVID-19.

17. The scope of the mission covered:

    17.1. **Public health management and prevention**, including through:

    (i) Identification, testing and quarantining of positive cases and tracing and isolation of their contacts

    (ii) Provision of key supports for the health and wellbeing of positive cases and close contacts

    (iii) Chief Health Officer (**CHO**) guidance on the strength and duration of physical distancing measures

    (iv) Co-ordination of COVID-19 testing – sites, guidelines and supply.

    17.2. **Adaptation of health care delivery,** including:

    (i) Maximising health system capacity (available beds, workforce, equipment and PPE) to meet expected demand

    (ii) Managing safe access and continuity of care

    (iii) COVID-19 case treatment and recovery

    (iv) Marshalling and direction of public and private sector resources.

18. In my Role as Mission Lead, I was also part of the Mission Coordination Committee (**MCC**) which was chaired by the Secretary of the Department of Premier and Cabinet. I discuss the MCC further below in response to questions 34 to 36.

19. A new Crisis Council of Cabinet (**CCC**) was established to replace all Cabinet Committees within the MCC arrangements. These arrangements recognised that COVID-19 presented an unprecedented global public health crisis, disrupting economies, health systems and social activities and wellbeing. The new crisis management arrangements reflected the need to focus not only on immediate public health risks, but

also the associated social and economic impacts – recognising that these will affect long term health outcomes. They also recognised the extraordinarily interconnected nature of the COVID-19 challenge – where workforce, economic, public health, social determinants and civil order matters all intersect.

20. These arrangements recognise that while DHHS is the control agency for the pandemic and the CHO guidance and directions underpin COVID-19 responses, the capabilities and capacities of the whole of government, indeed the whole of all levels of government, and broader society, are essential to an effective emergency response. The sheer scale and nature of the emergency response has required novel solutions to be rapidly developed and implemented, not just once, but routinely. In my experience as a senior public servant, I have not seen, or heard of, a public administration challenge or response of this nature in Australia, at least since the Second World War.

21. Recognising this, it has been routine in the context of the COVID-19 response for multiple departments and agencies to provide deputy commander positions to co-ordinate and oversee different aspects of the response – including actions in response to growing numbers of infections in public housing towers and enforcement of CHO directions. It is also routine for different agencies and departments to have accountabilities and leadership roles for aspects of novel operations.

22. Throughout the pandemic response, public health has provided expert guidance on infection prevention control and behavioural changes necessary to reduce transmission of COVID-19 in Victoria. As necessary to eliminate or reduce a serious risk to public health, the CHO and Deputy CHO had issued 122 legal directions relating to the COVID-19 response by 7 August. The development and implementation of these directions has required a multi-agency response to support individuals, businesses, industries and multiple enforcement agencies to acquit their role in managing the public health crisis by reducing movement and activity to reduce the speed and risk of transmission.

23. To provide two practical examples:

    23.1. Physical distancing and infection control guidance provided by public health experts within the Department has been applied by the Department of Transport and its agencies to the management of public transport timetables and cleaning requirements to enable critical workforces to continue to safely travel to work.

    23.2. More recently, legal directions on COVID-safe plans for industries permitted to remain open under Stage 4 restrictions have been informed by, and implemented

through, industry engagement and guidance led by the Department of Jobs, Precincts and Regions (**DJPR**).

Pandemic Pre-Planning

3. Before 16 March 2020, did Victoria have any plan for responding to an infectious diseases pandemic? If so, what was the plan?

24. Prior to 16 March 2020, Victoria had two pandemic response plans. It had the Victorian Health Management Plan for Pandemic Influenza[1] 2014 (**VHMPPI**) (the health pandemic management plan) and the Victorian Action Plan for Pandemic Influenza 2015[2] (the EMV pandemic plan).

25. The two plans work together but have a different focus. The purpose of the VHMPPI "*is to provide an effective health response framework to minimise transmissibility, morbidity and mortality associated with an influenza pandemic and its impacts on the health sector and community.*"[3]

26. The EMV pandemic plan "*sets out Victoria's strategic approach to reduce the social and economic impacts and consequences of pandemic influenza on communities*.[4]" Both plans were prepared in the context of the national response to the preparation and planning for an infectious disease pandemic.

27. The VHMPPI was originally written in 2007 but updated in 2014 following learnings from the H1N1 pandemic, declared by the World Health Organization in 2009, and during a period where the H5N1 virus (commonly known as the avian influenza virus) was still circulating throughout the world. When it was developed in 2007 it was the local reflection of the Australian Health Management Plan for Pandemic Influenza (**AHMPPI**). I believe similar plans would also have been developed in other states to reflect the AHMPPI.

28. With the onset of COVID-19 infections in Victoria, the VHMPPI was amended in February 2020, once the department assessed the seriousness of its potential impact for Victoria. That amended plan was the *COVID-19 Pandemic Plan for the Victorian Health Sector.*

1 Victorian health management plan for pandemic influenza, Department of health, October 2014, p 1.
2 Victorian action plan for pandemic influenza 2015.
3 Victorian health management plan for pandemic influenza, Department of health, October 2014, p 4.
4 Victorian action plan for pandemic influenza 2015, p 6.

29. The *COVID-19 Pandemic Plan for the Victorian Health Sector* also informed the development of sector specific plans within the Department's portfolio responsibilities, including disability services, aged care and community services.

30. The EMV pandemic plan and the arrangements pursuant to the *Emergency Management Act*, the Emergency Management Manual Victoria (**EMMV**) and the State Health Emergency Response Plan (**SHERP**)**,** to which I refer further below, were also relevant.

31. In general, state responses to emergencies, including health emergencies, are guided by the planning frameworks which operate under the *Emergency Management Act 2013* and which also involved specific functions for the Department generally, and also, as discussed below, for some of its individual staff. These frameworks are:

    31.1. The EMMV, which sets out policy and planning documents for emergency management in Victoria, provides details about the roles different organisations play in the emergency management arrangements. Under the EMMV, the department is the designated control agency for human disease emergencies

    31.2. The State Emergency Response Plan (**SERP**), which outlines the arrangements for a coordinated response to emergencies by all agencies with a role or responsibility in emergency response

    31.3. The SHERP, a sub plan of the SERP, used by people working in emergency services, such as paramedics, doctors, nurses and people working in public health, to help them effectively coordinate health services for the community during emergencies.

32. Health emergencies are a form of Class 2 emergency under the Emergency Management Act. The definition of a Class 2 emergency is a major emergency which is not:

    32.1. a Class 1 emergency (major fire, flood or other emergency managed by Fire Rescue Victoria, the Country Fire Authority or the Victoria State Emergency Service Authority); or

    32.2. a warlike act or act of terrorism, whether directed at Victoria or a part of Victoria or at any other State or Territory of the Commonwealth; or

    32.3. a hi-jack, siege or riot.

33. Biosecurity emergencies (unless linked to an act of terrorism) are another form of emergency that fall within the definition of a Class 2 emergency. A significant agricultural

emergency (such as bovine spongiform encephalopathy (mad cow disease)) would also be an example of a potential Class 2 emergency.

34. While Class 2 emergencies have been comparatively rare in Victoria, the department 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.

35. 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.

36. In November 2019, the CHO and the Director, Emergency Management Branch 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"* (the **Concept of Operations document**) which is an overarching guidance document for staff working in the department in emergency-related roles.

37. It is relevant to a number of public health emergencies including communicable disease such as an infectious disease pandemic. The document explains the department's incident management structure and arrangements used to effectively exercise its emergency-related responsibilities as a control and support agency, across its key functions:

    37.1. Public Health Command

    37.2. Departmental Command

    37.3. Health Coordination

    37.4. Relief and Recovery Coordination and services.

38. The Concept of Operations document recognises the Department's responsibilities in the *Public Health and Wellbeing Act 2008* (**PHWA**), the *Emergency Management Act 2013*, the EMMV and the health specific incident management and escalation arrangements identified in the SHERP.[5]

[5] *Concept of Operations, Department of Health and Human Services as a Control Agency and as a Support Agency in Emergencies,* DHHS, 25 November 2019, p2.

39. The Concept of Operations document recognises that communicable diseases "can build over day weeks or months… [to be] eventually recognised as a pandemic."[6] 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." [7] These roles, activities and deliverables are largely tested and practised by the department in regular exercises in preparation for public health emergencies.

40. In September 2019, the Health Protection Branch and Emergency Management Branch of the department conducted an exercise, titled "Exercise Teapot", which was the second annual exercise of the SHERP, and built on lessons learnt from the previous 2018 SHERP exercise (exercise Sundial) which focussed on the impacts of a bushfire.

41. Exercise Teapot was attended by representatives from over 16 agencies. Participants considered and contributed to a discussion by the CHO of departmental and health sector responses the context of a hypothetical complex class 2 health emergency, with the scenario a major communicable disease outbreak in two rural locations, potentially affecting 10,000 children and young people from Australia and other countries at an international event.

42. Other examples of planning exercises directed to infectious diseases pandemics involving the department and other agencies of government include the following:

    42.1. *H1N1 (Swine Flu) Debrief, 2009:* The debrief process was designed to capture input from internal stakeholders both regionally and centrally, functional stakeholders and external agencies and other organisations. Over 300 people participated in or provided input as part the debrief process.

    42.2. *Pandemic Exercise Fledermaus, 8 December 2013:* Exercise Fledermaus was a Victorian based pandemic influenza discussion exercise. The scope of the exercise was to focus on the internal arrangements of then Department of Health and the Department of Human Services Emergency Management Branch as a shared service, and to validate the current response arrangements under the then draft VHMPPI. The exercise focused on senior staff and key personnel and was built around the discussion of a developing scenario. Participants worked in syndicate

[6] *Concept of Operations, Department of Health and Human Services as a Control Agency and as a Support Agency in Emergencies,* DHHS, 25 November 2019, p3.

[7] *Concept of Operations, Department of Health and Human Services as a Control Agency and as a Support Agency in Emergencies,* DHHS, 25 November 2019, p2.

groups based on the Australasian Inter-service Incident Management System Incident Management Team structure.

42.3. *Alchemy Exercise, 8 August 2018:* On 8 August 2018, Emergency Management Victoria ran the 'Alchemy Exercise' at the State Control Centre (**SCC**). The purpose of this exercise was to assess state level communications processes relevant during a Biosecurity Emergency that transitions to a Pandemic Emergency. Specifically, to test strategic communications roles, processes, agency roles and state level coordination arrangements in the event of an Avian influenza pandemic. Exercise Alchemy was an education process to familiarise participants with the communications plans, structures, processes, protocols and methods with a focus on collaboration, across agencies and departments. Feedback from this exercise identified that the role and function of any team or structure needs to be clearly defined and practical in terms of implementation and the need for control agency clarity given that class 2 emergencies have unique challenges especially when a department, rather than an emergency service organisation, is leading. The SCC needs to be flexible enough to adapt to the needs of these departments and enable their connectivity into the SCC infrastructure.

4. If there was a plan for responding to an infectious diseases pandemic, did that plan provide for or envisage detention of people arriving in Victoria from interstate or overseas, or large-scale detention? If it did, what did it provide?

43. Neither the VHMPPI nor the *COVID-19 Pandemic Plan for the Victorian Health Sector* Covid specifically envisaged the involuntary detention of people arriving from interstate or overseas in large scale detention, noting the existence of Commonwealth Government human biosecurity powers to enable large scale detention. The focus of the plan in regard to isolation or quarantine was on the voluntary isolation of people in their own homes, as was the initial response to the COVID-19 pandemic in Victoria and throughout Australia.

44. At a national level, Australian border control more generally was a consideration of the national pandemic response plan by virtue of the Commonwealth's National Pandemic Influenza Airport Border Operations Plan (**Fluborderplan**).[8]

[8] *Fluborderplan*, National Pandemic Influenza, Airport Border Operations Plan, February 2009, Department of Health and Ageing.

45. The Fluborderplan was developed by the Office of Health Protection in the then Commonwealth Department of Health and Ageing, with contributions from the Australian Health Protection Committee and the Communicable Diseases Network of Australia.[9]

46. The Fluborderplan recognised the importance of border control and the possibility of quarantining. However, even at that national level, I am not aware that there was an in-depth consideration of the potential need for a large scale detention based quarantine program to the extent that has been necessary in response to the COVID-19 pandemic. The August 2019 AHMPPI also considered quarantine of travellers at the border, however, relied on the quarantine of acutely ill travellers in a hospital setting, rather than the mass quarantine of all returning travellers.

Initial planning

5. 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 when and how you became aware.

47. I have a general familiarity from my role with the circumstances in which a State of Emergency can be declared in Victoria, and am always aware that any situation affecting public health, if it escalates, can lead to the declaration of a State of Emergency.

48. By about late January 2020, when there had been a meeting of the Australian Health Protection Principal Committee (**AHPPC**) to consider a national response to COVID-19, I was aware of the possible potential for the emergency management framework to apply to the COVID-19 pandemic.

49. Prior to the AHPPC meeting, on 10 January 2020 the CHO issued an alert for patients who had travelled from Wuhan, China who experienced the onset of fever and respiratory symptoms within 14 days of their return. I was therefore aware from about this time that there was a virus, about which at that stage little was known, that had the potential to infect travellers coming from Wuhan. There had previously been a number of overseas communicable diseases about which the department had been on the alert, for instance SARS, H1N1 swine flu, the avian flu, Zika virus and Hendra virus, but that had not eventuated to a threat level in Victoria that required a declaration of the State of Emergency. The swine flu pandemic in particular had a very significant impact globally, and a significant impact in Victoria, where there had been over 3,000 cases,[10] and some

[9] *The Victorian health pandemic response plan recognised the relationship with these plans for border control: Victorian health management plan for pandemic influenza*, Department of health, October 2014, p 8.

[10] *Epidemics and pandemics in Victoria: Historical perspective,* Research paper No. 1, B. Huf and H Mclean, Parliamentary Library & Information Service, Parliament of Victoria, 2020, p 2 https://www.parliament.vic.gov.au/publications/research-papers/send/36-research-papers/13957-epidemics-and-pandemics-in-victoria-historical-perspectives ; Influenza A (H1N1) in Victoria, Australia: A Community Case Series and Analysis of Household Transmission, Clare Looker, Kylie Carville, Kristina Grant, Heath Kell, 2010 - https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0013702#pone.0013702-State1

special measures such as school closures taken, but no declaration of a State of Emergency.

50. In the following weeks the risk of the COVID-19 outbreak increased, particularly in late January 2020 after the Chinese Lunar New Year holiday mass migration within and to China, which appeared to lead to an increased risk of infection in China and raise the risk internationally. In late January 2020, I, with the Deputy Secretary, Regulation, Health Protection and Emergency Management, and the State Health Emergency Management Coordinator under SHERP considered the needs under the SHERP with respect to the COVID-19 outbreak.

51. On 1 February 2020, the AHPPC recommended that entry to Australia should be denied for people who have left or transited through mainland China, with the exception of Australian citizens and permanent residents and their families, and air crews. From 1 February 2020, I was of the view, as were others, that the COVID-19 outbreak met the definition of a 'major emergency' under the Emergency Management Act as it had the potential to have significant adverse consequences for all or part of the Victorian community.

52. On 1 February 2020 I appointed, after considering the advice of the Deputy Secretary, Regulation, Health Protection and Emergency Management, the Director of the Emergency Management Branch (and the State Health Coordinator), as Class 2 State Controller for the 2019 novel Coronavirus (2019-n-Cov) outbreak. Ms Spiteri had previously been appointed as a Class 2 State Controller on 1 November 2019 in the context of a thunderstorm asthma event in Victoria.

53. The SHERP default position is that the State Controller for human disease emergency will be the CHO. Departmental policy, including the Concept of Operations document prepared by the CHO and the Director, Emergency Management Branch,[11] acknowledges this will not always be the case. In this operation, my decision to appoint the Director, Emergency Management Branch as the State Controller was based on my understanding of the very significant operational responsibilities the CHO was already undertaking in response to the pandemic at both state and national level (including through the AHPPC which I discuss further below).

[11] *Concept of Operations – Department of Health and Human Services as a Control Agency and as a Support Agency in emergencies*, Version 1.0, 25 November 2019. See Part 4: Principles.

54. Prior to 16 March 2020, my colleagues in the department and I were conscious of the potential for a State of Emergency or a State of Disaster to be declared under the Emergency Management Act 1986 with respect to the COVID-19 outbreak.

55. In anticipation of this possibility, my department received advice on the basis for declaring a State of Emergency under the PHWA, and additional powers available where a State of Emergency is declared. This included scenario planning to test the adequacy of powers for the CHO to:

    55.1. impose entry and exit restrictions over a defined area;[12]

    55.2. enter private residences for the purpose of assessing residents;[13]

    55.3. cancel privately run public events;[14]

    55.4. close childcare facilities; [15]

    55.5. close schools; [16]

    55.6. impose restrictions on individuals such as to remain at a place or residence, to not visit a place, or to not come into contact with a class of persons; [17]

    55.7. to test, obtain samples, treat and require individuals to receive treatment or to remain in or attend a medical facility; [18]

    55.8. require individuals to wear specified clothing or equipment (for instance masks);[19] and

    55.9. to contact trace, collect and share data.

56. During this period the department also prepared for the possibility of either the Minister for Health or in some instances me as the Secretary of the Department having to exercise powers in relation to directing hospital and health service capacity under the *Health Services Act 1988* and the *Ambulance Services Act 1986* and the *Non-Emergency Patient Transport Act 2003* including in a State of Emergency.

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[12] Emergency powers: s 200(1)(b) *Public Health and Wellbeing Act 2008.*
[13] Examination and Testing Orders: s 113(3)(a), s 113(3)(b) *Public Health and Wellbeing Act* 2008.
[14] Emergency powers: s 198, s 200(1)(c), s 200(1)(d) and public health risk powers: s189 and s 190(1)(i) *Public Health and Wellbeing Act* 2008.
[15] Emergency powers: s 198, s 200(1)(c), s 200(1)(d) and public health risk powers: s189 and s 190(1)(i) *Public Health and Wellbeing Act* 2008.
[16] Emergency powers: s 198, s 200(1)(c), s 200(1)(d) and public health risk powers: s189 and s 190(1)(i) *Public Health and Wellbeing Act* 2008
[17] Emergency powers: s 200(1)(a), s200(1)(b) and s 200(1)(c) and public health risk powers: s 190(1)(b), s 190(1)(j) *Public Health and Wellbeing Act* 2008
[18] Examination and testing orders: s113(3)(a) and s 113 (3)(b)) and public health orders: s 117(5)(f), s 117(5)(j) and s 117(5)(k) *Public Health and Wellbeing Act* 2008
[19] Emergency powers: s 200(1)(d) and public health risk powers: s 190(1)(i) *Public Health and Wellbeing Act* 2008.

57. Through February and March, I was in regular communication with the CHO about the development of the pandemic. By mid-March the CHO 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.

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

58. The declaration of the State of Emergency on 16 March 2020 by the Minister for Health did not cause any functions to be allocated to the department as such; instead it allowed for the exercise by the CHO of a number of powers in order to reduce the risk to public health.

59. Emergency powers can only be exercised following the declaration of a State of Emergency. Pursuant to section 198 of the PHWA, the Minister for Health may, on the advice of the CHO and in consultation with the Minister for Police and Emergency Services and the Emergency Management Commissioner, declare a State of Emergency arising out of any circumstances causing a serious risk to public health.

60. During a State of Emergency, the PHWA allows for the exercise of emergency powers to detain individuals in the emergency area for a reasonably necessary period, and for the CHO to authorise authorised officers to exercise related powers. By way of example, emergency powers allow the authorised officers to:

    60.1. quarantine individuals in an emergency area, including, for example, those who refuse to self-isolate and pose a risk to others: s 200(1)(a);

    60.2. restrict the movement of any person or group of persons within an emergency area: s 200(1)(b); and

    60.3. give any other direction the authorised officer considers is reasonably necessary to protect public health s 200(1)(d).

61. Following the declaration of the State of Emergency on 16 March 2020, the provisions in the PHWA for the exercise of emergency powers became available to respond to the COVID-19 pandemic. The department had responsibilities for public health interventions to suppress the virus, including through investigation and management of public health risk.

62. In particular, the power of the CHO to issue directions under s 200 of the PHWA could be exercised. The CHO issued the first set of directions on the same day, 16 March

2020, which related to non-essential mass gatherings (500 people or more) and to self-quarantine following overseas travel. On 18 March 2020 the Deputy CHO issued a further direction relating to self-quarantine following overseas travel. In the first four weeks of the state of emergency, the CHO and Deputy CHO issued 26 sets of legal directions, usually within 24 hours of National Cabinet decisions.

63. In addition to roles under the PHWA, the department had three areas of responsibility with respect to the hotel quarantine program:

    63.1. **Operational command** to ensure an operational plan was established to provide governance for the program and provide a forum for bringing together the departments and agencies involved in the quarantining of returned travellers;

    63.2. **Overseeing the delivery of health and wellbeing services** for returned travellers subject to detention in the hotels;

    63.3. **Delivery of public health functions,** including issuing legal directions under the PHWA setting out the conditions of detention, providing permissions under those directions and regular review of the detention of the returned travellers.

Operational command responsibilities

64. As I discuss further below, on 27 March 2020, the National Cabinet made the decision to require all returned travellers to be subject to mandatory quarantine in designated locations such as hotels.

65. Following the National Cabinet decision, it was communicated to me at a meeting of the Victorian Secretaries Board on 27 March 2020 that the Department would take lead responsibility for developing the legal directions and that DJPR had secured hotel capacity which should be used for this program.

66. In parallel, I am informed that the Health Controller for the Class 2 emergency and the Emergency Management Commissioner initiated integrated planning for the program through the State Control Centre the same day, looking to connect together all departments and agencies with roles in the program.

67. The first operational plan was finalised and approved for distribution by the Emergency Management Commissioner in the State Control Centre on 28 March 2020, with support

from the Australian Defence Force.[20] The first operational plan was approved for distribution by the Emergency Management Commissioner.

68. Roles, responsibilities and accountabilities for the hotel quarantine program were defined through the operational plan (which was regularly updated as the program was established and expanded).

69. The operational plan identified the participating departments and agencies in the hotel quarantine program, namely the Department, DJPR, the Department of Transport, the Department of Premier and Cabinet, Victoria Police, the Australian Federal Police and Border Force.

70. A formal governance group, comprising representatives from each department and agency, provided the decision-making framework in a networked governance model. The composition of the governance group evolved as the operational structures developed and were outlined in more detail in the second operational plan, distributed on 26 April.

71. The governance group was initially chaired or co-ordinated by a Deputy Controller Class 2 – Health, a role initially filled by two senior officers of the Department of Environment, Land, Water and Planning (**DELWP**), chosen for their expertise and capabilities arising from bushfire emergency management. Subsequently this role was replaced by the COVID-19 Accommodation Commander following the establishment of a dedicated Emergency Operations Centre (**EOC**) for the hotel quarantine program on 17 April 2020.

72. The first operational plan set out the joint mission for all departments and agencies engaged in the program, namely to implement enforced quarantine measures for all passengers entering Victoria through international air and sea points-of-entry to stop the spread of COVID-19.

73. The governance group met daily for the first month of operations to provide a forum for further planning and escalation of issues that could not be resolved by the relevant department or agency, with a standard agenda covering:

    73.1. Actions arising from previous minutes

    73.2. Situation awareness

[20] *Operation Soteria Plan V1*, as authorised for release and approved for distribution by the Emergency Management Commissioner on 28 March 2020.

73.3. Operations (with updates provided from all departments and agencies as relevant)

73.4. Planning

73.5. Health and wellbeing (staff and travellers)

73.6. Communication

73.7. Other business.

74. The second version of the operational plan[21] detailed that operational leads would form the governance group for the program and would meet three times per week (or more frequently as required) for the duration of the program. Chaired by DHHS Commander COVID-19 Accommodation, and co-ordinated by SCC support, the membership included:

74.1. State Controller – Health

74.2. Public Health Commander

74.3. DHHS Enforcement and Compliance Commander

74.4. DHHS Agency Commander

74.5. DJPR Agency Commander

74.6. SCC Strategic Communications

74.7. Department of Premier and Cabinet representative

74.8. Department of Transport representative

74.9. Senior Police Liaison Officer – Victoria Police.

Overseeing the delivery of health and wellbeing services

75. The Department played the lead role in overseeing the provision of health and wellbeing services to returned travellers in hotel quarantine. This included engagement of appropriately skilled contractors to deliver clinical health services in hotels. It also included facilitating access to a wider range of health and social services to meet the needs of returned travellers. This did not include responsibilities for procurement of hotels, hotel cleaning services or security services.

[21] *Operation Soteria Plan V2*, as approved by the Emergency Management Commissioner on 26 April 2020; Operation Soteria Plan V2.1, as approved on 8 May 2020.

76. Health services were available on-site at each hotel, including mental health services, with a broader array of social services available on referral through a Complex Assessment and Referral Team (**CART**) which I discuss further below in response to question 20.

Public health functions, including issuing legal directions

77. The relevant powers used to give effect to the hotel quarantine program are the "emergency powers" set out in s 200 of the PHWA. It was the responsibility of designated public health officials within the Department to issue the legal detention orders to give effect to mandatory hotel quarantine.

78. Each returned traveller was issued with an individual detention order requiring them to remain within a designated hotel room for a 14-day quarantine period. The Department was responsible for setting out the conditions of detention, providing permissions under those directions and regular review of the detention of the returned travellers.

79. Under the PHWA, the CHO is able to authorise the exercise of certain powers by Authorised Officers (**AO**s) where he believed it was necessary to grant an authorisation to eliminate or reduce a serious risk to public health.[22] In practice, this meant that AOs were based at each hotel to oversee the detention of returned travellers, with the powers to grant temporary permissions for returned travellers to leave detention (for instance, to receive medical treatment or on compassionate grounds). I explain the role of AOs in more detail in response to questions 43-45.

80. By way of wider public health functions, the Department was also responsible for providing infection prevention and control (**IPC**) advice for the Victorian community to assist in reducing transmission of COVID-19. General advice was provided to assist Victorian workplaces to apply in their local context and setting.

81. On 29 March 2020 (the first day of operation of the hotel quarantine program), a medical expert engaged by the Department developed initial guidance for operations within a hotel quarantine context, including IPC advice.[23] This set out that each hotel site would be separated into three zones, a red zone for any locations where confirmed COVID-19 positive returned travellers were located, an orange zone where other returned travellers were located for the period of their quarantine for monitoring for the development of symptoms, with all residents in that zone required to maintain social distance, and a

[22] PHWA, s 199(2). In addition, the Chief Health Officer may, under section 22 of the PWHA, delegate any of his powers, duties or functions to a registered medical practitioner who meets the necessary criteria of the Act. An instrument of delegation was published by the Chief Health Officer on 8 November 2019 delegating a number of powers to the two Deputy Chief Health Officers (Communicable Diseases and Environment).

green zone for staff engagement only. Initial PPE advice was set out for each of these three zones. Signage was erected at each hotel site to provide clarity to all on-site staff as to the specific zones that applied.

82. To support the hotel quarantine program, physically distancing and wider IPC advice was consolidated by the Public Health Command within the first week of program operations. This included particular advice on how to safely accompany any traveller leaving their room for permitted purposes.

83. This advice, along with wider public health advice being prepared by the Department, formed the basis of the development of enforcement guidance and guidelines on the use of PPE for health workers engaged in the hotel quarantine program.

84. The second operational plan, distributed on 26 April, consolidated operational guidance on responding to a passenger who became a confirmed case or close contact while in quarantine, along with guidance on infection control and hygiene (cleaning, laundry and PPE).[24]

85. Public Health Command also recommended the specialist consultancy Infection Prevention Australia which was subsequently engaged by the Department to support hotel quarantine operations.

86. A review of infection control across all of hotel functions was submitted to DHHS by Infection Prevention Australia on 5 May, which was generally positive. I provide more details about the outcomes of this review and additional guidance provided to security guards and authorised officers at paragraphs 210 to 212.

87. Under contracts between security and hotel providers and DJPR, those service providers were obligated to provide adequate training, induction and protective equipment to their staff and ensure it was worn appropriately. Contracted hotels were also responsible for providing appropriate cleaning services.

7. Did you or your department 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?

88. The Department of Premier and Cabinet led the briefing process for the Premier for his attendance at the National Cabinet. I did not attend National Cabinet meetings.

89. My Department had input into the information available, through the Premier, to the National Cabinet, in two ways:

18.1. through the CHO, Professor Brett Sutton's membership of and contributions to the AHPPC, which comprises all state and territory Chief Health Officers and is chaired by the Australian Chief Medical Officer, and

18.2. contributing to the briefing process for the Premier, through the Department of Premier and Cabinet, on matters relating to the health emergency mission.

8. Did you or your Department play a role in the decision announced nationally on 15 March 2020 to direct those entering Australia to "self-isolate" for 14 days?

90. I understand the decision of the National Cabinet to require those entering Australia to self-isolate have followed advice to this effect from the AHPPC.

91. The CHO, as a member of the AHPPC had a role in providing his views on this issue to the AHPPC.

9. Did the Department have a role in planning for the possibility of any form of quarantine for returned travellers prior to 27 March 2020?

92. The Department was not involved in planning for the possibility of hotel or other compulsory quarantine for returned travellers prior to 27 March 2020.

93. On 10 March 2020, the Department released the COVID-19 Pandemic Plan for the Victorian Health Sector (**the Plan**).[25] This plan was released to the sector to prepare for what, at the time of its release, was an emerging pandemic in Australia. This document was guided by the Australian Health Sector Emergency Response for Novel Coronavirus released by the Commonwealth Government in March 2020.

94. At the time, consistent with how the initial presentation of COVID-19 cases were being identified in the Victorian community, the focus was on quarantine by way of home isolation of people who were *"deemed at risk of COVID-19 due to travel location or contact with a case*."[26]

95. The Plan outlined a staged response and guidance to the Victorian health sector:

95.1. Stage 1: Initial containment - reducing exposure

95.2. Stage 2: Targeted action - If pandemic escalates

95.3. Stage 3: Peak action - severe and sustained outbreak

95.4. Stage 4: Stand-down and recovery – transition back to normal.

[25] *COVID-19 Pandemic plan for the Health Sector,* 10 March 2020.
[26] *COVID-19 Pandemic plan for the Health Sector*, 10 March 2020, p 10.

96. At that time, the scale of the potential transmission of the COVID-19 virus by returning travellers had not become fully apparent and the Plan did not address mass quarantine, whether in hotels or otherwise.

97. In the context of the national directive of 15 March 2020 that travellers returning to Australia from overseas must self-isolate for 14 days, and also informed by an understanding of the difficulties homeless and other vulnerable communities may experience in seeking to self-isolate if unwell, the Department had given consideration to the need for emergency accommodation to enable safe quarantine for certain returned travellers.

98. The intended purpose was to provide emergency facilities for self-isolation where necessary, irrespective of whether the person needing to self-isolate was a returned traveller or a member of community. For those needs, the Department was considering a range of flexible options that might be adapted to family or other needs, such as self-contained apartments and supported accommodation.

26 to 28 March 2020

10. Prior to 26 March were you or members of the Department (and if so who) aware of the possibility of a hotel quarantine program? If so, how and when did you/they become so aware?

99. On 26 March 2020, the CHO engaged with me on a draft paper prepared for the AHPPC by the then Australian Chief Medical Officer Professor Brendan Murphy about a range of measures supported in response to the COVID pandemic, including in general terms the need for quarantine for returning travellers, whether in their own home or, in high risk cases, some form of alternative accommodation. I am not aware whether that proposal was ever taken to the National Cabinet. It was a proposal limited to an emergency response to provide accommodation as a last resort for people without other options, and would not have involved a large scale accommodation program.

100. I was not aware before 27 March 2020 of the possibility of a mandatory hotel quarantine program for returned travellers.

101. At that time, the Department's COVID-19 response was heavily focussed on identifying the appropriate approach to and implementation of physical distancing and movement requirements, growing the contact tracing capacity within the Department, and negotiating funding agreements with Victorian private hospitals as part of an integrated health system response to the COVID-19 pandemic.

11. Do you know or have you been made aware as to why the initial directions to those re-entering Australia to self isolate for 14 days (referred to in Question 8 above) changed to directing those people into the Hotel Quarantine program?

102. In March, the primary source of transmission of the COVID-19 virus in Australia was from travellers returning from overseas, initially from China and subsequently from other countries as the virus spread.

103. I understood this to be the basis for the initial direction on 15 March 2020 that people returning to Australia should self-isolate for 14 days.

104. The decision to introduce the hotel quarantine program for returned travellers was a decision of National Cabinet. The Prime Minister provided further detail to the Australian public on the rationale for the introduction of mandatory hotel quarantine following the National Cabinet decision.

12. When did you first learn that a hotel quarantine program was to be implemented in Victoria?

105. I first learnt that a hotel quarantine program was required to be implemented in Victoria after the National Cabinet meeting on Friday 27 March at which that decision was made.

13. As at 26 March 2020, what plans, if any, were already in place for a hotel quarantine program in Victoria?

106. As at 26 March 2020, there were no plans in place for a mandatory hotel quarantine program for returned travellers.

14. As at 26 or 27 March 2020, what was your understanding of the proposed structure of the Hotel Quarantine Program and the role the Department would play in it?

107. Following the national announcement of the requirement for hotel quarantine for returned travellers, there was a debrief session conducted by the Department of Premier and Cabinet on Friday 27 March, led by senior officials who had attended the National Cabinet. The debrief discussed the decision and the need for the quarantine program to be set up by 11.59pm the following day.

108. I did not attend that debrief, but received an update from departmental staff who attended, including an overview of the key roles allocated to the Department for action.

109. Later that afternoon, there was a Victorian Secretaries Board (**VSB**) meeting, chaired by Chris Eccles, the Secretary of the Department of Premier and Cabinet. The VSB comprises the Secretaries of each department, the Chief Commissioner of Police and the Victorian Public Sector Commissioner. While it does not have a legal status, VSB

plays an important role in coordinating policy initiatives and information exchanges across the public sector.

110. Based on information from the debrief and the VSB meeting, my understanding was that an immediate focus of the Department was the drafting of legal directions and detention notices necessary to give effect to the mandatory quarantine. I understood that DJPR was responsible for standing up of the hotels and wider logistics to accommodate returned travellers.

111. Across 28 and 29 March 2020, I am informed that departmental officials were engaged in conversations about establishment of the hotel quarantine program through the State Control Centre, with the emergency management framework used to connect relevant agencies in preparation for imminent overseas arrivals on Sunday 29 March 2020.

112. The operation being planned and undertaken required significant resources and planning across agencies.

113. The establishment of the hotel quarantine program was facilitated by different departments acting as a governance group in the context of the emergency management framework. I understand that a small team within the State Control Centre with the assistance of the Australian Defence Force (**ADF**), and working with this governance group, developed the initial operational plan for the hotel quarantine program, which was titled Operation Soteria.

114. As noted at paragraph 67 above, the initial Operation Soteria plan was approved for release by the Emergency Management Commissioner on 28 March 2020 and has continued to be refined since that time.

115. Under this plan, and consistent with the EMMV and SHERP, the Department's role was to provide operational control by ensuring appropriate governance was in place, to facilitate sharing of intelligence, enable escalation and resolution of operational issues. I refer to the nature of the specific roles under the Operation Soteria in response to questions 21, 23 and 25 below.

116. In addition to the drafting of legal directions and detention notices, the Department's role extended to the provision of Authorised Officers (**AOs**) appointed under the PHWA in order to effect the mandatory detention under that Act. There was also a critical role for the Department in facilitating support to meet the health and wellbeing related needs of returned travellers, including the provision of nursing staff and support services.

15. Did you or any member of the Department recommend that the Department of Jobs, Precincts and Regions be responsible for the contractual arrangements with the service providers for the Hotel Quarantine Program?

117. I was not engaged in the decision to define responsibilities for contractual arrangements with hotel and security service providers for the hotel quarantine program. I am not aware that any departmental officials were involved in this process.

16. Did you or any member of your Department engage with or give advice to the Department of Jobs, Precincts and Regions as to the skills, training and experience needed for entities engaged to deliver services in the Hotel Quarantine Program?

118. In relation to the establishment of the hotel quarantine program in the period 26 to 28 March 2020, I am not aware that I or any member of the Department gave advice to or otherwise engaged with the DJPR with respect to the skills, training and experience needed when engaging entities to deliver services in the hotel quarantine program.

119. Separate to the entities engaged to deliver services by DJPR, the Department was responsible for engaging qualified service providers to deliver health and wellbeing services to returned travellers. This included services provided by nurses, mental health nurses, and general practitioners, as well as the wider CART team which I discuss in more detail below in response to question 20.

17. Who decided that private security companies would provide services for the Victorian Hotel Quarantine Program?

120. I am not aware of who made the decision that private security companies would provide services for the Victorian hotel quarantine program. The Department was not involved in the decision making as to how security services would be provided.

18. Were you or any member of your Department consulted about the suitability of using private security firms to assist in the Hotel Quarantine Program?

121. I was not consulted about the suitability of using private security firms to assist in the hotel quarantine program during the period in which the security firms were being engaged. I am also not aware of any member of my Department having been consulted about this issue.

19. Were you or any member of your Department consulted about the contents of the contracts with the private security firms who were engaged to deliver services into the Hotel Quarantine Program?

122. I was not consulted about the contents of the contracts with the private security firms who were engaged to deliver services into the hotel quarantine program. I am not aware of any member of my Department having been consulted about this issue.

20. Did you or any member of your Department consider it your responsibility, once those contracts were entered into with the hotels, private security firms and other service providers, to oversee and administer the delivery of the Hotel Quarantine Program at each site where it was being delivered? If so, how did your Department oversee and administer the program at each site?

123. The Department was not responsible for contracting with hotels and related services including the provision of security by private security firms for the hotel quarantine program.

124. At an overall program level, the Department facilitated the establishment of the EOC, and the COVID-19 Accommodation Commander chaired the interagency governance group to oversee the delivery of accommodation services and health and wellbeing supports.

125. The Department also facilitated the co-ordination of intelligence for reporting on the hotel quarantine operation. DJPR compiled a daily Situation Report, which included information such as the number and location of people in hotel quarantine, and entries and exits from the program. The Department consolidated the DJPR Operation Soteria reports into broader COVID-19 response reporting prepared by the DHHS intelligence unit and the State Control Centre. All relevant departments and agencies received these daily reports.

126. The contracts with hotel operators provided that hotel management would retain responsibility for occupational health and safety of their staff and providing and maintaining a safe site and safe hotel services.

127. Site management responsibilities were shared between DHHS, DJPR and hotel management with:

127.1. DHHS providing ongoing oversight of the delivery of its roles and responsibilities at each site where the program was being delivered. This chiefly included oversight of the provision of health and wellbeing services and the function performed by Authorised Officers. Command structures to oversight DHHS responsibilities are described in more detail at question 21 below.

127.2. DJPR managed services for all passengers, including food, and helped coordinate reception of arriving passengers (with DHHS) and provided an escalation point for any queries from, or contractual issues with, accommodation and security services.

127.3. Hotel management continuing to manage their own staff and facilities.

128. Concierge services for the COVID positive hotel were provided by DHHS, with DJPR providing an offsite contact for escalation of any contract issues about hotel cleaning, accommodation services or security services.

129. DJPR Site Managers were initially on site at hotels being used for quarantine, working with hotel management and the contracted security staff. While over time DJPR reduced the number of their Site Managers on site, I am informed that the preference of DJPR remained for DHHS officers to escalate issues with hotel and security staff to relevant DJPR staff, rather than engaging with DJPR contracted service providers directly.

21. What were the roles of the various personnel engaged in the program at each Hotel Quarantine site?

130. The following personnel were engaged in the program at each hotel quarantine site:

130.1. DHHS staff acting as hotel-based team leaders, reporting to the Deputy Command Hotels, supported by one or more team leader supports at each hotel;

130.2. DHHS welfare staff, under the supervision of the Deputy Command Welfare;

130.3. AOs, reporting through AO team leaders to the Enforcement and Compliance Commander;

130.4. nursing staff (including mental health nursing staff) and other clinical and welfare service providers (as required) under the health coordination team (which was overseen by the State Health Co-ordinator);

130.5. DJPR Site Managers or Site Contacts;

130.6. security staff (engaged by DJPR); and

130.7. hotel staff (employed by the hotels contracted by DJPR).

131. Under the Operation Soteria Plan, Victoria Police also had a role in supporting containment and responding to any issues that required escalation or law enforcement.

132. The responsibilities of DHHS hotel team leaders, as set out in the DHHS Hotel Team Leader Job Packs, included to:

132.1. facilitate a daily meeting with staff on site from DJPR, hotel management, security and nurses to share intelligence on issues and activities in the hotel;

132.2. liaise with the hotel and distribute to nurses, hotels and authorised officers the welfare and food safety questionnaires and check food safety questionnaires as to whether special procedures required for management of guests with food allergies;

132.3. ensure sufficient PPE to last three business days and order PPE for departmental staff and contractors;

132.4. ensure clinical waste bins and sharps were placed for at the collection point for collection;

132.5. support AOs with operational requirements for hotel exit, including calling rooms, escorting guests to taxi or troubleshooting issues if necessary;

132.6. assist with ordering pharmaceuticals if necessary;

132.7. direct orders for groceries and items other than health equipment, PPE or stationery to DJPR;

132.8. work with DJPR site leads and hotel management to resolve any on-site issues, or otherwise escalate issues to the EOC; and

132.9. attend twice daily teleconference check-ins with the EOC if possible.

133. Standard Operating Procedures were developed as a guide for team leaders.

134. DHHS Welfare Support Staff also provided services remotely to each hotel site.

134.1. The Welfare Checking Team conducted two telephone welfare checks during the quarantine period: a comprehensive health and wellbeing assessment, typically on day 3 (including verifying health information provided by guests upon hotel arrival to ensure essential information about medications, allergies or health issues have been identified and are being managed appropriately, as well as issues such as family violence and drug and alcohol dependencies, and wellbeing strategies); and a shorter health and wellbeing assessment on day 9, focused on ensuring needs are being addressed and providing an opportunity for feedback. The Welfare Check Team was initially established on 30 March 2020 as a small group of departmental staff to make welfare calls to guests, before ramping up to a larger day 3 and day 9 checking project.

134.2. The CART, which would remotely assess and respond to referrals of individuals or families with more complex psychosocial needs from any service

involved in hotel quarantine. The CART engaged with DHHS staff in the Mental Health and Alcohol and Drugs Branch, and the Maternity, Child Health and Early Parenting Unit, to coordinate safety and risk management plans for such guests. The CART was initially established on 28 March 2020 as an on-call roster to respond to issues arising for guests, before evolving to a team of practitioners to assess, support and refer guests with psychosocial complexity.

135. AOs on-site at each hotel were responsible for issuing detention notices, ensuring compliance with notices, issuing and managing permissions, actioning approved exemptions, actioning the release of detainees from hotels and engaging Victoria Police for assistance as required. A detailed description of the role of AOs provided in response to question 43 below.

136. Nursing staff, including mental health nursing staff, provided 24-hour on call medical support and performed a daily health and welfare check (to inform AOs of medical and welfare issues and convey any dietary requirements to hotel staff, or referring cases to the CART team). Medical staff (nurses and doctors) also performed daily checks as to guests' COVID-19 symptoms. Nursing staff escalated medical issues to a GP (the on-site GP, a telehealth GP, or an off-site GP), NorthWestern Mental Health, Maternal and Child Health Services, or hospital as necessary.

137. The DJPR Site Manager represented DJPR as the accommodation and security contract manager.

138. Security staff were engaged by DJPR to support AOs and Victoria Police to uphold the CHO directions. Specific duties set out in a roles and responsibilities guide prepared by DJPR included supporting the enforcement of the Directions at hotel premises; supporting Victoria Police, hotel staff, and Victorian Government staff to register people at the hotel and escort them to their rooms; ensure people under quarantine do not leave their rooms without AO permission (including a security presence at the foyer, on each floor where guests are located and at entry and exit points throughout the hotel); refer enquiries and concerns from guests to AOs and other support services being provided at the hotel; ensure that disputes are de-escalated without physical contact and if unable to de-escalate, to immediately escalate to Victoria Police.[27]

139. Hotel staff employed by each of the hotels contracted by DJPR continued to have roles in the management of the hotel facility.

[27] Private security support for hotel quarantine as at 30 March 2020, DJPR document [DHS.5000.0001.1401].

140. Following the establishment of the dedicated Emergency Operations Centre on 16 April, a DHHS Safety Officer was appointed with responsibility to assess and manage identified occupational health and safety issues relevant to departmental staff and contractors working as part of the hotel quarantine program.

141. This included a role in reviewing on-site operations, working in close collaboration with the DJPR Safety Officer. The DHHS Safety Officer and the DJPR Safety Officer worked together on several key matters relating to on-site operations, such as the development of evacuation plans for each hotel and the operating procedures for exercise (or fresh air) breaks, drawing on public health advice.

142. The DHHS Safety Officer was to be notified in the case of any significant health and wellbeing incident affecting departmental staff and contractors. The DJPR Safety Officer was required to be immediately notified by hotel management and security management of any known exposure to or infection of COVID-19 of hotel or security personnel.

22. What was the hierarchy of decision making at each site where the Hotel Quarantine Program was being delivered? That is, was there a designated person who was managing the site 24 hours a day 7 days a week? If there was not, should there have been such a person?

143. I am informed that the management of the sites involved a matrix structure, with DJPR having responsibility over the contractual arrangements with the hotels and subcontractors, the usual hotel manager in place pursuant to the hotel owners' ordinary arrangements also having continuing responsibility for the hotel, and the Department having responsibility for all aspects of guest health and welfare as well as key functions performed by AOs.

144. DHHS hotel team leaders were present at each site on the ground, operating under the Operation Soteria Command structure, as described in Question 21 above. DHHS hotel team leaders reported to Operational Team Leaders off-site at the EOC, who in turn reported to the Deputy Commander Hotels, and the COVID-19 Accommodation Commander. One hotel team leader was on site at each hotel, rostered in two shifts between 7am and 10pm, 7 days a week and there was also a team leader rostered overnight to serve all hotels.

145. The DJPR Site Lead, who in the initial stages of the program were on site at each hotel being used for quarantine, worked with the hotel management and the contracted security staff. Subsequently, around late April DJPR gradually reduced the number of their site leads on site and there were no longer a DJPR site leader at each hotel site. Some site leaders worked remotely.

146. I understand from discussions with operational staff that the matrix structure for on-site management had value in that it facilitated the ability to escalate issues through appropriate reporting lines to those who were able to address specific issues, for example through addressing matters through contractual arrangements with the hotels or service providers.

147. For instance, I am informed that DJPR requested that DHHS officers did not instruct DJPR staff or service providers directly, but rather escalated any risks or issues through the DJPR accommodation lead so that contractual or policy issues could be resolved at an organisational level and operationalised through the appropriate chains of command.

148. There were AOs on site 24 hours a day, 7 days a week. They did not have a role in site management, but had a constant presence in order to ensure that there was a person available for any of the roles that are specifically allocated, under the PHWA, to an AO. There was a separate hierarchy of decision-making for AOs, through the Compliance and Enforcement Command, which I describe in my answer to question 43 below.

23. If there was such a person, was that person appointed by your Department?

149. As noted in my answer above, site oversight was jointly managed by hotel management, DHHS and DJPR site leads.

150. The DHHS hotel team leaders on site at each hotel, along with other members of the Operation Soteria Command structure, were appointed by my Department, and DJPR appointed their own site leaders or hotel team leaders for each site.

151. AOs and AO team leaders were authorised by the CHO to exercise public health risk and emergency powers under the PHWA, as described further in my answer to Question 43 below. Other members of the Enforcement and Compliance Command structure were appointed by the Department.

24. If there was such a person, how effective was that role?

152. As noted above, there was no single designated person with responsibility for managing each hotel site.

25. (a). What was your involvement, if any, in the inception and development of Operation Soteria?

153. In the period 26 to 28 March, I was chiefly focused on the preparation of legal directions and recruitment of key personnel to support the Department's roles in the hotel

quarantine program. I was not directly involved in activities being coordinated through the State Control Centre to develop the first Operation Soteria plan.

154. Through the period of Operation Soteria, I continued to conduct daily meetings with senior staff leading COVID-19 response activities and engaged more deeply at critical moments necessitating my involvement as Secretary.

155. Following the establishment phase, there were also some significant events in the course of Operation Soteria in which I was involved given their individual significance. On or about 9 April 2020, after we were informed about the imminent repatriation of a large number of travellers from the Gregory Mortimer cruise ship moored in Uruguay, many of whom had tested positive for COVID-19, I was heavily involved over one weekend in planning around 'presumed positive' returned travellers from Uruguay. There were questions to be resolved about whether Australia were going to allow them to return and the port of entry. The EOC was engaged in detailed planning to ensure services were available if needed to transfer medically unwell individuals to hospital, and to manage of the safe transfer, clinical oversight and testing of travellers within the COVID-19 positive hotel. The return of the travellers was successful and there was no transmission arising from passengers on the ship.

156. My early involvement was significantly focused on whether the approach to health and wellbeing of people in quarantine was appropriate. This was because, very early on, there was an unexpected death in hotel quarantine on 11 April 2020 and it was clear that there were vulnerable people in hotel quarantine.

157. I asked the State Health Coordinator, a role to which, as discussed in paragraph 188 below, I appointed the CEO of Safer Care Victoria, Professor Euan Wallace, to oversee a process to develop stronger clinical governance settings for hotel quarantine and also asked for a tailored incident reporting system to be established for departmental responsibilities forming part of Operation Soteria.

158. I was also involved in identifying an appropriate person with the skills and experience to take on the role of Commander, COVID-19 Accommodation.

159. Following the outbreaks in the Rydges hotel, I became more directly involved in the hotel quarantine program, including on the decision for a Victorian health service to assume responsibility for clinical governance in a COVID-positive hotel. Following the subsequent outbreak at the Stamford Plaza hotel, the Department advised the Minister for Health on options to transition out of the use of private security firms and the

subsequent process to consolidate governance with the Department of Justice and Community Safety (**DJCS**). I discuss this further in response to question 29 below.

25(b). What was the role of your Department, if any, in the inception and development of Operation Soteria?

160. As noted above, National Cabinet made the decision on 27 March 2020 to require all travellers arriving in Australia to undertake their mandatory 14 day self-isolation at designated facilities such as hotels.

161. To give effect to that decision, on 28 March 2020, Operation Soteria was established as the dedicated operation to bring together all departments and agencies involved in the hotel quarantine program, including functions relating to enforcement of and compliance with directions relevant to hotel quarantine.

162. Operation Soteria was established under the emergency management framework, with the Department as control agency for a Class 2 emergency working to coordinate the input of all relevant departments and agencies.

163. While Operation Soteria operated under the emergency management framework, it did so in the context of the critical missions framework specifically adopted to respond to the unprecedented nature of this crisis, as discussed in paragraph 14 and in response to questions 34 to 36 below.

164. The Department as control agency had the role of bringing together all departments and agencies with defined roles and responsibilities as part of the hotel quarantine program. The first Operation Soteria Plan[28] set out responsibilities for reception, transport, accommodation and return to the community.

165. Under the first Operation Soteria Plan the Department had operational responsibility, with the SCC monitoring and coordinating actions; and

165.1. in the accommodation phase, was responsible for managing, monitoring and responding to guests at accommodation and managing their release at the end of the 14 day period, and for supporting health and wellbeing; and

165.2. had specific responsibilities for accommodation including reconciling passenger data with airside entry data, detailed identification, capture and management of special/social needs (with DJPR), establish field emergency management officers teams at accommodation points to undertake initial health screening, if required, social workers to provide support to passengers with complex

[28] *Operation Soteria Plan V1,* as approved by the Emergency Management Commissioner on 28 March 2020.

needs, provision of psycho-social first aid, access to 24/7 nursing support for emerging health needs, and provision of regular welfare calls to all quarantined passengers.

166. DJPR was responsible in the accommodation phase for managing accommodation contracts including hotel cleaning, managing private security contracts to enforce quarantine requirements at accommodation, reception parties established to coordinate movement of passengers from transport into accommodation (with DHHS and Victoria Police), and detailed identification of passengers.

167. The requirement for mandatory hotel quarantine took effect from 11.59 pm on 28 March 2020. On 29 March, the first plane load of passengers to be transferred to hotel quarantine arrived into Victoria. The hotel quarantine program grew quickly; within the first five days of operations there were over 1,000 returned travellers detained in mandatory quarantine.

168. The specific roles within the Operation Soteria Plan that were allocated to the Department included the State Controller working to the Emergency Management Commissioner, and the Public Health Commander, a role performed by the Deputy Chief Health officer by way of delegation with responsibility for making the direction and detention notices under s 199(2)(a) and s 200 of the PHWA relevant to Operation Soteria and approving and granting approvals to alter the way in which mandatory quarantine applies.

169. The Operation Soteria command structure scaled up quickly, and roles, responsibilities and reporting structures evolved, and on the ground both within and between departments. The State Controller Health, in consultation with the Emergency Management Commissioner decided on 28 March that a Deputy Controller should be appointed to oversee Operation Soteria given the importance of the program. As noted in paragraph 71 above, two staff members from DELWP were initially appointed in this role.

170. The other key roles and responsibilities in Operation Soteria were as follows:

170.1. Operation Soteria Commanders (initially titled DHHS Emergency Accommodation Commander" or "COVID-19 accommodation commander") had responsibility for day to day management of Operation Soteria at the EOC and reported directly to the Deputy State Controller – Health (and subsequently directly to the State Controller – Health, under Operation Soteria Plan version 2.1 and following).

170.2. Deputy Commander Hotels was responsible for overseeing the operational cell, which in turn had oversight of team leaders on the ground at hotels. Operational Team Leaders were located at the EOC and were responsible for oversight of the hotel team leaders on the ground, with an overarching responsibility for operationalising plans to ensure the health and wellbeing of hotel guests. Largely, operational team leaders worked with hotel team leaders (whose role is described further in my answer to Question 21 below) to solve issues and help them develop procedures.

170.3. Deputy Commander Welfare was responsible for managing the operation of the Welfare Checking Team and the CART team, and playing a role in the coordination of the welfare needs of those detained in hotel quarantine, working collaboratively with nursing and mental health nursing staff on site.

170.4. Deputy Commander Ports of Entry was responsible for transporting arrivals from maritime ports to hotels, with a team leader on the ground at the airport.

171. Other roles filled by departmental officers or appointments included the State Health Coordinator, a role to which, as discussed in paragraph 188 below, I appointed the CEO of Safer Care Victoria, Professor Euan Wallace. The State Health Coordination oversaw a Health Co-ordination Team, which facilitated the provision of nursing / mental health nursing services to the population in hotel quarantine.

172. Operation Soteria Plans continued to be developed and refined as the operation progressed.[29] On around 17 April 2020, the Emergency Operations Centre for Operation Soteria was established under the SHERP, and was stood up from 16 April. As noted, the EOC included the roles of COVID-19 Accommodation Commander, Deputy Commander Ports of Entry, Deputy Commander Welfare and Deputy Commander Hotels.[30]

173. From early June 2020, transition planning commenced to exit DJPR from Operation Soteria, with initial planning for responsibilities to move to the Department. Structural changes within the Department were implemented from 1 July 2020 to bring Operation Soteria Command and Compliance and Enforcement Command within the Regulation Health Protection and Emergency Management Division of the Department. A senior executive role of Director COVID-19 Response Operation Soteria was created to provide dedicated oversight and be accountable for the aforementioned teams.

[29] O*peration Soteria Plan V2*, as approved by the Emergency Management Commissioner on 26 April 2020; *Operation Soteria Plan V2.1*, as approved on 8 May 2020; *Operation Soteria Plan V3*, approved on 26 May 2020.
[30] *COVID-19 EOC OS operational structure v 2.0* 18 April 2020 (page 5).

Public health function

174. The role of the public health function of the Department with respect to Operation Soteria was primarily with respect to authorisation of directions, including the directions and detention notices which were the instruments which formally required that travellers stay in hotel quarantine, and the authorisation of the AOs who exercised roles on site. The Public Health Commander and Deputy Public Health Commander also had roles in with respect to the provision of public health advice on issues escalated to them.

175. On 28 March, the Deputy CHO signed off on the Victorian *Charter of Human Rights and Responsibilities Act 2006* (**Charter**) assessment and form of the Direction and Detention notice to be used with respect to quarantine returned travellers. This is a requirement because the Deputy CHO is a public authority within the meaning of s 38 of the Charter.

176. This was a complex exercise of considering a number of human rights in the Charter and their compatibility with the exercise of powers under the PHWA to detain travellers in accordance with the national requirement for 14 days hotel quarantine. The assessment involved consideration of a relevant human rights in the Charter, and consideration of whether interferences with those rights were reasonable and justified in response to the exceptional circumstances of the COVID-19 pandemic.

177. These rights included the right to liberty (s 21); the right to humane treatment when deprived of liberty (s 22), freedom of movement (s 12), the right to privacy, family and home (s 13) and rights with application to specific groups within hotel quarantine including freedom of religion (s 14), and protection of cultural rights (s 19); protection of families and children (s 17) and the right to equality (s 8).

178. The assessment concluded that, taking into account the need to be able to modify the conditions of quarantine in exceptional circumstances including for medical or compassionate reasons, as well as measures to ensure the health and wellbeing of persons in quarantine, the measure of hotel quarantine was the least restrictive means reasonably available to stem the spread and effect of the COVID-19 virus.

179. The early involvement of the Department in Operation Soteria particularly involved ensuring there were adequate AOs appointed and in place to carry out required functions including undertaking daily checks to monitor welfare and satisfy the requirements of the PHWA.[31]

[31] PHW Act, s 200(6).

180. Initially, the Department rapidly assembled staffing from across government, despite significant uncertainty as to the scale and duration of the program. For example, conditions of the quarantine, authorised by Directions made under the PHWA, meant that a range of functions were to be performed by AOs. The need to source appropriately qualified staff for those roles was met from a number of sources after the first four weeks of operations, including from local government.

181. In addition to the Operation Soteria Command structure, the Enforcement and Compliance Command was responsible for compliance with the Public Health Directions including those relevant to the hotel quarantine program. The Enforcement and Compliance Command structure became established with the following key roles and responsibilities:

181.1. Enforcement and Compliance Commander: responsible for leading and providing oversight to compliance matters under all Public Health Directions, providing advice and input into complex compliance matters, advising and support the CHO on compliance, addressing interagency issues, and approving requests for changes to alternative detention arrangements and daily review of those subject to detention;

181.2. Deputy Command, AO Operations: responsible for providing oversight to AOs, ensuring effective communications between AO operations, Command and Policy and Exemptions, ensuring operations are compliant with protocols, engaging with the Emergency Operations Centre as required around hotel operations and leading the provision of guidance to the AO Team Leaders, reporting on daily review of people being detained; and

181.3. Senior AOs / AO team leaders: responsible for providing leadership to AOs, monitoring the approval of permissions, supporting AOs through complex matters, making exemption requests where appropriate and ensuring appropriate parties are aware of complex matters.

182. The functions of AOs are referred to in more detail in response to questions 43 to 45 below.

Health and wellbeing

183. Given the rapid establishment and changing needs within the hotel quarantine program, including because of a changing demographic from primarily business and holiday travellers to include repatriating families, the availability of health and wellbeing support evolved over time.

184. The department facilitated initial access to the health and social services required to meet the changing physical and mental health needs of the population in hotel quarantine. The Department leveraged existing contractual and other departmental arrangements and engaged contractors to deliver health and wellbeing services on-site.

185. Anticipation of medical and wellbeing needs was challenging when timely and accurate information about incoming arrivals was often unavailable. There was little advance insight on the demographics and needs of returned travellers, until they arrived. Often young children (aged under 2) were not listed on airline manifests so advance notice of their arrival was not available, and there was limited visibility of unaccompanied minors and children aged between 13-17 requiring supervision.

186. The increasing complexity of the cohort over time required additional medical, mental health and social supports as well as increased demand for interpreting services. It quickly became apparent that additional mental health support was required to supplement the mental health nursing services available from the outset, with additional specialist mental health nursing staff added to general nursing and medical staff available. This was complementary to services provided through the CART, which was available by referral from the beginning of the program to support returned travellers with complex needs.

187. After issues were identified in the escalation of health concerns between relevant clinical team members available on site, strengthened processes for escalation of health conditions were developed, including protocols on transportation of guests from hotel quarantine for medical care, including to hospitals.

188. Improvements were also made to the health and welfare screening of returned travellers (in addition to the day 3 and day 9 health and welfare check described at paragraph 134 above), as well as to incident reporting arrangements and overarching clinical governance.

189. In late March I requested Professor Euan Wallace, the CEO of Safer Care Victoria, to take on the role of State Health Co-ordinator with the role of oversight for co-ordinating DHHS' emergency response activities across the health system, encompassing hospitals, primary health and other acute care activities, including the health and wellbeing services required by the population in hotel quarantine. While the role is a position in the emergency management framework, it was intended to involve oversight and coordination of clinical services across the Victorian health system.

26. What did you understand to be the objective of Operation Soteria?

190. Operation Soteria was responsive to the National Cabinet decision to require returned travellers to stay in mandatory quarantine in a designated facility for 14 days.

191. I understand that decision to have been intended to address the risk of transmission of COVID-19 from returned travellers into the community, by isolating returned travellers from the community in hotels, and have been informed by the understanding in late March 2020 that the major form of transmission of COVID-19 in Australia at that time was from returned travellers.

27. As at 27 March 2020, did you consider that Operation Soteria was the best available option for achieving that objective?

192. As at 27 March 2020, a decision had been taken at National Cabinet to mandatory quarantine in a designated facility, for example hotels, for all international travellers returning to Australia. The Department and other Victorian Government departments and agencies were responsible for implementing it in Victoria.

193. Operation Soteria was the operation used to give effect to this requirement, within the rapid timeframe required for its implementation.

28. When was Operation Soteria first approved, and when was it first operational?

194. With planning and logistical support from the ADF, the first version of the Operation Soteria Plan was rapidly developed, and was authorised for distribution by the Emergency Management Commissioner on 28 March 2020. It was operationalised the following day, on 29 March, when the first plane of returned travellers to be subject to mandatory hotel quarantine arrived.

195. The Emergency Management Commissioner and State Controller agreed to the rapid appointment of a Deputy State Controller on 28 March and this role commenced on 29 March to oversee Operation Soteria.

29. As at the date of its approval and subsequently, did you have a view about the appropriateness of the following elements of Operation Soteria, in light of its objective:

(a) the use of private security companies; and

(b) the quarantining of detained persons in hotels.

If you did have views on those matters, what were your views, and to whom, if anyone did you express them?

196. I was not directly required to consider the logistical elements of Operation Soteria including hotels and use of private security companies at the time of the operation's approval so did not have a view on them at the time.

197. Following the first outbreak at Rydges in May which involved six security staff testing positive for COVID-19 as well as two other site based staff members, I considered, following recommendations from the Outbreak Management Teams, that it would be appropriate to have a Victorian public health service assume responsibility for clinical governance in COVID-positive hotels and to use their security services accustomed to working in a hospital environment.

198. Following the second outbreak at the Stamford Plaza hotel in mid-June, I considered there were more systemic problems in the use of private security firms for hotel quarantine operations. On the request of the Minister for Health, the Department developed advice on alternative options for the provision of security services as part of the hotel quarantine program. In late June the government announced the decision for Corrections Victoria to assume responsibility for security provision, which progressively came into operation from on or about 2 July 2020.

30. Save as provided for in answer to the above, did you have any reservations about any aspect of Operation Soteria at any time? If you did, what were your reservations, and to who, if anyone did you express them?

199. I have noted in response to question 25 that I considered it necessary early on for there to be a stronger focus on the mental health and wellbeing of vulnerable people in hotel quarantine, particularly following the unexpected death on 11 April.

200. From mid-April, a stronger clinical governance framework for the delivery of health and mental services was introduced, with a Health Coordination Team introduced under the oversight of the State Coordinator – Health.

201. Given the increasing number of family groups returning to Australia and entering hotel quarantine, including family groups with complex needs, I also expressed a view that more flexible accommodation settings were required, such as hotels with connecting rooms or self-contained apartments, to better support these family groups.

202. As I noted in response to question 29, I also became more involved in the need for stronger clinical oversight of infection control arrangements following the outbreaks experienced in hotel quarantine.

203. I also note in response to question 31 below that certain reviews were conducted into specific events occurring within, and aspects of the functioning of, the hotel quarantine program which required further assessment and response.

204. I did communicate with and appoint appropriate people as described in response to questions 25, 29 and 31 to address the matters that I saw needed specific or additional attention in the operation of the program.

31. Did the Department conduct any and what reviews, formal or otherwise, into Operation Soteria? Please identify any document which contains the outcome of such reviews.

205. In the course of Operation Soteria reviews were conducted into specific aspects of the operation as they arose. These included reviews into matters relating to the health and wellbeing of individuals in quarantine, and into specific matters relating to infection control and related procedures at the hotels. The department also responded to a number of complaints raised with the Victorian Ombudsman, in particular about food (which were referred to the Department of Jobs, Precincts and Regions) and access to fresh air.

Incidents

206. In relation to specific events relating to people in hotel quarantine:

206.1. On 11 April there was an unexpected death, not arising from COVID-19 infection, in hotel quarantine. I referred this to Safer Care Victoria to undertake a review into the matter, and Safer Care Victoria provided a confidential report on the issue dated 10 June 2020.

206.2. In the first part of April, there was an event relating to an elderly person in hotel quarantine developing COVID-19 symptoms, and being admitted to intensive care with COVID-19 on 13 April, with concerns raised about the response of clinical staff while he was in the hotel. I also referred this to Safer Care Victoria. Safer Care Victoria reviewed the incident and reported on it in a confidential report dated 17 June 2020.

Reviews of PPE and infection control procedures

207. In early April 2020, the Department engaged an external infection prevention specialist from Infection Prevention Australia to review hotel quarantine infection control procedures with a focus on departmental staff and health contractors. The specialist had a site visit to Rydges on Swanston at the start of May and made recommendations afterwards relating to cleaning of uniforms and keeping guests to their rooms for the quarantine period to the extent possible. This advice underpinned tailored policies for the COVID-positive hotel.

208. The specialist was subsequently formally engaged to undertake further assessments. The Public Health Branch Infection Control Consultant referred Operation Soteria command to Infection Prevention Australia and subsequently engaged the relevant specialist as required. On 21 April, the PPE advice for hotel based health care workers based on this review was approved for sharing with staff and on 22 April it was distributed by the Operation Soteria EOC to all hotel team leaders.

209. The Infection Prevention Australia specialist considered issues relating to the use of PPE for health care workers engaged in the hotel quarantine program, including noting the different uses of PPE for different functions, and provided a guide for the use of PPE on 17 April 2020.

210. The Infection Prevention Australia specialist subsequently undertook a further review into the use of PPE across all hotels in Operation Soteria and provided a 'Summary of Findings' on 5 May 2020.

211. This review was generally positive. It noted familiarity with infection control guidance and procedures by health care teams and good availability of information about correct use of PPE on sites for security and AOs.

212. The review identified overuse of PPE and hand hygiene as the main areas of non-compliance by these workforces, noting improvements at Rydges and that health care teams were educating these workforces about appropriate PPE and hand hygiene. Updated advice from Infection Prevention Australia on hand hygiene and avoiding overuse of PPE was prepared for hotel-based security staff and AOs in contact with quarantined clients, and was approved by the Accommodation Commander on 5 May.

213. This guidance was distributed to on-site staff and redistributed on the request of the Rydges security firm on 12 May.

214. The Infection Prevention Australia specialist was again engaged on 17 May 2020 to undertake a review of IPC and PPE use by healthcare workers for Day 3 and Day 11 testing across hotels, as well as for security at Rydges, and provided a report. The

Infection Prevention Australia specialist's report of 5 May 2020 was also provided to Outbreak Squad nurses who undertook site visits to the Rydges and Novotel hotels between 28 May and 8 June which included providing training given to staff in relation to PPE and hand hygiene.

215. The Infection Prevention Australia specialist subsequently prepared PPE advice for security guards, AOs and health care workers in the hotels.

216. On 13 June 2020, the Infection Prevention and Control Outreach Nurse (**IPCON**) team of the Department reviewed the Rydges Hotel ahead of its anticipated reopening and recommended certain steps with respect to cleaning and infection control signage be displayed before reopening.

217. On 16 to 17 June 2020, following the case of a COVID-positive security guard, the IPCON team conducted an interim review of Stamford Hotel and gave recommendations on a number of issues, including as to education of hotel and security staff in hand hygiene and PPE. This advice was provided to the DJPR command, who led engagement with the Stamford Hotel on enhanced cleaning protocols (applying advice from the outbreak squad) and

218. The following day, staff members and contractors who had spent 30 minutes or more at the hotel between 8 and 17 June inclusive were asked to quarantine for 14 days.

Ombudsman complaint responses

219. A number of complaints were made by persons detained in hotel quarantine, including to the Ombudsman. Many complaints related to food – including the quality of food, food allergies and other dietary requirements – and to fresh air breaks. DHHS responded to the Ombudsman's questions arising from those complaints on a number of occasions.

220. There were also a range of more specific complaints. For example, in response to a complaint about the special needs of children with autism, the Department stated that children who enter quarantine and have a diagnosis of autism may be assessed by a GP onsite, with additional paediatric nurses available for specialist monitoring and care and additional fresh air breaks.

Complaints to local Members of Parliament by constituents

221. Complaints about the quarantine program were received by both state and Federal MP's and Ministers from constituent detainees or their relatives. The issues raised included the size and amenity of hotel rooms, noise, the quality of the food (including

specialist dietary requests), access to personal items and clothing, requests for fresh air and exercise breaks and concerns around the medical and psychological supports available. The Department kept a register of all complaints and responded in writing to each complaint brought to a member of Parliament.

32. During the months of:

(a) April 2020

(b) May 2020

(c) June 2020

(d) July 2020

were you or other members of your Department (and if so who) aware 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? If so, please provide the details of that information or those allegations in each month referenced.

33. If you or members of your Department were so aware, what actions were taken in response?

222. Across the period of the Department's COVID-19 response, I held a daily meeting with senior departmental staff to enable significant issues or incidents to be escalated. Critical and systemic concerns about the capabilities of security guards were raised by the Outbreak Management Squad and Operation Soteria command following the Stamford Plaza Outbreak.

223. In most cases, I was not personally aware of the information or allegations and I have included in this answer information as to the awareness of, and actions taken by, members of my Department. This information has been identified with the assistance of members of the Department and the lawyers assisting the Department in the preparation of this statement.

224. The severity and treatment of issues and allegations raised can best be defined into four distinct phases.

April – mid May

225. Until the first outbreak at Rydges, concerns raised about compliance with IPC by security staff were managed at a site or EOC level. These concerns mainly related to the appropriateness of PPE usage. In response, and as set out below, the Department worked with DJPR and onsite nurses to ensure appropriate PPE access and usage.

226. Over 4 April 2020, the Department was working with DJPR to ensure enough PPE and equipment. The minutes record reports of security staff not following good social distancing practices with *'a few'* breaches reported.

227. On 5 April 2020, DJPR and the Department considered how to jointly "ensure effective safety, procedures and induction of staff and services."

228. On 6 April 2020, DJPR raised concerns with the Department around differing views around correct and appropriate use of PPE. Consistent with wider public health advice, the critical role of appropriate physical distancing measures was reinforced through public health advice, with a view that staff should not be put in a position where they require more than a mask and gloves.

229. On 8 April 2020 it was agreed that Rydges would take its first confirmed COVID-19 case, and would be kept for the purpose of accommodating confirmed cases from both Operation Soteria and the community as required (ie become a "COVID positive" or "hot" hotel). The Department made a site visit on 10 April 2020. On 11 April 2020, the Department decided that all hotel staff at the Rydges, including security staff would do a short tutorial on infection prevention, organised by DHHS.

230. On 5 May Infection Prevention Australia completed their review of infection control compliance across the hotel network. While generally positive, the review drew attention to overuse of PPE and gaps in hand hygiene by security guards and provided additional guidance to support improved practices by this workforce.

231. On or around 12 May 2020, there was a complaint from health care workers to departmental staff onsite at Rydges that security guards were overusing PPE and that some PPE was missing. Concerns were also raised that security guards were congregating and not observing social distancing requirements and were not responding to requests and advice to maintain distance.

232. This complaint coincided with officers of the Department learning of allegations of sexual harassment by security guards, subcontracted by Unified Security. The allegations included inappropriate behaviour and remarks towards female staff on site. There was also an incident in which a note was left under the door of a guest, allegedly by a housekeeping contractor, containing Snapchat contact details.

233. These complaints and allegations were escalated to the Operation Soteria (COVID-19) DJPR Hotel Quarantine Agency Command. DJPR staff convened a meeting with the security company 12 May 2020 referred to above at which these and other matters were discussed.

234. In response to these matters:

234.1. DJPR led the investigation into these allegations.

234.2. The Department assisted by collecting and providing to DJPR relevant information relating to security guard behaviour. This occurred through Deputy Commander Hotels.

234.3. By the next day, the head security contractor had stood down the entire sub-contracted security team at the hotel, and had replaced them with their own security personnel, brought from locations other than the Rydges.

234.4. In addition, the Security company agreed to do an audit of PPE, expressing a desire to continue to provide PPE to their staff in line with their contract. The security company manager asked the Department to re-send the applicable PPE protocols, which occurred.

234.5. The DHHS Rydges team leader also moved PPE to a locked storeroom and left the key with the overnight nurse.

234.6. On 26 May 2020, version 3 of the Operation Soteria Plan was approved,[32] and this version addressed IPC and PPE in more detail than previous versions. Version 3 of the Operation Soteria Plan provided specific guidance for security guards escorting persons in and around the hotels, including instructions as to maintaining a distance of 1.5 metres or greater from the person; use of single use face masks if a distance of 1.5 metres or greater cannot be maintained when escorting the person; instructions as to hand hygiene with an alcohol-based hand rub or wash hands in soapy water before each break; instructions as to touching of surfaces both by the guard and persons escorted; and ensuring exercise is only undertaken in a cordoned off area with no public access.

Events associated with Rydges outbreak – mid May to mid June

235. The first COVID-positive case detected in what became the Rydges outbreak was identified on 26 May 2020. DJPR and Worksafe were informed of the positive case and an outbreak management team was immediately established. DJPR had also been notified directly by hotel management of the positive COVID-19 case of a hotel staff member.

[32] *Operation Soteria Plan v3.0 with annexes v2.0* 1 June 2020.

236. Over the next three days, DJPR assisted in working with the security provider to provide roster details for contact tracing and arranged a deep clean of the hotel.

237. On 27 May 2020 two outbreak squad nurses went to the Rydges Hotel to carry out a review. The outbreak nurses observed significant gaps in the practical application of IPC measures by security staff and Rydges management staff. Outbreak squad specialists attended Rydges on 27th, 28th, 30th and 31st of May to provide guidance and education to all workforces.

238. On 30 May, an inspection of security staff PPE use and hand sanitation at Rydges was conducted by the Department's Infection Control Team and found to be satisfactory.

239. DJPR and the security organisation's management were kept informed of the findings and interventions by the outbreak management squad.

240. With significant numbers of staff quarantined, it was necessary to stand up alternative accommodation for positive passengers at the Novotel hotel. Outbreak squad nurses attended the Novotel on the 1st, 3rd, 6th, 7th and 8th of June to ensure appropriate prevention control practices were adhered to.

241. At my request, urgent work was undertaken to develop a hospital-led operational model for the COVID positive hotels. I briefed the Minister for Health on this option and the Department entered into an agreement with Alfred Health to take on operational management of clinical and security services. A hospital led hotel model was implemented progressively from 15 June 2020.

242. The Accommodation Commander also worked with Public Health and made the decision to:

242.1. embed an infection control lead for the COVID-19 positive hotel;

242.2. engage REDACTED as an educational consultant to provide infection prevention training to all security staff; and

242.3. schedule infection control assessments by the outbreak management teams for all COVID positive hotels throughout June.

<u>Events associated with the Stamford outbreak – 16 June to July</u>

243. On 14 June 2020, the DHHS team leader at the Stamford Plaza reported to secretariat staff at Operation Soteria EOC concerns about security guards hugging and approximately 70 attending a meeting in a small room (and thus not social distancing). In addition, the team leader was concerned that guards were incorrectly using PPE, including wearing gloves for long periods of time while touching their phone and going to

the bathroom. The EOC secretariat escalated to the DJPR Site Manager, who requested that all matters relating to security staff be raised directly with them.

244. On 15 June the DJPR Hotel Quarantine Agency Commander undertook to convene a meeting with the security company.

245. The first COVID-positive case identified as part of the Stamford outbreak was identified on the evening of 18 June. An outbreak management team was established and DJPR and Worksafe were advised.

246. The outbreak management squad rapidly identified systemic weaknesses amongst a much larger security cohort at Rydges and at other hotels they assessed from the middle of June. Complaints and concerns about security guards were also raised by other workforces:

246.1. On 18 June 2020, complaints were received about guards at the Crowne Promenade not wearing PPE/masks while delivering people to rooms and wearing gloves and then applying hand sanitiser.

246.2. On 20 June 2020, issues were raised regarding incorrect us of PPE by security at Four Points Sheraton Hotel during exiting (masks worn incorrectly, people wearing gloves and then sanitising and handling luggage without sanitising in between contacts). The nurse who observed the behaviour paused the operation for 10 minutes in order to do an all staff briefing/reminder on correct use of PPE.

247. The Minister for Health requested and received daily briefings on the Rydges and Stamford outbreaks. As a result of a request by the Minister for Health on 18 June 2020 (following the Stamford outbreak), urgent work was completed on alternative security arrangements for the hotel quarantine program. These options were developed with the DJCS.

248. On 27 June 2020, the Government announced that Corrections Victoria would progressively assume responsibility for hotel security.

249. Prior to this announcement, and in order to prevent any further outbreaks while this work was rapidly undertaken, the Department took a series of actions at the Stamford Plaza and across the hotel network, including:

249.1. organising further infection control training for MSS Security at Stamford;

249.2. a meeting between the COVID-19 Accommodation Commander and DJPR security contractor management on 22 June, to discuss learnings from both Rydges

and Stamford, raise concerns and agree upon measures such as increased surveillance and screening of workers;

249.3. training being provided to security staff at the Stamford (and Park Royal) by REDACTED the educational consultant engaged following the Rydges outbreak, with the intention of rolling out the training material more broadly;

249.4. working with DPJR to create a Security Guards PPE Training Log, to ensure that all security guards on shift had done their training with the DHHS Infection Control Team on PPE usage, when to wear masks and how to correctly fit and remove them, hand hygiene, including correct hand washing and sanitising techniques, and social distancing;

249.5. developing low literacy resources on PPE.

250. At the request of the Department, on 22 June 2020, the Behavioural Insights Unit (**BIU**) from the Department of Premier and Cabinet (**DPC**) was engaged to assist in facilitating training and instruction of guards. The BIU visited the Grand Chancellor and Stamford hotels to review hotel quarantine staff's use of PPE with the objective of improving understanding and compliance by promoting effective use of PPE by hotel quarantine staff. Also, on 22 June 2020, the Commander, COVID-19 Accommodation addressed security firms about PPE and to reinforce the importance of proper IPC practices amongst security guards. On the same day, DJPR records in the Operation Soteria interagency meeting that they are engaging with security firms regarding safety.

251. On 23 June 2020, the BIU reported their findings on the effectiveness of PPE training. These were to the following effect:[33]

251.1. Comprehension seemed to be a barrier to the correct use of PPE, especially where English was not the first language. Religious concerns and a lack of knowledge about how to use PPE also contributed to resistance to use.

251.2. Nurses were found to be well trained in PPE, but security guards potentially needed more training on hygiene and PPE use. While guards had been told to not wear gloves and remain 1.5m at all times, there was potential contact within the 1.5m zone for activities including guest arrival, fresh air and in lifts, at guest exits and when delivering meals to rooms.

[33] BIU - COVID - DHHS - PPE - 23-06-20.pdf, 10.07.2020, DHS.0001.0001.0711.

251.3. Cleaners would disinfect an area but would not clean it first. Cleaners also would take instructions from their own company. Further, there was no auditing of cleaning activities.

251.4. Recommendations were made as to the improvement of existing policies falling into three categories:

(i) Policies - to update the PPE advice documents to make them more informative for their recipients with specific amendments;

(ii) Zone management - building on the traffic light zone system to include areas which change designation when guests are in them (i.e. the hotel lobby); ensure zones are demarcated; information sheets for each zone; have PPE material required at the border of the relevant zone;

(iii) Communication between groups - improve onsite communication by more regular briefings for key groups and documenting good practices from each site for considered at other different hotels.

End June to End July

252. As at 24 June 2020, intensive training in relation to infection prevention and control had occurred at 12 hotels, with the final two to be completed during the day. An IPC briefing was being conducted at all hotels, repeating on every shift. The EOC was working with the BIU at DPC to develop further actions to drive behavioural change in the security workforce.

253. Following government's announcement on 27 June, departmental efforts moved to supporting the Department of Justice and Community Services (DJCS) through the transition to new arrangements.

254. Corrections Victoria progressively transitioned their staff into hotels between 2-11 July. An administrative order was agreed on 8 July to ensure DCJS, under the Attorney-General, could exercise necessary legal authorities under the PHWA. DJCS assumed full operational responsibility as the lead agency for the hotel quarantine program on 27 July.

34. What was the role and function of the Mission Coordination Committee established on 3 April 2020?

255. As I have noted above, on 3 April 2020, the Premier announced changes to the operation of the Victorian Government, designed to ensure the government was

responding to the immediate work required from the health, economic and social issues raised by COVID-19.

256. A key component of these changes was the establishment of the CCC, replacing all Cabinet Committees and functions as the core decision making forum for matters related to the COVID-19 emergency.

257. Supporting this, and in recognition of the scale, complexity and rapid pace of managing the consequences of COVID-19, changes were also announced to reorient the public service into mission structures.

258. The Missions Coordination Committee (**MCC**), chaired by the Secretary of the DPC, comprises membership of Mission Lead Secretaries, DPC Deputy Secretaries with responsibilities for Economic, Social, Corporate matters, and senior leadership from the Premier and Treasurer's Private Offices.

259. MCC was established as the principal officials' forum to support the delivery of the Missions, including strategic decisions taken by National Cabinet and the CCC, and considers a range of policy matters.

260. Both the CCC and the MCC are supported by the Mission Coordination Unit within DPC.

35. Did you have any and what role on the Mission Coordination Committee?

261. As I noted above at paragraph 16, under the mission-based governance initiatives introduced in early April 2020, I was appointed Mission Lead Secretary – Health Emergency and as such I am a member of MCC.

262. As lead of the Health Emergency Mission, my position covered the following scope:

262.1. Health data and analysis (with insights and actions)

262.2. Public health management (prevention)

262.3. COVID-19 case treatment

262.4. COVID-19 testing – sites, guidelines, supply

262.5. COVID-19 case isolation and contact tracing

262.6. Health workforce – monitoring of supply, COVID-19 cases, union negotiations; protocols and guidance

262.7. Marshalling and direction of private sector health resources

262.8. Health supply (chain) needs

262.9. Aboriginal community health sector prevention and response

262.10. Mental health

262.11. Ageing.

36. What was the relationship between the Mission Coordination Committee and Operation Soteria?

263. The MCC had a strategic overview of the departments' mission responses to COVID-19, with the objective of maintaining a cohesive strategic direction. The MCC coordinated submissions to the CCC for strategic decisions about public health interventions and management of the social, economic and health consequences of the pandemic.

264. The MCC also played a key role in overseeing the preparedness of the Victorian public sector to respond to the pandemic, playing a stewardship role to promote sustainable and safe working arrangements as part of the unprecedented emergency response across all departments and agencies.

265. Issues relating to Operation Soteria were raised with the MCC on occasion, including with respect to the resources required for AO positions which required recruiting of appropriately qualified people outside the DHHS and across government, and use of hotels for other vulnerable cohorts.

266. For the purposes of the MCC, hotel quarantine operations were reported on through regular Health Emergency Mission implementation plans as a public health intervention.

267. Hotel quarantine operations were also covered in regular reporting through the Economic Program Delivery, Supply, Logistics & Procurement Mission, which was led by the Secretary of DJPR.

37. Did Operation Soteria, at some point, stop using private security contractors or reduce its use of private security contractors (stating which)?

268. As I have observed in response to question 17 above, my Department was not involved in entering into or managing contracts with private security firms for services at quarantine hotels.

269. I understand that the number of private security firms contracted for hotel quarantine fluctuated over time, and that DJPR would be in a position to provide more precise information on that issue. I understand that in the course of the program, the COVID-19 Accommodation Commander discussed the issue of whether the number of security contractors could be reduced, as this would assist in infection control measures, and

DJPR did do this, in measures which included increased use of CCTV and also security guard patrols.

270. Over 17 to 18 June 2020, the Department stood up a new hotel for COVID-19 positive persons, and quarantined travellers were moved to that hotel, Brady's, from 18 June. The Department entered into agreements and contracts directly with service providers, including with the hotel provider and Alfred Health, to provide core clinical staff and progressively assume responsibility for security services. Initially, security services at the new COVID-19 positive hotel were provided under an existing contract with DJPR. From 23 June 2020, a contractor of Alfred Health supported security services at the hotel. These contractors were subsequently replaced by Victoria Police. On 27 June the Victorian Government announced a new model for provision of security under the hotel quarantine program, with Corrections Victoria staff to perform security related duties, with support from Victoria Police in COVID-positive hotels. This model was progressively implemented from 2 July.

38. If so, which person or body made the decision to stop using private security contractors and when was that decision made?

271. Government made the decision for Corrections Victoria to transition from 2 July 2020 to provide security services replacing the need for private security providers, with the support of Victoria Police to enforce CHO directions and provision of security services at the COVID-positive hotels.

39. How was the decision to stop using private security contractors implemented and communicated to your or your Department?

272. Following the Stamford Plaza outbreak, the Minister for Health requested advice on alternative options for the provision of the security function in the hotel quarantine program. The Department worked with the DJCS on these options for consideration by government. Following consideration by government, I was informed that Corrections Victoria staff would transition over time to replace all private security staff engaged in the hotel quarantine program.

40. What reason (if any) was given to you or the Department for ceasing or reducing the use of private security contractors?

273. The Department was involved in preparation of options to replace the use of private security contractors following the outbreak at the Stamford Plaza and concerns about more systemic weaknesses in the skills and capabilities of this workforce. The reason for the decision to transition away from the use of private security contractors for all hotels

was linked to the significant infection prevention and control breaches identified during and after the outbreaks at Stamford Plaza.

41. As at the date of this statement who is undertaking the function within Operation Soteria previously performed by private security contractors?

274. As at the date of drafting this statement, DJCS is the lead agency for supervision of quarantined returned travellers in Operation Soteria.

275. This includes overseeing the provision of security in all quarantine hotels. Corrections Victoria is responsible for undertaking the functions previously performed by private security firms, supported by Victoria Police in COVID positive hotels.

42. State the qualifications and training [relevant to the function they are performing] of those referred to in your previous answer.

276. As the Department is not involved in the engagement of the staff referred to in the previous answer, I am not in a position to answer this question.

43. (a) Who were 'Authorised Officers'?

277. Authorised Officers are appointed under the PHWA.

278. As Secretary of the Department, I have the power to appoint persons who are employed under the *Public Administration Act 2004*, as AOs, pursuant to s 30 of the PHWA. This power is able to be delegated.

279. In appointing a person as an AO, the decision-maker must be satisfied that the person is suitably qualified or trained to be an authorised officer for the purposes of the PHWA.[34] AOs may also be appointed by local government councils.[35]

280. The appointment can specify the functions, duties or powers under the PHWA to which it relates and may be subject to conditions that are considered appropriate.[36] By delegation, the CHO was able to appoint persons as AOs, as set out above.

281. An AO can also be given a direction, that is general or specific in nature, in relation to the performance of their functions, duties, or the exercise of their powers under the PHWA.[37]

282. The CHO has, under my delegation, appointed approximately 200 persons as AOs, to enable their involvement in the hotel quarantine program and other operations

[34] PHWA, s 30(2).
[35] PHWA s 31.
[36] PHWA, s 30(3).
[37] PHWA, s 30(6) and 30(7).

relevant to the COVID-19 pandemic response. There was a wider available capacity of approximately 280 AOs in May, and over 300 AOs in June 2020 to support hotel quarantine program operations as needed.

b) What was the role of Authorised Officers

283. The role of AOs involved three main phases, shaped by the scope of the powers which they are authorised to exercise under the PHWA: first, exercising the powers under the PHWA to serve upon individuals at the airport the Directions and required their detention on arrival; second, during a person's quarantine in a hotel, grant permission for them to leave his or her rooms (being the place of detention under the Directions), and finally approve the release of that person, at the end of the period of quarantine.

284. As noted above, an AO was present at all hotels, 24 hours a day, seven days a week, to ensure that a person with the necessary powers under the PHWA could authorise a person to leave their room if the circumstances required, and were able to call senior departmental staff for assistance at any time. AOs were not responsible for the supervision of security guards at hotel sites. The role of AOs under the PHWA is not a safety officer role and AOs as with all other staff on site acted within the IPC framework as established at the outset of the program by the clinical staff and operationalised by the team leaders on site.

285. As at 3 April 2020, AOs on rosters were provided with a document explaining the role of Authorised Officers at that time. The document provided specific instructions to AOs as to their roles and responsibilities with respect to detainees, including the need to explain to returned travellers the quarantine order and to explain to hotel staff, security contractors and police what quarantined people were permitted and not permitted to do; and that it would be necessary to request the assistance of and authorise Victoria Police to do so.

286. From 30 April 2020, the Annex 1 "COVID-19 policy and procedures – Detention authorisation" was provided to AOs by the Department. This included a detailed overview of the role of AOs in hotel quarantine, including Authorised Officer powers;; the role of the AO at the Airport and Hotel Check-in; review of detention and check-in responsibilities; grant of leave from detention; authorised departure from accommodation; the policy and procedure for unaccompanied minors; departure release procedures and OHS, including use of PPE. It also referred to the obligations of AOs under the Charter, given their status as public authorities under that Act, with obligations to consider human rights when making decisions such as the facilitation of fresh air breaks or variation of the terms of detention on compassionate grounds.

287. Version 3 of the Operation Soteria Plan, dated 26 May 2020, provided further detail of the role of AOs, noting that:

287.1. monitoring or ordering PPE or other supplies is outside the role of AOs (pp 42-3);

287.2. IPC measures for AOs including leaving in separate lifts to security and nursing staff after serving a detention notice on a COVID-positive person (p58); and

287.3. identifying PPE provided by DHHS (single-use surgical masks, gloves, hand sanitiser), and requiring AOs to wear surgical masks when on hotel floor, among other OHS measures set out in table form (p58-9).

43(c) what training or qualifications did Authorised Officers have

288. As stated above, a person appointed as an AO must be suitably qualified or trained to be an authorised officer for the purposes of the PHWA. Usually, AOs within the Department are trained and work in specific areas, such as health and wellbeing, supported residential services, food safety, radiation, Legionnaires disease, and other areas related to public health.

289. At the time Operation Soteria commenced, the Department's health and wellbeing AOs were already working on other aspects of the COVID-19 pandemic response. When Operation Soteria had to be very rapidly operationalised, AOs from all over the Department were called upon to fulfil the AO functions in the first hotels, and were on site in hotels from the first day of hotel quarantine operations, Sunday, 29 March.

290. Given the speed at which Operation Soteria was established and the need for AOs to be on site at hotels at all times of the day and night from the very outset, there was no opportunity for hotel quarantine-specific policies or training to be prepared and implemented before AOs were required to be performing functions on site.

291. Instead, in the beginning while protocols were still being developed, there were Senior AOs and members of the Compliance and Enforcement Executive team 'on the ground' at hotels at all times to ensure the AOs understood what they were required to do and had adequate supervision. Subsequently, Senior AOs were on call 24 hours a day, 7 days a week, so that AOs could escalate any issues as required.

292. AOs sourced from outside the Department were recruited by Expression of Interest processes in the organisations in which they worked, and had very varied experience and expertise, from public health to animal management to local laws. As new AOs from other parts of government (including local councils, the Victorian Commission for

Gambling and Liquor Regulation, DELWP and Public Transport Victoria, as well as secondees to the Department from the national organisation Environmental Health Professionals Australia) commenced from late April, there were more formal processes in place for induction and training.

293. This included an interactive online training program that covered various aspects of the role of an AO in hotel quarantine, including the use of PPE, the PHWA, privacy and records management. Unlike the Department's existing AOs, the new AOs from outside the Department also needed to be formally appointed under the PHWA. As the number of hotels, and therefore the required number of AOs grew, the Department's People & Culture team became more involved in the recruitment of AOs.

294. The requirement for large numbers of AOs was magnified by the fact that because of the nature of the protections and powers under the PHWA for which AOs had responsibility, they were required to be present at each hotel 24 hours a day, 7 days a week. The Department identified, early on, that this would require specific efforts to increase the available pool of AOs. On 30 March 2020, there were 70 AOs under section 30 of the PHWA, including the CHO and Deputy CHO, and the CHO appointed new officers as AOs on an ongoing basis. The number of AOs has grown now to an available pool of over 300.

295. In making appointments from 2 April 2020, the CHO did not place any restrictions or limitations on the public health risk powers or emergency powers of the AOs appointed.

296. The shortage of AOs was raised at MCC across April and May 2020. Steps were taken to fill the shortage by sourcing authorised officers and by 8 April an additional five had been secured, ten expected the next day with a further 22 possible. Twelve secondees from the Environmental Health Professionals Australia were appointed AOs on or about 12 April 2020.

297. Despite efforts to appoint AOs over the first three weeks of hotel quarantine, as at 20 April 2020, the Deputy CHO was advised that there was still a continuing need for AOs. By 21 May 2020, there were a sufficient number of AOs and the focus shifted to recruit permanent AOs to replace staff that were secondees or were temporarily filling the AO function.

298. Formal training for AOs was established by 14 April 2020.

299. The Department prepared guidelines to assist AOs to carry out their duties under the Charter. Guidelines include:

299.1. Permission for Temporary Leave Guidance for AO

299.2. Authorised Officers Charter Info Sheet (unaccompanied minors)

299.3. Template directions were also prepared by the Department for use by AOs for airport arrivals.

300. The Charter Assessment for hotel quarantine was made by the Deputy CHO.

301. From 17 May the Department also prepared five operational instructions which were issued to AOs:

301.1. Operational Instruction 1-2020 Searching personal belongings

301.2. Operational Instruction 2-2020 AO Team Leaders accountabilities

301.3. Operational instruction 3-2020 Use of improvement and prohibition notices

301.4. Operational Instruction 4-2020 Detainee Person Carer Policy

301.5. Operational Instruction 5-2020 Management of detainee movement from hotel to hotel.

43(d) What were the powers of Authorised Officers

302. Following the declaration of a state of emergency,[38] the CHO was able to authorise the exercise of certain powers by AOs where he believed it was necessary to grant an authorisation to eliminate or reduce a serious risk to public health.[39]

303. The relevant powers used to give effect to the hotel quarantine program are the "emergency powers" set out in s 200 of the PHWA. While AOs were also authorised in general terms to use the public health risk powers in s 190 of the PHWA, they were not in practice generally required to use those powers for the purposes of Operation Soteria.

304. The emergency powers include powers to:

- detain a person within the emergency area for a period reasonably necessary to eliminate or reduce a serious risk to public health;
- restrict the movement of a person within the emergency area;
- prevent people or a group of people from entering the emergency area; and

[38] Pursuant to the PHWA, s 198.
[39] PHWA, s 199(2). In addition, the Chief Health Officer may, under section 22 of the PWHA, delegate any of his powers, duties or functions to a registered medical practitioner who meets the necessary criteria of the Act. An instrument of delegation was published by the Chief Health Officer on 8 November 2019 delegating a number of powers to the two Deputy Chief Health Officers (Communicable Diseases and Environment).

- make any other direction that they consider reasonably necessary to protect public health.[40]

305. In exercising the emergency powers to detain a person, the AO must:

- unless it is not practicable, briefly explain the reason why it is necessary to detain the person;[41]
- before exercising any emergency powers, unless it is not practicable to do so, warn the person that a refusal or failure to comply without a reasonable excuse, is an offence;[42]
- facilitate any reasonable request for communication made by a person subject to detention;[43] and
- as soon as reasonably practical notify the CHO in writing and in the required form of this detention.[44] As soon as reasonably practicable, the CHO must notify the Minister of the receipt of the notice relating to the detention.[45]

306. The PHWA also required that at least once every 24 hours during the period that a person is subject to detention, there must be a review of whether the continued detention of the person is reasonably necessary to eliminate or reduce a serious risk to public health.[46]

307. The PHWA provides that an AO may be assisted by any person in exercising a power under an authorisation[47] and may request assistance of a police officer. This request must be made directly to the Chief Commissioner of Police or their delegate.[48] The CHO made such a request on 16 March 2020, and another on 29 March 2020, in terms relating to "any actions that police officers need to take to monitor compliance with the directions" made under s 200 of the PHWA, and to investigate and respond to any alleged breaches, and in cases of failure to comply with the directions without lawful excuse, to take any necessary enforcement action. This was agreed and reflected in the

[40] PHWA, s 200(1) and definition section.
[41] PHWA, s 200(2) and (3).
[42] PHWA, s 200(4).
[43] PHWA, s 200(5).
[44] PHWA, s 200(7).
[45] PHWA, s 200(9).
[46] PHWA, s 200(6).
[47] PHWA, s 202(1).
[48] PHWA s 202(2). The PHWA does not include any requirement that the Chief Commissioner is compelled to respond to such a request.

first operational plan for Operation Soteria. Enforcement protocols with Victoria Police were agreed on 4 April to assist in oversight of the hotel quarantine program.

308. While AO had extensive powers under the Act, in practice, the exercise of these powers was limited in the hotel quarantine program to the three phases identified above: issuing the detention notice at airports, facilitating fresh air breaks as an exemption from detention, and managing the exit from quarantine process.

44. Did Authorised Officers involved in Operation Soteria undertake a daily review of the Hotel Quarantine sites at which they were working and provide reports to your Department? If so, what did this review and reporting function involve?

309. Daily reviews of quarantine for individual passengers were undertaken by a Senior AO reviewing a spreadsheet where each person in hotel quarantine was listed by name, room number, and how many days they had been in quarantine. This was supplemented by daily contact, with more in-depth welfare reviews occurring on day 3 and day 9 of the 14-day quarantine period by dedicated health and wellbeing staff.

310. AOs did not have a wider function for the daily review of all hotel quarantine sites, but did escalate compliance issues as required.

45. In your view, has the current legislative public health framework created some difficulties and highlighted issues that made the delivery of the Hotel Quarantine Program more difficult for your Department? If so, in what way has this occurred and how do you suggest it be addressed?

311. The COVID-19 pandemic has tested the existing public health legislative framework, much of which is directed to management of public health risk posed by an individual case or small numbers of cases, and is not readily adapted to application to large classes of people over an extended period.

312. The decision-making principles under the PHWA largely envisage a behavioural model of enforcement underpinned by a therapeutic relationship, with public health officers involved in enforcement, in contrast to alternative legislative frameworks where decisions on public health orders are vested in the health portfolio, but enforcement action in the event of non-compliance is legally vested in police. For instance, in New South Wales under the emergency management regime, a quarantine detention direction was made by the Minister for Health, and directed that travellers would be in the custody and under the direction of the Chief Commissioner of Police.

313. Under the PHWA, police can be asked to assist with respect to enforcement and compliance in certain circumstances, but under s 30(1), but neither police officers nor the

ADF are permitted to be Authorised Officers, as they are not employed under the *Public Administration Act 2004* (Vic) as required by that section. This meant that they could not perform the essential roles relating to detained persons under the PHWA, including compulsory reviews of the necessity of detention each 24 hours.

314. Alongside other operations requiring enforcement of CHO directions, the need to source and deploy large numbers of Authorised Officers to enforce legal Directions for the hotel quarantine program added a significant operational impost that tested best practice rostering patterns. In the first instance, most Authorised Officers were drawn from existing departmental staff with experience in regulation, and over time a wider pool of trained staff for this purpose were identified by the Department from other government agencies and local government. Given the number of hotels involved at the peak of the program, the operational requirements for the roles of hotel team leaders also presented challenges to best practice in filling rostering requirements for that position.

315. There are opportunities to reflect on changes to the enforcement model, noting this would require legislative change.

316. The legislative scheme in the *Health Records Act 2001 (Vic)* contains principles about when health information can be disclosed. Any health information of an individual in possession of the Department, that is proposed to be disclosed to a third party, needs to be assessed in relation to these principles. This process may act as a partial constraint on public health efforts to contain the pandemic.

317. There may be opportunities for future legislative amendment to clarify permitted disclosures of personal health information in an emergency context, though this will need to be carefully balanced against privacy and Charter considerations.

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

318. The response to the COVID-19 pandemic has presented an operational task of great complexity. It has relied on the individual contributions and behaviours of thousands of people, across many government departments and agencies and non-governmental partners.

319. While the Inquiry will focus, as it should, on specific decisions, documents and facts relevant to hotel quarantine operations, this challenging experience also provides an opportunity to reflect on the way that individuals and operational systems can be best be configured to manage an extreme emergency in the future.

320. The appropriateness of legislative frameworks, both in relation to public health and wellbeing and emergency management arrangements, are worthy of reflection. I believe there are significant learnings from this experience which could better position Victoria to respond to future public health emergencies.

321. Comparative analysis with other jurisdictions may be useful, noting other Australian states and territories have stronger emphasis on the use of legislative provisions enabling quarantine directions to be issued, operating under the auspices of police authorities.

322. In addition to the legislative framework, the wider operational framework for class 2 emergencies is not as well established as for class 1 emergencies, despite the likelihood that a higher volume of departments and agencies may be required to support class 2 emergency responses.

323. After the devastation caused by Black Saturday to many communities across Victoria, there was rightly a stronger emphasis on all hazards, all agencies responses, with Victorian Government departments and agencies working as one in a unified response framework. Significant effort has been put into development of robust operational guidance for class 1 emergencies. Until this unprecedented pandemic there has been less drive for a more dedicated and detailed focus on the operational frameworks for class 2 emergencies.

324. More broadly, the nature of the collaborative governance framework used for the hotel quarantine program, drawing on wider emergency management arrangements, is worthy of reflection.

325. The nature of the collaborative governance framework used for the hotel quarantine program is not unique to an emergency response of the scale and magnitude required for the COVID-19 pandemic.

326. For instance, the New Zealand Government response to the devastating Christchurch earthquakes in 2010 and 2011 included use of tailored multi-agency emergency response settings that involved many supporting departments and agencies, under the leadership of central government agencies. Given the complex nature of the emergency response, the then emergency management legislative frameworks were overtaken by a more flexible approach to governance, coordination and direction.

327. In recent decades the public sector has seen a strengthened emphasis on collaboration across traditional departmental lines, creating new whole-of-government mechanisms, such as interdepartmental committees, to promote joint problem solving

and coordinated action. This is particularly the case for 'wicked' problems that the public sector has increasingly recognised cannot be solved by a single department or agency acting in isolation.

328. By way of example in the Victorian context, there has been a trend towards establishment of multi-agency panels to better support community members with complex needs, particularly those with multiple touchpoints across the health and social service systems, as well as the justice system. While multi-agency panels are chaired and run by a lead department or agency, they comprise a range of supporting departments and agencies that bring detailed knowledge of their individual service systems and the ability to problem solve to create a tailored service response. While each multi-agency panel has a defined lead, member departments and agencies remain accountable for service delivery oversight relevant to their respective roles and responsibilities.

329. Emergency management has reflected the trend towards of collaborative governance. Collaboration has become the key operating method for crisis management and responding to emergencies, involving the bringing together of the various specialist skills of multiple actors.

330. The State Crisis and Resilience Council (**SCRC**) is an example of the application of collaborative governance in the emergency management context, being enshrined in legislation. SCRC is comprised of all departmental heads, the Chief Commissioner of Police, the Emergency Management Commissioner and others. Chaired by the Secretary of DPC, the legislative role of SCRC is to act as the peak crisis and emergency management advisory body in Victoria, with responsibility for providing advice to the Minister for Police and Emergency Services in relation to whole-of-Victorian Government policy and strategy for emergency management, and implementation of that policy and strategy.

331. While the policy and strategy for emergency management is set through regular plans endorsed by SCRC as a collaborative governance mechanism, each individual department and agency head is then responsible both to the Chair of SCRC for implementing parts of the endorsed plan relevant to their roles and responsibilities, while also being accountable to their relevant portfolio Minister.

332. While there are inherent benefits in collaboration, there is a recognised tension between collaborative governance and traditional Westminster accountability models. By bringing together multiple s and agencies into a single governance framework, collaboration necessitates new lines of joint accountability with greater complexity.

Collaborative governance arrangements do not align neatly with individual Ministerial accountabilities, which is a hallmark of the traditional Westminster system of democracy.

333. Collaborative governance requires clarity on roles, responsibilities and ultimate accountability for decisions taken. It can make it harder for rapid response as situations present, given the need for collaboration as part of the decision-making process.

334. Given the nature of health emergencies and the multiple actors likely involved in response, it is worth reflecting on how best to harness the benefits of collaborative governance while retaining clear accountability and an ability to take prompt and decisive action when required.

335. While I believe that collaborative governance frameworks have been able to greatly advance the response to many complex public policy issues, there are opportunities to strengthen how they are best applied to Class 2 emergencies under the Emergency Management Act, particularly those that will likely require the input from multiple government departments and agencies.

336. In closing, I want to acknowledge the many Victorian families and communities that have been personally affected by the COVID-19 pandemic, and in particular those who have lost family members, friends or loved ones.

337. I also want to again acknowledge the teams from across the Department, the wider Victorian Public Sector and non-government sectors who have worked tirelessly to tackle the dynamic and multi-sector emergency that has resulted from the COVID-19 pandemic.

338. I would particularly like to acknowledge the extent of engagement and cooperation across the Victorian Public Service that is, and has been, very significant, in supporting the Department to respond to the scale and pace of the pandemic.

339. Finally, I would like to record again my sincere thanks for the response of my Department, and of the many people who work for it. Serving the public has rarely been more complex or consequential.

Signed at Melbourne

in the State of Victoria

on 14 August 2020

Kym Lee-Anne Peake