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The Honourable Jennifer Coate AO
Board of Inquiry into the COVID-19 Hotel Quarantine Program

Via email: lawyers@quarantineinquiry.vic.gov.au

Dear Justice Coate,

Thank you for your letter of 10 July 2020 to commence engagement between the Department of Health and Human Services (**department**) and the Board of Inquiry into the COVID-19 Hotel Quarantine Program (**Inquiry**).

The department is committed to supporting the Inquiry with its important work and is mindful of tight timeframes. The department will comply with all requests made by the Inquiry as a critical review into the hotel quarantine program which will inform ongoing management of the coronavirus (**COVID-19**) pandemic and future management of health emergencies.

We appreciate your recognition that many departmental staff continue to actively engage in management of the pandemic. Given this, the department is yet to undertake a forensic review of its response to the pandemic, though in this initial response we provide observations that we hope will assist the Inquiry.

COVID-19 has presented an unprecedented global public health crisis, disrupting economies, health systems and social activities and wellbeing. Consequence management has focused not only on immediate public health risks, but also the associated social and economic impacts – recognising that these will affect long term health outcomes.

The scale of the response required has been extraordinary – in terms of cost, human resources and operational response.

The epidemiological and empirical understanding of transmission of the virus continues to evolve – requiring continual monitoring and policy responses.

Necessary policy shifts at a national and state level have required daily recalibration and high levels of execution skill.

The constant evolution of risks and responses to the virus (both as a result of scientific and factual analysis) has meant that there has been a constantly evolving response drawing on the capabilities and capacities of the whole of the Victorian Government. There are also many people who are outside the department, but who have been instrumental in our response – including in the community sector, health services and the private sector.

The dynamics of the pandemic do not allow for a ‘set and forget’ strategy – but rather require 24/7 governance, management and monitoring.

To understand the department's response to the pandemic (in particular as it relates to the hotel quarantine program), it is useful to understand the governance and legislative framework within which it operates. An overview of this framework is set out below, with further detail at Annexure 1.

Victoria's response structure

Recognising the scale and breadth of impacts of COVID-19, and the required pace of response, new Cabinet governance structures were created at a national and state level. These crisis-management structures have set strategic objectives and led co-ordination of the pandemic response and delivery of timely and appropriate public information:

- National Cabinet was instituted on 15 March 2020 to deliver a consistent national response to COVID-19, drawing on advice of the Australian Health Protection Principal Committee (**AHPPC**).
- A Crisis Council of Cabinet and Mission Coordination Committee were announced by the Premier of Victoria on 3 April 2020, designed to enable rapid and coordinated whole of government decision-making and oversight. Departmental Secretaries were commissioned to lead missions focused on the pandemic response and recovery.

Following a National Cabinet discussion on 16 April 2020, subsequently the Prime Minister communicated the decision to pursue a suppression strategy to balance immediate health, social and economic consequences, noting that this would mean Australia would continue to have outbreaks that would require rapid ongoing responses.

Victoria's execution of this strategy has predominantly been managed under the Public Health and Wellbeing Act 2008 (**PHWA**).

The PHWA's public health response framework vests significant powers in Victoria's Chief Health Officer (**CHO**) to investigate, eliminate or reduce a risk to public health. Relevantly, the PHWA allows for the exercise of emergency powers to detain individuals in the emergency area for a reasonably necessary period when a State of Emergency has been declared. When exercising powers under the PHWA, consideration needs to be given to privacy concerns and the Victorian Charter of Human Rights and Responsibilities Act 2006 (**Charter**).

Most of the CHO's powers are delegated to Deputy Chief Health Officers. The CHO may also authorise persons employed under the Public Administration Act, or by local councils, and appointed by the Secretary as authorised officers, to exercise emergency and public health risk powers.

Given the scale, complexity and rapid pace of managing the consequences of COVID-19, core capabilities throughout the department and across many other departments and agencies have been engaged through the mission structures to deliver on strategic decisions taken by National Cabinet and the Victorian Crisis Council of Cabinet.

Within this mission structure, the capabilities of the State Control Centre and associated emergency management arrangements operate under the Emergency Management Act 2013 (**EMA**) have been leveraged for whole of government intelligence, exercising implementation of compulsion powers and sourcing and deployment of interstate resources.

Victoria's response to emergencies, including health emergencies, is guided by the *Emergency Management Manual Victoria* (**EMMV**), the *State Emergency Response Plan* (**SERP**), and the *State Health Emergency Response Plan* (**SHERP**).

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

Under the EMMV, the department is the designated control agency for human disease emergencies. In the context of the governance architecture for the COVID-19 response, this means that the department has been responsible for coordinating the contributions of relevant Victorian and Commonwealth Government departments and agencies to gather whole of government intelligence and execute compulsion powers under the PHWA.

Department response structure

Within the Victorian response structure, the department had responsibility for public health interventions to suppress the virus (including investigation, management of public health risk, and communication of risk). This role is primarily played by the CHO (or delegates), drawing on powers in the PHWA.

CHO decisions about risk and emergency powers and public advisories have been informed by information and recommendations of AHPPC and the Communicable Diseases Network of Australia. Decisions have also been informed by expert modelling and genomic mapping through the Peter Doherty Institute for Infection and Immunity.

At a state level, a State of Emergency under the PHWA was declared on 16 March 2020 and the CHO issued the first set of directions, which related to non-essential mass gatherings (500 people or more) and self-quarantine following overseas travel. In the first four weeks of the state of emergency, the CHO and Deputy CHO issued around 20 sets of legal directions, usually within 24 hours of National Cabinet decisions.

The department was also responsible for stewardship of health and human service sector responses to the pandemic, including overseeing delivery of services that support the health and wellbeing of Victorians, a role that extended to supporting returned travellers in hotel quarantine.

As noted above, the department is the designated control agency for human disease emergencies. A designated State Controller for the Class 2 Emergency was appointed on 1 February 2020. Consistent with the SHERP, the State Controller was supported by a Public Health Commander, State Health Coordinator and State Health Commander.

It is ordinarily envisaged that the State Controller for human disease emergency will be the CHO, though departmental policy acknowledges this will not always be the case. In this operation, the Director of the Emergency Management Branch within the department was appointed as the State Controller. The decision reflected the significant operational responsibilities the CHO was already undertaking in response to the pandemic at both state and national level (including through AHPPC).

An overview of departmental roles key to the response to the health emergency is at Annexure 2, with a depiction of the current departmental structure responding to the health emergency at Annexure 3.

Application of departmental response structure to the hotel quarantine program

The hotel quarantine program has been managed at the intersection of emergency management and broader crisis management arrangements.

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

The department led the drafting of model directions for other states and territories to give effect to this decision. 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, and mandatory detention of international arrivals was introduced from 11.59pm on 28 March 2020.

This complex program required incredible effort from multiple departments and agencies to establish in less than 48 hours. The program also grew quickly; within the first two days of operations there were over 1,000 returned travellers detained in mandatory quarantine.

By 30 June 2020, 20,306 returned travellers had entered quarantine as part of the Victorian hotel quarantine program since it commenced, a significant proportion of which were returning residents from states other than Victoria. In this time, the program has accommodated at least 240 COVID-19 positive returned travellers.

Subsequent to the initial commissioning of hotels and security services by DJPR, a dedicated operation (Operation Soteria) was established under emergency management arrangements to support co-ordination of support agencies, and enforcement of and compliance with Directions relevant to hotel quarantine.

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

Through its public health function, the department is responsible for investigating and monitoring outbreaks, including the conduct of contact tracing to limit the spread of the virus. The department played the lead role in investigating the two outbreaks linked to hotel quarantine operations.

As noted above, multiple departments and agencies were involved in the establishment and ongoing operation of the hotel detention program. The department's role did not extend to the establishment and management of accommodation contracts for the hotel quarantine program until mid-June 2020. The department's accountabilities did not include establishing or managing contracts for the provision of security services for the hotel quarantine program.

A high-level summary of the responsibilities of other departments and agencies for hotel quarantine operations is provided at Annexure 4, drawing on the approved operational plan. A chronology of key dates relevant to the program and wider pandemic response is also provided at Annexure 5.

Initial Observations – Shortcomings and Improvement Opportunities

Infection control breaches represent a significant risk to the community – and while the vast majority of people completed their quarantine without transmission occurring, two outbreaks associated with hotel quarantine have been identified. The consequences of these are significant.

In light of the unfolding emergency, the department, while continuing to consider and implement operational improvements as the situation develops, has not had the opportunity to undertake a detailed review of shortcomings of the hotel quarantine program.

The department is currently in the process of reviewing key documents created during establishment of the program and key decisions taken thereafter. This work is ongoing. However, the department makes the following initial observations on issues which have arisen, responsive actions taken to date, and further actions that could be considered.

There are important contextual factors relevant to the below initial observations.

First, the rapid establishment of the program concurrently with broader COVID-19 responses and bushfire recovery activities meant that in many cases, operational policies and procedures for the program were finalised in days and weeks following commencement of the legal directions.

Through continuing risk assessment, ongoing refinements were made to reflect substantial changes to service delivery, practical on-the-ground learnings and changes in public health advice (in turn responsive to the developing scientific understanding of the virus and its treatment).

Further, the demographic profile of the returned travellers entering hotel quarantine changed over time, in a way which had material impact on the services provided under the program. Initially, there was a higher proportion of returning holidaymakers and business travellers. Over time, there were an increasing number of repatriation flights returning to Australia, bringing a more diverse cohort with more complex needs, people who had lived as expatriates for years, and a higher proportion of children and family groups.

Following initial observations on the adequacy of the legislative framework, further observations below are organised by way of the department's key areas of responsibility for the hotel quarantine program. Observations reflect on actions taken to date, and further actions that could be considered.

Legislative framework

Generally in emergency management, operational planning and deployment of resources are coordinated by the control function under the EMMV.

As noted above, the response framework for COVID-19 has required introduction of new crisis-management Cabinet governance structures, with targeted use of emergency management arrangements. The State Controller has not had responsibility for management of the responses to the broader social and economic consequences of the virus.

There have been significant successes across the COVID-19 response in cross-government collaboration, rapid learning and adaptive program management and emergency responses. However, accountabilities and delivery are more dispersed than arrangements envisaged under the EMMV. This is evident in the hotel quarantine program.

Additionally, the legislative framework for public health enforcement was not designed for the scale and duration of public health interventions that have been necessary. There is a fundamental tension between the individual interventions delivered by clinicians which are the primary focus of the decision-making principles of the PHWA and the large-scale intervention and enforcement required to protect the public from the serious community-wide threat presented by COVID-19.

An emergency of this scale and complexity requires reflection on whether new structures, processes and legislative frameworks are needed (for both emergency management and public health).

Governance and coordination of the hotel detention program

As noted, the hotel quarantine program has operated at the interface between emergency management and wider national and state crisis management governance arrangements.

The SCC and associated emergency management planning frameworks were instigated following initial urgent commissioning and establishment of the hotel quarantine program by the Department of Jobs, Precincts and Regions (**DJPR**).

The Emergency Management Commissioner (**EMC**) and State Controller agreed to the rapid appointment of a Deputy State Controller. With planning and logistics support from the ADF, an operational plan was rapidly developed, incorporating contracted services. This plan was endorsed by the EMC and Public Health Command on 28 March 2020 and continued to be refined. Coordination responsibilities were subsequently transitioned to a designated COVID-19 Accommodation Commander (sourced from DHHS).

These positions facilitated regular meetings of all relevant departments and agencies engaged in hotel quarantine and associated emergency accommodation operations to promote coordinated action, intelligence sharing and enforcement of Directions.

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 Directors made under the PHWA, meant that a range of protective functions were to be performed by Authorised Officers. 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. The department quickly moved to also consider other health and human services that would need to be provided to those in quarantine.

While an operational plan was agreed, accountabilities under the program were fragmented. For instance, early discussions were required to clarify the responsibilities of relevant departments and agencies, particularly on-site at hotels.

Command structures evolved throughout the hotel quarantine program to mitigate the risks of this fragmentation. An Emergency Operations Centre (**EOC**) was established for Operation Soteria on 17 April 2020, led by the dedicated COVID-19 Accommodation Commander. An Enforcement and Compliance Commander was also appointed who worked under the authorisation of the Public Health Command.

Staff who were initially undertaking senior roles in Operation Soteria as well as their usual Emergency Management roles are being gradually replaced with new staff appointed to dedicated Operation Soteria positions for 6 to 12-month periods. This is supporting the transitioning of Operation Soteria from emergency management response settings to more enduring settings more consistent with the management of an ongoing government program.

Actions were also taken to manage risks of COVID-19 transmission in hotel quarantine, focused on:

a. Reducing inconsistent application and use of personal protective equipment (**PPE**)

b. Case finding through the introduction of asymptomatic testing

c. Establishing a COVID-positive hotel

d. Managing provision of fresh air, exercise breaks and other movements of quarantined people.

Reducing inconsistent application and use of PPE

Infection control was a key consideration from commencement of the hotel quarantine program, with briefings and signage provided at ports of entry and in hotels.

The COVID-19 Accommodation Command and Authorised Officers operating under the Enforcement and Compliance Command followed public health guidance on PPE use and broader infection control policies for the hotel quarantine program.

However, there was a range of staff on hotel sites, provided by or contracted by multiple departments, with differences in training and contractual arrangements. This posed a challenge to consistent PPE and wider infection prevention and control practices at a site level. Under contracts entered into, hotels and security providers were responsible for providing relevant training and PPE to their staff. Instances of inadequate or inappropriate PPE being used in some locations, such as a single pair of gloves being used throughout a shift, resulted in the department taking action to make available PPE to all staff at hotel sites (including security staff and hotel staff).

In response to some of the concerns identified above, in early April 2020 infection prevention and control (**IPC**) consultants were engaged by the department to assist in promoting more consistent use of PPE. Following outbreaks, further IPC training and advice was instigated by the department's Outbreak Management teams who visited all hotels and advised on improved future IPC arrangements.

From mid-June 2020, the department provided staff and contractors across all sites with enhanced information and training materials tailored to the hotel quarantine context, developed by Alfred Health and specialist department infection prevention staff. All staff working in hotel quarantine are required to undertake regular training in IPC, the correct use of PPE and other key protective measures, delivered by onsite clinical staff.

This includes face-to-face IPC training with videos and other aids tailored for this workforce. Staff and contractors are briefed in IPC at the commencement of every shift, with regular reminders during shifts. Briefings are provided by on-site nurses with IPC training and/or staff who have been trained to deliver the infection prevention messages. This is complemented by prominent communication materials and signage provided in all hotels.

Infection control audits continue across all hotels to inform further enhancements to this training and support.

All Authorised Officers that joined the department also received IPC training as part of their induction prior to commencement at the hotels.

Given the outbreaks that occurred, a stronger focus on more consistent site-wide training and briefing on IPC and PPE could have been an improvement. Having a streamlined delivery approach, with one entity responsible for all sourcing of PPE, IPC guidance, training and compliance for all staffing cohorts on site may also have better mitigated infection risks.

Case finding through asymptomatic testing

In the beginning of the hotel quarantine program, COVID-19 testing was provided to individuals only if they became symptomatic, consistent with the approach in the broader community.

As the value of broader testing was understood, Victoria was the first state to offer all quarantined individuals (regardless of age or other risk factors) with COVID-19 testing on day 3 (from 3 May 2020) and day 11 (from 2 May 2020) of the mandatory quarantine period. This allowed positive cases to be identified earlier, including many that were asymptomatic, enabling better care and management to avoid community transmission.

From 28 June 2020, changes were made to the legal directions to require returned travellers to undergo a further ten days of hotel quarantine if they did not engage in COVID-19 testing.

Establishment of a single COVID-19 positive hotel

Initially, people who tested positive for COVID-19 were relocated to separate floors in the hotels (so called ‘red floors’). On or about 9 April 2020, the SCC was informed about the imminent repatriation of a large number of travellers from a cruise ship moored in Uruguay, many of whom had tested positive for COVID-19.

Operation Soteria supported detailed planning for the return of these travellers on 12 April 2020, including designating a single hotel for COVID-19 positive passengers (the Rydges on Swanston).

The Rydges on Swanston continued to be used for relocating people who tested positive for COVID-19 and their close contacts, with 240 returned travellers being accommodated in this hotel to 30 June 2020.

In late May, following notification to the State Controller of staff working at Rydges on Swanston testing positive, the department contracted Alfred Health to establish core clinical and non-clinical leadership and support roles at COVID-19 positive hotels.

This arrangement, implemented progressively from 15 June 2020, provided streamlined clinical governance and oversight of all functions at the COVID-19 positive hotel, with clinical staff, auxiliary staff and security staff all being drawn from individuals experienced in the IPC requirements of hospital environments.

Managing provision of fresh air and exercise breaks and other movements of quarantined people

Given the nature of hotel accommodation initially available, with many rooms not having windows or balconies, the need for access to fresh air was an early issue identified by departmental staff, particularly for returned travellers who were experiencing material welfare concerns.

Informed in part by the Charter of Human Rights, while balancing public health objectives, the fresh air policy involved managed movement of guests out of hotel rooms to locations in or around the hotel where they could access fresh air within social distancing and other infection control requirements.

To minimise the need for movement of people out of their rooms (and associated infection control risks), use of hotels with opening windows or balconies were progressively increased use in hotel quarantine from May 2020.

Earlier engagement of hotels with greater access to fresh air may have mitigated the need for the fresh air policy, which did bring increased transmission risks. The department understands that other jurisdictions did not have similar fresh air break policies in place.

Public health

As noted above, the COVID-19 pandemic has also tested the existing public health legislative framework, some of which is directed to management of public health risk posed by an individual case and is not readily adapted to application to large classes of people over an extended period.

The decision-making principles under the PHWA largely envisage a behavioral model of enforcement underpinned by a therapeutic relationship, in contrast to alternative legislative frameworks (for example in NSW), where decisions on public health orders are vested in the health portfolio, but enforcement was legally vested in police.

Under the PHWA, police can be asked to assist, but neither they nor the ADF are permitted to be Authorised Officers performing the essential roles relating to detained persons under the PHWA, including compulsory reviews of the necessity of detention each 24 hours. Neither the Minister for Health, Secretary of the department or the CHO have the power to direct resources of Victoria Police.

In the instance of mandatory hotel quarantine, the need to source and deploy large numbers of Authorised Officers to enforce legal Directions 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.

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

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.

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 considerations.

Health and wellbeing

Given the rapid establishment and changing needs within the hotel quarantine program, the availability of health and wellbeing support evolved over time.

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.

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, with specialist mental health nursing staff added to general nursing and medical staff available. This was complementary to services provided through a coordinated Crisis Assessment Response Team, which was available by referral from the beginning of the program to support returned travellers with complex needs.

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.

Improvements were also made to the health and welfare screening of returned travellers, as well as to incident reporting arrangements and overarching clinical governance. Specifically, a clinical governance structure was established whereby Public Health Command developed the health pathways for implementation and oversight by the EOC.

A formal clinical review reporting process was also established by the department for any adverse health incidents, providing access to streamlined and independent review by Safer Care Victoria (**SCV**). Findings and recommendations from these reviews were provided to the EOC with SCV support for action plans.

Ongoing actions

Genomics

As noted in the Inquiry's terms of reference, recent epidemiological evidence (including genomic analysis) has linked COVID-19 in quarantined travellers to the spread of the virus to the broader Victorian community.

There are currently two identified outbreaks relating to the hotel quarantine program which will be relevant to the Inquiry:

- Rydges on Swanston, with the first case notified on 26 May 2020. Of this outbreak, most cases were attributed to security staff (with a REDACTED and a REDACTED also testing positive) and household close contacts of these staff members.
- Stamford Hotel, with the first case notified on 16 June 2020. Significant transmission from this outbreak was among security staff at the facility.

Whole genome sequencing analysis is ongoing to identify the path of these outbreaks. The department will be able to provide further material to the Inquiry to assist in understanding potential epidemiological implications of these outbreaks.

Managed transition of Operation Soteria to single entity

Since mid-June, responsibilities for the hotel quarantine program have been progressively consolidated, drawing on planning that was commenced in May.

Developments have included new models of security (including through Corrections Victoria and Alfred Health), and consolidation of operational responsibilities ahead of transition to the Department of Justice and Community Safety (**DJCS**).

Recommendations from the Outbreak Management teams have also been implemented, with Alfred Health assuming responsibility for clinical governance in COVID-19 positive hotels. This means that all staff on site at COVID-19 positive hotels are now managed by Alfred Health (including security and cleaning staff), drawing on personnel experienced in hospital operations.

The State Controller and wider departmental staff are continuing to support the program, including transitional planning for the delivery of health care. The Chief Health Officer and Public Health Command will continue to support DJCS in this program through the making of Directions and authorisation of Authorised Officers of the department.

Some of the improvements identified in this letter would require legislative change – which will be informed by the outcomes of this Inquiry.

Conclusion

While the Inquiry will focus, as it should, on specific decisions, documents and facts relevant to hotel quarantine operations, it is also worth reflecting on the human factors involved in some detail, and to use this experience to improve the way we manage individuals and operational systems in an extreme emergency in the future.

Teams across the department and across government and non-government sectors have worked tirelessly and with skill and professionalism to tackle the dynamic and multi-sector emergency that has resulted from the COVID-19 pandemic.

I am proud of the response of my department, and of the many people who work for it. Serving the public has rarely been more complex or consequential.

I would like to acknowledge the extent of engagement and cooperation across the Victorian Public Service that is, and has been, very significant.

The response to the pandemic presented an operational task of great complexity that relied on the individual contributions and behaviours of hundreds of people. The response has, however, highlighted that there are natural limits to how rapidly arrangements can become effective and how quickly individuals can adapt and learn.

I trust this initial information has been of assistance to the Inquiry. As noted, the department is committed to supporting the important work of the Inquiry and looks forward to further engagement.

Kym Peake

Secretary

17 / 7 / 2020

Annexure 1
Legislative Framework

The PHWA vests significant powers in Victoria's Chief Health Officer (**CHO**) to investigate, eliminate or reduce a risk to public health. Relevantly, 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:

- 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)
- restrict the movement of any person or group of persons within an emergency area: s 200(1)(b)
- prevent any person or group of persons from entering an emergency area: s 200(1)(c)
- give any other direction the authorised officer considers is reasonably necessary to protect public health s 200(1)(d).

Emergency powers can only be exercised following the declaration of a State of Emergency. Pursuant to s 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.

A State of Emergency can be in force for up to four weeks and extended for up to six months. If a State of Emergency exists the CHO can, if he considers it necessary to do so to investigate, eliminate or reduce a risk to public health, authorise officers to exercise any of the emergency powers or public health risk or powers: s 199(2).

The PHWA provides guidance that decisions under the PHWA including decisions to declare a State of Emergency and exercise specific emergency powers) must take a number of matters into account including that the decision must be evidence based, but not postponed if there is a lack of full scientific certainty; prevention is preferable to remedial measures (ss 5, 6, 7); and measures should be proportionate to the public health risk, and not arbitrary (s 9).

There are other powers of the CHO under the PHWA that do not rely on the existence of a State of Emergency, but are still relevant to the response, which also allow for the protection of the public through the reduction or elimination of health risks including powers to:

- direct a person to be tested to identify if that person has been infected with an infectious disease (here COVID-19): s 113(1);
- if a person does not comply with a testing order, to detain them in isolation: s 113(3)(c);
- make a public health order requiring that a person submit to being detained and/or isolated: s 117(5)(k);
- direct a person to provide information necessary to investigate or manage a risk to public health: s 188(1), (which can be used for contact tracing).

Most of the CHO's powers have been delegated to the Deputy Chief Health Officers, pursuant to the CHO's delegation power (s 22).

When exercising any powers under the PHWA including in a State of Emergency, consideration must be given to both privacy concerns where relevant and, as the department is a public authority, the Victorian Charter of Human Rights and Responsibilities Act 2006 (**the Charter**).

Relevant Charter rights include:

- Freedom of movement (s12);
- Protection of families and children (s17);
- Right to liberty and security of person (s21);
- Humane treatment when deprived of liberty (s22);
- Freedom of thought conscience religion and belief (s14), (which was relevant to food choices);
- Peaceful assembly and freedom of association (s16).

The requirement to consider Charter rights applies to exercising the power to detain, including by imposing rules on what quarantined individuals could and could not do, where they could go and what they could bring into their rooms.

Having regard to the Charter the restrictions imposed were the least restrictive means reasonably available to achieve the purpose of containment of COVID-19 infection potentially brought into Victoria from overseas.

Emergency Management Act 2013

The emergency management regime in Victoria is governed by the Emergency Management Act 2013 (**EMA**), the Emergency Management Manual Victoria (**EMMV**) and the State Emergency Response Plan (**SERP**) under which the relevant sub plan for a health emergency is the State Health Emergency Response Plan (**SHERP**). The COVID-19 pandemic is a Class 2 Emergency pursuant to s 39 of the EMA, and the EMMV sets out that DHHS assume the role of control agency for human disease/epidemics. The Act also sets out the role of the Emergency Management Commissioner (EMC):

Section 32 of the EMA sets out the functions of the Emergency Management Commissioner during a Class 2 emergency, which encompasses the COVID-19 pandemic. These include:

- responsibility for the coordination of the activities of agencies having roles or responsibilities in relation to the response to Class 1 emergencies or Class 2 emergencies: s 32(1)(a);
- ensuring that control arrangements are in place: s 32(1)(b);
- managing the State's primary control centre on behalf of and in collaboration with all agencies s 32(1)(d);
- ensuring the Minister for Police and Emergency Services is informed of actual and imminent events and emergencies and the response to major emergencies (32(1)(e);
- responsibility for consequence management (32(1)(f); and
- coordinating recovery (32(1)(g) and coordinating data collection and impact assessment (32(1)(l).

The following arrangements are in place to support the delivery and execution of these legislative responsibilities:

- *State Coordination Team* – Chaired by the EMC - Oversees the coordination functions and responsibilities on behalf of the EMC; sets the strategic context of the readiness, response, relief and recovery phases; identifies, understands and manages consequences. The Chief Health Officer and the State Controller (Class 2) are members.

- *State Control Team* – Chaired by State Response Controller - Oversees the control functions and responsibilities on behalf of the EMC; and implements the strategic context of the readiness, response and relief and recovery phases.
- *State Emergency Management Team – Chaired by the EMC* - Oversees the management of strategic risks and consequences of the emergency. The State Controller (Class 2) is a member.

State responses to emergencies, including health emergencies, are guided by the following planning frameworks:

- *Emergency Management Manual Victoria*, which sets out policy and planning documents for emergency management in Victoria, and provides details about the roles different organisations play in the emergency management arrangements
- *State Emergency Response Plan*, which outlines the arrangements for a coordinated response to emergencies by all agencies with a role or responsibility in emergency response.
- *State Health Emergency Response Plan*, 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
- *Victorian action plan for pandemic influenza*, prepared by each government department and agency to address the possible impacts and consequences of pandemic influenza on their organisations, and their responsibilities to communities.

In addition, the COVID-19 Pandemic Plan for the Victorian Health Sector was prepared in March 2020, articulating a four-stage response to COVID-19. This plan was an overarching guidance document to inform more detailed planning at individual practice and institutional level.

Detailed operational plans were required across healthcare services in order to be fully prepared for the potential impact of COVID-19 on our healthcare services and community more broadly.

Annexure 2

Key roles and responsibilities – departmental COVID-19 health emergency response

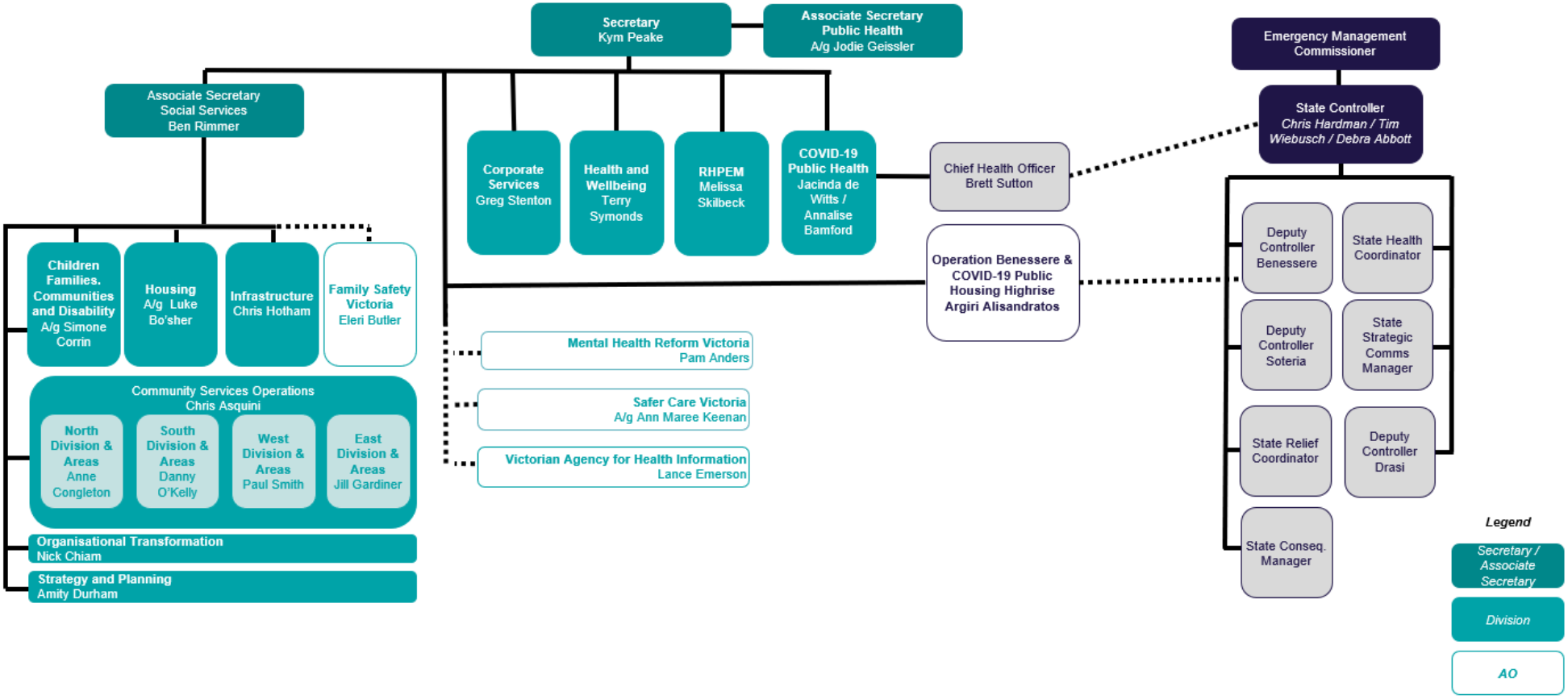
Key roles and responsibilities under the PHWA and EMA as relevant to management of the COVID-19 health emergency are set out in the following table:

Role	Key responsibilities
Secretary	Under SHERP, responsible for appointing senior roles including the State Controller (Class 2) and State Health Emergency Management Coordinator. Under PHWA, responsible for appointing Chief Health Officer, who is subject to the Secretary's general direction and control. Under PHWA, special powers to order Councils to perform any functions or duties or exercise powers. Power to make a broad range of directions to public hospitals, denominational hospitals, MPS and ambulance service under the Health Services Act or Ambulance Service Act relevant to the management of COVID-19.
State Health Emergency Management Co-ordinator	Under SHERP, responsible for ensuring that appropriate appointments are made to state tier functions (State Health Commander, State Health Coordinator and Public Health Commander). May advise Secretary who should fulfil the function of the State Controller according to the nature of the emergency and response. Provides executive support to ensure that the state tier functions operate effectively.
Class 2 State Controller (also referred to as State Controller – Health)	Under SHERP, reports to Emergency Management Commissioner. Leads coordination of response activities through State Emergency Management Team. Can appoint deputies and may delegate certain functions to others.
Deputy State Controller	A Deputy Controller can be appointed by the State Controller to support them in the management of the emergency, within the parameters agreed to with the State Controller.
Chief Health Officer (CHO)	Under PHWA, has authority to make decisions on matters of public health and to exercise management, control and emergency powers in health emergency situations. Powers include authorising an authorised officer to exercise emergency powers (including detaining persons within an emergency area for a period reasonably necessary to eliminate or reduce a serious risk to public health, and restricting the movement of persons), and issuing examination and testing orders.

Role	Key responsibilities
Public Health Commander / Deputy Chief Health Officer (DCHO)	DCHO reports to the CHO and is authorised by the CHO to exercise emergency powers under the PHWA. Responsible for the public health functions of a health emergency response (including investigating, eliminating or reducing a serious risk to public health). Responsible for approving the Operation Soteria Plan, in consultation with the Enforcement and Compliance Commander, COVID-19 Accommodation Commander, the State Health Coordinator and the State Controller.
Deputy Public Health Commander	Reports to Public Health Commander. Can be delegated responsibility for approving the Operation Soteria Plans on behalf of the Public Health Commander, in consultation with the COVID-19 Enforcement and Compliance Commander, COVID-19 Accommodation Commander, the State Health Coordinator and the State Controller.
COVID-19 Accommodation Commander	Leads Operation Soteria, reporting to State Controller, giving effect to the decisions and directions of the Public Health Commander and Enforcement and Compliance Commander. Chairs regular meetings of Operation Soteria to ensure combined oversight. Responsible for oversight of welfare and healthcare to individuals in mandatory quarantine, ensuring the safety and wellbeing of quarantined individuals and DHHS staff, ensuring a safe environment at all times.
Commander COVID-19 Compliance and Enforcement	Under Operation Soteria Plan, leads and provides oversight to compliance matters under all Public Health Directions, provides advice and input into complex compliance matters, provides advice and support to the CHO and their delegate on compliance, and approves exemptions. Responsible for oversight of Authorised Officer operations.
State Health Coordinator	Reports to State Controller under SHERP. Responsible for co-ordinating DHHS' emergency response activities across the health system (including hospitals, primary health and other acute services) at the State tier. In performing functions, liaises directly with the State Health Commander and Public Health Commander.

Annexure 3

Department COVID-19 emergency response structure (as at July 2020)



Annexure 4

Roles and Responsibilities – Other Agencies – Hotel Quarantine Program

Source: Operation Soteria Mandatory Quarantine for All Victorian Arrivals v 3 with Annexures dated 1 June 2020

Role Operation Soteria	Key responsibilities of role
Department of Foreign Affairs and Trade	Assesses and approves all applications for returning Australians.
Australian Border Force (ABF)	Responsibilities in airside operations, including: • Coordinating the return of passengers during their flight. • Melbourne airport security and customs liaison. • Provide passengers with required information about Direction/requirements. • Collection of entry data (manifest). • Marshall passengers in an area that is secure and be able to facilitate health screening. • Establish arrivals area for transport. • Assist boarding of passengers onto bus transport airside. • Escort bus transport to accommodation.
Australian Federal Police (AFP)	Responsibilities in airside operations, including: • Support ABF and other agencies in the management of any compliance or criminal issues. • Escort bus transports to assigned accommodation. • Transfer manifest to Victoria Police on arrival at accommodation.
Department of Transport	Responsibilities include: • Ensure transport of passengers who do not have any immediate health needs requiring hospitalisation between point of entry, to quarantine accommodation and returning to approved transit location following exit from quarantine accommodation. • Provision of transport to passengers to airport or approved transit location (where exemption granted).

Role Operation Soteria	Key responsibilities of role
Ambulance Victoria	Responsibility for pre-hospital care and transport of passengers where required.
Victoria Police	Responsibilities include: • Providing support to AFP, DHHS and DJPR for enforcement and compliance issues. • Preparation and establishment of and preparation for transition for State-side security. • Liaise with AFP and ABF. • Security management of passenger disembarkation from transport to accommodation. • Marshalling and security for incoming passengers. • Receive manifest and passengers from AFP upon arrival at accommodation. • Provision of support to private security as required.
Department of Jobs, Precincts & Regions (DJPR)	Responsibilities include: • Sourcing appropriate accommodation contracts, including food, concierge and security, to support mandatory passenger isolation and providing ongoing support to passengers for these needs. • Manage accommodation contracts, transport arrangements/contracts for deliveries (i.e. Commercial Passenger Vehicles) and private security contracts to enforce quarantine requirements at accommodation. • With DHHS – prepare for incoming passenger accommodation registration, reception parties established to coordinate movement of passengers from transport to accommodation, reception parties established, and coordinated at identified accommodation and detailed identification of, capture and management of welfare needs and detailed identification of, capture and management of special/social needs. • Management of services for all passengers including food, amenities and transport for deliveries.

In addition, national and whole-of-government policy support and communications support has been provided through the Department of Premier and Cabinet.

Workplace occupational health and safety responsibilities have continued to be exercised through Worksafe Victoria.

Annexure 5

Chronology of key events

Date	Key events
10 January	Victoria's Chief Health Officer issued an alert for patients who had travelled to Wuhan, China and experienced the onset of fever and respiratory symptoms within two weeks of return
20 January	The Australian Health Protection Principal Committee comprising all state and territory Chief Health Officers and the Chief Medical Officer of Australia met to consider a national response to COVID-19
29 January	The Commonwealth CMO recommended anyone travelling from Hubei province should isolate for 14 days. In Victoria, Public Health and Wellbeing Regulations were updated to require COVID-19 test results to be notified to the department
1 February	Advice on self-isolation was extended to anyone returning from mainland China (excluding Hong Kong, SAR, Macau and Taiwan. The Commonwealth Government cancelled visas for Chinese travellers due to enter Australia
1 February	Designated State Controller for the Class 2 Emergency appointed in Victoria
February and early March	CHO advisories defining case definitions (describing relevant symptoms and criteria for testing) were refined in line with guidance from the National Communicable Diseases Network
First half of March	Australian travel bans were extended to Iran, South Korea and Italy, with all non-residents banned from entering Australia from 21 March
10 March	Release of the COVID-19 Pandemic Plan for the Victorian Health Sector
15 March	Inaugural National Cabinet meeting, with regular meetings following to decide a nationally consistent approach to the pandemic response. AHPPC also met daily from the second half of March, providing advice to National Cabinet on nationally co-ordinated pandemic responses
16 March	**State of emergency declared in Victoria** and the CHO issues the first set of directions, banning gatherings of 400 or more people in a single undivided indoor or outdoor space; and self-quarantine for airport arrivals
18 March	Directions issued banning gatherings of 100 persons or more in a single undivided indoor space
19 March	Directions issued requiring cruise ship arrivals to self-isolate for 14 days
21 March	Directions on mass gatherings reissued to include minimum space requirements (four square metres per person) for non-essential gatherings. Directions on aged care facilities also issued, placing restrictions on visitors
23 March	Directions issued restricting hospital visitors and non-essential business or undertakings prohibited. Aged Care Sector Plan released
25 March	Directions issued expanding the list of prohibited activities

26 March	**National Cabinet decision made to commence mandatory hotel quarantine for international arrivals,** with announcement by Prime Minister following the evening meeting
28 March 11.59PM	**Hotel quarantine program commenced.** Directions issued requiring a person who has travelled to Victoria from overseas to be detained in a hotel for 14 days
29 March	Deputy State Controller appointed to give greater focus on hotel quarantine operations.
30 March	Stay at home directions issued requiring a person to stay at home unless they had to obtain goods or services, for care or compassionate reasons, to attend work or education or for exercise
3 April	Release of the COVID-19 Plan for the Disability Sector and guidance for family services, and family violence and sexual assault services
3 April	New Crisis Council of Cabinet and Mission Coordination Committee announced by the Premier of Victoria to enable rapid and coordinated whole of government decision-making and oversight through pandemic response
12 April	First returned travellers exit from hotel quarantine program after mandatory 14 day period
16 April	Prime Minister communicated the decision to pursue a suppression strategy, noting that this would mean Australia would continue to have outbreaks that would require ongoing rapid responses.
17 April	Emergency Operations Centre (EOC) established for Operation Soteria, led by dedicated COVID-19 Accommodation Commander.
From 2 May	All quarantined individuals (regardless of age or other risk factors) offered COVID-19 testing on day 3 and day 11 of the mandatory quarantine period
26 May	First case notified - outbreak at Rydges on Swanston
15 June	Alfred Health commenced core clinical and non-clinical leadership and support roles at COVID-19 positive hotels
16 June	First case notified - outbreak at Stamford
28 June	Changes made to legal directions to require returned travellers to undergo a further ten days of hotel quarantine if they did not engage in COVID-19 testing
30 June	Establishment of Board of Inquiry into the Victorian Government COVID-19 Hotel Quarantine Program announced

Wider departmental actions

Throughout late March and early April, the department and its administrative offices also led the development of the COVID Plan for the Community Sector, and guidance and advice for young people in care services, community health services, maternal and child health services, mental health services, neighbourhood houses and social housing, kinship and foster carers, new parents, volunteers and Aboriginal and Torres Strait Islander communities.

The department also amended the homelessness services guidelines and conditions of funding and issued fact sheets and procedural advice for specific issues, including use of PPE, diffusing tense situations during the pandemic, protective strategies to lessen the impact of COVID-19 restrictions, advice to support children and young people with learning during the pandemic, and advice on isolation management in disability accommodation services.

The CHO and the Public Health Command also provided advice to the Department of Education and Training and critical industry sectors on their own pandemic responses.

The department also released guidance for critical sectors to support their own preparedness throughout March, including:

- Updated whole of government pandemic influenza action plan (with Emergency Management Victoria)
- COVID-19 Amendment to Homelessness Services Guidelines and Conditions of Funding.

Other programs operationalised by the department during March and April included:

- Emergency relief packages
- Centralised procurement of PPE and critical supplies for the health sector.
- Temporary accommodation for people experiencing homelessness during the pandemic
- Health surveillance support for young people in residential care
- $600 payments to foster and kinship carers
- Respite and emergency contingency placements for children in care
- Extra staffing to address risk and safety concerns in residential care
- Additional resources for cleaning in residential care
- Expansion of the Home Stretch program to support young people turning 18 years and due to leave care during the coronavirus (COVID-19) pandemic
- Carer phone line to support children and families

Full chronology of Legal Directions issued

Signing date	**Direction**
16 March 2020	Non-Essential Mass Gatherings
18 March 2020	Airport Arrivals
	Mass Gatherings
19 March 2020	Cruise Ship Docking
	Revocation of Airport Arrivals
21 March 2020	Mass Gatherings (No 2)
	Visitors to Residential Aged Care Facilities
23 March 2020	Hospital Visitor Directions
	Non-essential Business Closure Directions
25 March 2020	Isolation (Diagnosis) Direction
	Prohibited Gatherings Directions
	Non-Essential Activity Directions
26 March 2020	Non-Essential Activity Directions (No 2)

28 March 2020	Revocation of Airport Arrivals Direction and Cruise Ship Docking Direction
30 March 2020	Restricted Activity Directions
	Stay at Home Directions
2 April 2020	Stay at Home Directions (No 2)
7 April 2020	Care Facilities Direction
	Restricted Activity Directions (No 2)
	Stay at Home Directions (No 3)
13 April	Hospital Visitor Directions (No 2)
	Care Facilities Direction (No 2)
	Isolation (Diagnosis) Direction (No 2)
	Restricted Activity Directions (No 3)
	Stay at Home Directions (No 4)
	Direction and Detention Notice
17 April 2020	Restricted Activity Directions (No 4)
24 April 2020	Restricted Activity Directions (No 5)
11 May 2020	Hospital Visitor Directions (No 3)
	Care Facilities Direction (No 3)
	Diagnosed Persons and Close Contact Directions
	Restricted Activity Directions (No 6)
	Restricted Activity Directions (No 7)
	Stay at Home Directions (No 5)
	Stay at Home Directions (No 6)
24 May 2020	Restricted Activity Directions (No 8)
	Stay at Home Directions (No 7)
31 May 2020	Hospital Visitor Directions (No 4)
	Care Facilities Direction (No 4)
	Diagnosed Persons and Close Contact Directions (No 2)
	Restricted Activity Directions (No 9)
	Stay Safe Directions
	Direction and Detention Notice
16 June 2020	Hospital Visitor Directions (No 5)
21 June 2020	Hospital Visitor Directions (No 6)
	Care Facilities Direction (No 5)
	Diagnosed Persons and Close Contact Directions (No 3)
	Restricted Activity Directions (No 10)
	Stay Safe Directions (No 2)
	Direction and Detention Notice
27 June 2020	Direction and Detention Notice
1 July 2020	Hospital Visitor Directions (No 7)
	Care Facilities Direction (No 6)
	Diagnosed Persons and Close Contact Directions (No 4)
	Restricted Activity Directions (No 11)
	Restricted Activity Directions (Restricted Postcodes)
	Stay Safe Directions (No 3)
	Stay at Home Directions (Restricted Postcodes)
	Area Directions
4 July 2020	Area Directions (No 2)
	Detention Direction (9 Pampas Street, North Melbourne)

	Detention Direction (12 Holland Court, Flemington)
	Detention Direction (12 Sutton Street, North Melbourne)
	Detention Direction (33 Alfred Street, North Melbourne)
	Detention Direction (76 Canning Street, North Melbourne)
	Detention Direction (120 Racecourse Road, Flemington)
	Detention Direction (126 Racecourse Road, Flemington)
	Detention Direction (130 Racecourse Road, Flemington)
	Detention Direction (159 Melrose Street, North Melbourne)
8 July 2020	Restricted Activity Directions (Restricted Areas)
	Restricted Activity Directions (No 12)
	Stay At Home Directions (Restricted Areas)
	Stay Safe Directions (No 4)
	Area Directions (No 3)
9 July 2020	Revocation Detention Direction (9 Pampas Street, North Melbourne)
	Revocation Detention Direction (12 Holland Court, Flemington)
	Revocation Detention Direction (12 Sutton Street, North Melbourne)
	Revocation Detention Direction (33 Alfred Street, North Melbourne)
	Revocation Detention Direction (76 Canning Street, North Melbourne)
	Revocation Detention Direction (120 Racecourse Road, Flemington)
	Revocation Detention Direction (126 Racecourse Road, Flemington)
	Revocation Detention Direction (130 Racecourse Road, Flemington)
	Revocation Detention Direction (159 Melrose Street, North Melbourne)
10 July 2020	Stay Safe Directions (No 5)
	Stay At Home Directions (Restricted Areas)
15 July 2020	Diagnosed Persons and Close Contact Directions