WITNESS STATEMENT OF THE HONOURABLE JENNY MIKAKOS MP

Name: the Honourable Jenny Mikakos MP

Address: Level 22, 50 Lonsdale Street, Melbourne VIC 3000

Occupation:
Minister for Health
Minister for Ambulance Services
Minister for the Coordination of Health and Human Services: COVID-19.

Date: 17 September 2020

1. I make this statement to the Board of Inquiry in response to Notice to Produce NTP-144, (**Notice**) dated 9 September 2020 (and reissued on 14 September 2020 to correct a number of typographical errors). This statement has been prepared with the assistance of my lawyers and, where appropriate, my staff.
2. This statement is based on matters of knowledge, information and belief. Where I refer to matters of which I am aware on the basis of information or belief, I believe those matters to be true and correct.

Questions

1. For what departments and agencies are you accountable as Minister?

3. The Department of Health and Human Services (**DHHS**) is administered by five ministers. I am the Minister for Health and the Minister for Ambulance Services . On 3 April 2020 I was sworn in as the Minister for the Coordination of Health and Human Services – COVID-19 in order to coordinate the government's COVID-19 response across DHHS portfolios.
4. The other Ministers of the DHHS (and their portfolios) are as follows:[1]
    a. Martin Foley, Minister for Mental Health;
    b. Richard Wynne, Minister for Housing;
    c. Luke Donnellan, Minister for Child Protection and Minister for Disability, Ageing and Carers; and
    d. Gabrielle Williams, Minister for the Prevention of Family Violence.
5. On 3 April 2020, the Premier of Victoria established a Crisis Council of Cabinet (**CCC**). The CCC was established to be the core decision-making forum for the Victorian government on all matters related to the coronavirus (**COVID-19**) emergency, including implementing the outcomes of the National Cabinet.
6. The Premier chairs the CCC, and I am one of its members in my capacity as Minister for the Coordination of Health and Human Services – COVID-19. Other CCC Ministers who were also sworn in with new portfolios at around 3 April 2020 were as follows:
    a. James Merlino: Minister for the Coordination of Education and Training – COVID-19;

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[1] See further https://www.dhhs.vic.gov.au/our-ministers.

b. Tim Pallas: Minister for the Coordination of Treasury and Finance – COVID-19;
c. Jacinta Allan: Minister for the Coordination of Transport – COVID-19;
d. Jill Hennessy: Minister for the Coordination of Justice and Community Safety – COVID-19;
e. Martin Pakula: Minister for the Coordination of Jobs, Precincts and Regions – COVID 19; and
f. Lisa Neville: Minister for the Coordination of Environment, Land, Water and Planning – COVID-19.

7. Whilst we each retained our existing portfolios, these new portfolios conferred responsibility for COVID-19 response activities undertaken by our respective departments. DHHS Ministers retained responsibility for the day to day running of their portfolios. One key change was that I would bring submissions to the CCC on behalf of other DHHS Ministers.
8. Importantly, the establishment of the CCC and the centralisation of decision-making caused a change in the reporting structure within government. Departmental Secretaries were also assigned Mission Leads and they met as a Mission Coordination Committee chaired by Chris Eccles, the Secretary of the Department of Premier and Cabinet. Insofar as the DHHS was concerned, a key change in this regard was the appointment of Kym Peake, Secretary of DHHS, to a new public sector leadership role as Mission Lead Secretary – Health Emergency. This appointment was made by the Premier on or about 3 April 2020. Ordinarily, Ms Peake (as Department Secretary) would report directly to me, and other Ministers of DHHS, where required. However, as Mission Lead Secretary – Health Emergency, Ms Peake was accountable not just to me but also directly to the Premier.

2. When did you first become aware of the Hotel Quarantine Program (HQP) plan for Victoria?

9. The first time that I can recall becoming aware of the possibility of hotel quarantine being used for returned international travellers was during a meeting of Health Ministers with the Australian Health Protection Principal Committee (**AHPPC**) on 26 March 2020. That meeting was conducted by telephone.
10. The AHPPC is comprised of all State and Territory Chief Health Officers, and is chaired by the Australian Chief Medical Officer (who, at that time, was Professor Brendan Murphy). Victoria is usually represented at the AHPPC by the Victorian Chief Health Officer (CHO), Professor Brett Sutton, or his delegate. The role of the AHPPC includes advising the Australian Health Ministers' Advisory Council (**AHMAC**) on health protection matters and national priorities.[2] The membership of AHMAC comprises the heads of the Australian Government health department, each State and Territory health department and the New Zealand health authorities, and the Australian Government Department of Veterans' Affairs.[3] The role of the AHMAC includes

[2] See further https://www.health.gov.au/committees-and-groups/australian-health-protection-principal-committee-ahppc.
[3] See further https://www.coaghealthcouncil.gov.au/AHMAC/Membership.

supporting and advising the COAG Health Council or Health Ministers meeting informally, usually by teleconference. During the pandemic it has been the practice for either the AHPPC or more recently, its Chair, the Australian Chief Medical Officer, to brief Health Ministers about upcoming items of relevance to be considered by the National Cabinet.

11. During the 26 March 2020 meeting of Health Ministers with the AHPPC, Professor Murphy raised the concept of hotel quarantine for returned international travellers during his briefing about the issues to be discussed by the National Cabinet at its meeting the following day. At that time, the concept was only referred to at a high level, and it was not raised specifically in the context of Victoria but rather, was raised with all Commonwealth, State and Territory Ministers on the call. Professor Sutton was also present at that meeting but I do not recall him raising any concerns about this proposal.
12. I understand that the National Cabinet agreed on 27 March 2020 that a hotel quarantine program would be established for returned travellers, and that the Premier publicly announced that Victoria would establish such a program (the **HQP**) soon after that meeting concluded. There was no discussion by the Victorian Cabinet about the proposal prior to the National Cabinet decision.

3. What role did your departments and agencies play in the HQP?

13. The HQP was specifically for the quarantine of returned international travellers. It is important, when considering the HQP, to understand that it formed part of a broader approach to using hotels for COVID-19 quarantine in Victoria.
14. On or about 8 April 2020, as a member of the CCC, I learned that the Expenditure Review Committee of Cabinet (**ERC**) had, on 20 March 2020, approved $80 million for the Minister for Jobs, Innovation and Trade to secure and operate up to 5,000 hotel rooms and other accommodation. I also learned that the Department of Jobs and Priority Precincts (**DJPR**) went on to secure 4,870 hotel rooms across 23 providers by around the first week of April 2020.
15. I am not a member of the ERC. However, when I became aware of its decision to approve expenditure on hotel rooms, I sought to secure the use of some of the hotel accommodation for healthcare workers who may have needed to isolate by reason of COVID exposure or infection. This ultimately became the “Hotels for Heroes” program, which had been announced by the Premier and myself on 5 April 2020, and which provided emergency accommodation for healthcare workers (it was later broadened to include other frontline workers, who were required to quarantine or self-isolate, but who were unable to do so in their own homes).
16. Hotel accommodation was also made available for an emergency relief accommodation program for vulnerable members of the Victorian community who were unable to effectively quarantine or self-isolate in their own homes due to family violence or other reasons.
17. Sometimes these three programs (either individually or collectively) were referred to as the “COVID-19 Emergency Accommodation” (or “CEA”) program. The key difference between the “Hotels for Heroes” and emergency accommodation program for vulnerable cohorts on the one

hand, and the HQP on the other hand, was that the first two programs were almost always voluntary in nature, without a detention notice being put in place. For the avoidance of doubt, in this statement, when I refer to the HQP, I am referring only to the hotel quarantine program for returned international travellers.

18. I understood the HQP to be a multi-agency response with shared accountability. On 10 March 2020, the Premier and I joined Emergency Management Commissioner, Andrew Crisp, at the State Control Centre (**SCC**) to announce that the SCC had been activated to oversee and coordinate the State's COVID-19 pandemic response, with the objective of making the SCC the focal point to our response in order to help agencies better collaborate and ensure that key intelligence, mapping, planning, logistics and public information resources were available as and when they were needed. As a result, after the HQP was announced by the Premier, I understood the HQP to be coordinated out of the SCC with all relevant agencies working together on this multi-agency response.
19. Until the entire HQP transitioned to the Department of Justice and Community Safety (**DJCS**) from about July 2020 onwards (which I address further below in my response to questions 28 to 31), I understood that the DHHS's role in the HQP was essentially to (a) facilitate the legal framework for the HQP by issuing detention notices and (b) to provide health and wellbeing services to returned travellers participating in that program. I address these functions in turn.
20. In respect of the first point, the necessary powers to detain an individual for the purposes of the HQP could only occur after a series of steps had been taken under the *Public Health and Wellbeing Act 2008* (Vic) (**PHW Act**), including my declaring of a state of emergency under s 198, and the Chief Health Officer, under s 199, authorising authorised officers to exercise the relevant emergency powers under the PHW Act, including the power to detain under s 200.
21. In respect of the second point, by "health and wellbeing services" to support returned travellers, I am referring to those health and wellbeing aspects of the HQP, such as contracting GPs and other physicians such as Field Emergency Management Officers, nurses, mental health nurses and social workers through a Complex Assessment and Response Team and making the DHHS' child protection and family violence workers available, if required.

4. Did their role change over time? If so, please give details.

22. I was first briefed by the DHHS public health team about potential Infection Prevention Control (**IPC**) issues with the HQP after the outbreak at the Rydges Hotel on 26 May 2020.
23. I believe I spoke with the DHHS Secretary, Kym Peake, on or about 30 May 2020, about the Rydges outbreak, and that at that time, she recommended that Alfred Health be brought into the HQP to play:
    a. an advisory role for IPC for all hotels being used in the HQP;
    b. a clinical governance role in respect of health and wellbeing issues for all hotels being used in the HQP; and

   c. both clinical and non-clinical governance roles in running the so-called "hot hotel", where returned travellers diagnosed with COVID-19 were detained.

24. I endorsed this recommendation.
25. After the Stamford Hotel outbreak (which occurred in mid-June 2020), I requested that efforts be made to convince other government agencies on alternatives to the use of private security guards in the HQP. As the DHHS had no relevant contractual levers, no relevant funding levers nor an alternative workforce available at its disposal, it was critical that the DHHS worked with the SCC and other departments on this. As a result, on 24 June 2020 Deputy Secretary of the DHHS, Melissa Skilbeck developed options for consideration by government agencies that involved a mixture of predominantly Victoria Police, Alfred Health and other health services staff, Protective Services Officers (**PSO**s), Sheriffs, and a small number of Australian Defence Force (**ADF**) personnel. This proposal was set out in an options paper dated 24 June 2020, entitled 'Operation Soteria- Quarantine Hotels Options Analysis', forwarded to me by Kym Peake by email that same day, which document is produced under cover of this statement as **MIK.0144.0002.0001**.
26. Also at around that time, I formed the view that the multi-agency response to the HQP meant there were "too many cooks spoiling the broth", and I worked to have all aspects of the program moved to one department, being the DJCS. As stated in the previous paragraph, it was apparent to me that the DHHS lacked any contractual levers with either the hotels or security contractors and that this was a significant weakness in how the program had been structured. I supported the transition of the HQP (along with the Hotels for Heroes and the vulnerable cohort quarantine program) to one agency who would be responsible for running all aspects of that program.
27. Following a decision by the CCC on 27 June 2020, the overall responsibility for the HQP was transferred to the DJCS from about July 2020 onwards (which transition I address further in response to questions 28 to 31). I understand that, as part of this transition, all contracts between the DJPR and hotels and security contractors have been transitioned or are being transitioned to the DJCS. In a similar manner, all health services contracts have been transitioned or are being transitioned from the DHHS to the DJCS. In addition, certain powers of the Minister for Health, the Secretary of the DHHS and the DHHS were designated (by Government Gazette S 347 dated 9 July 2020) to the Attorney-General, the Secretary of the DJCS and the DJCS, respectively, which had the effect of facilitating the transfer of certain legislative powers to the DJCS.

5. Which government department or agency did you understand had overall responsibility for the structure and operation of the HQP? How did you come to your understanding? If the position changed over time, please specify.

28. As stated in answer to question 3 above, I understood the HQP to be a multi-agency response with shared accountability between those departments and agencies involved. In so far as the position changed over time, I refer to my answer to question 4 above.

6. Why, as you understood it, was overall responsibility for the structure and operation of the HQP allocated to that department or agency?

29. As I was not involved in approving the governance, structure, funding or operational plan of the HQP at the time it was established I am not able to answer this question.

Events prior to 27 March 2020

7. Were you consulted about the decision to appoint someone other than the Chief Health Officer to the role of State Controller on 1 February 2020?

30. I was not consulted on the initial appointment of the State Controller (or on any subsequent changes to this appointment) until Kym Peake, Secretary of DHHS, was appointed to that role on about 27 July 2020.

8. After the declaration by you of a state of emergency on 16 March 2020 did you receive any briefings or advice about the ongoing appropriateness of persons other than the Chief Health Officer holding that role? If so, what were the contents of those briefings or advice?

31. No. I refer to my response to question 7 above.

9. When you signed off on Victoria's COVID-19 Pandemic Plan for the Victorian Health Sector on 10 March 2020, were you in possession of any advice about the state of planning for the risk posed to the Victorian community by Australians returning from international travel? If so, what was that advice?

32. The COVID-19 Pandemic Plan for the Victorian Health Sector (**COVID Pandemic Plan**) was designed to guide the Victorian health sector in its preparation for and response to COVID-19. Prior to approving the COVID Pandemic Plan, I had been briefed on modelling scenarios that did not specifically reference the risks posed by returned travellers other than to identify source countries of contemporary cases.

    From the start of the COVID-19 pandemic, I was advised in verbal briefings with DHHS officials, including by the CHO and other officials from the Public Health Unit, about the risk posed to Victoria by international travellers introducing the virus to our State. I was monitoring the spread

of the virus in Victoria, across Australia and internationally closely, and was concerned that our borders were not shut quickly enough to certain "hot-spot" countries such as the United States. The increasing number of cases in our community in March clearly demonstrated that Australians returning from international travel posed a public health risk to their fellow Australians if they did not isolate for the 14-day incubation period of this virus. At that time, I was particularly focused on ensuring hospital preparedness and increasing the size of the public health team.

10. At the time that the attached directions of 16 and 18 March 2020 were issued, did you consider they were sufficient to meet and mitigate that risk? Why or why not?

33. I am aware that on 15 March 2020, the Prime Minister announced a decision of the National Cabinet that from 11:59 pm on Sunday 15 March 2020, all international arrivals would be required to self-isolate for 14 days upon arrival in Australia.
34. Separately, on 15 March 2020, I received advice from the CHO that there was a serious, and potentially catastrophic, risk to public health in Victoria posed by COVID-19. That advice is produced under cover of this statement as **MIK.0144.0003.0001**. The Chief Health Officer's advice recommended the declaration of a state of emergency under the PHW Act. That advice did not address the risk specifically posed by returning international travellers in any detail. It did, however, observe at page 5 that:

    Early evidence suggests measures such as quarantine, contact tracing, infection prevention and control interventions will assist to control spread, minimise morbidity and mortality, delay and reduce the epidemic peak and preserve health resources.

35. On this advice, and following consultation with the Minister for Police and Emergency Services, Lisa Neville MP, and the Emergency Management Commissioner, Andrew Crisp, I formed the view that it was appropriate to declare a state of emergency arising out of the circumstances caused by COVID-19, which were causing a serious risk to public health. I did not make that decision with a view to establishing the HQP, as no such proposal had been put to me at that time (as stated above, I first learned of the possibility of a hotel quarantine program on 26 March 2020). I made a declaration of a state of emergency on 16 March 2020 pursuant to s 198 of the PHW Act, effective from 12:00 pm that day for a period of four weeks. That declaration has been extended on a number of occasions since 16 March 2020.
36. From the time that I first declared a state of emergency on 16 March 2020, the Chief Health Officer and/or others authorised by him pursuant to s 199 of the PHW Act have issued a number of directions pursuant to the PHW Act. For example, on 16 March 2020, a direction was issued that required international traveller returnees (with some exceptions) to self-isolate for 14 days in premises in which it was suitable for them to reside for that period. I understand that on 18 March 2020, the aspect of that direction dealing with the self-quarantine of international arrivals was re-issued.

37. The power to make a legal direction vests in the CHO and others authorised by him under the PHW Act. I have never been required to give my formal endorsement of any legal direction proposed to be made by the CHO or persons authorised by him. Given the specialist public health knowledge and expertise of those issuing these directions, and the 15 March 2020 decision of the National Cabinet, I considered the 16 and 18 March 2020 directions to be appropriate to meet the risk posed by international arrivals at that time. That said, as a result of the matters referred to in my response to question 11 below, my view changed between the making of those directions, and the further CHO direction that was made on 28 March 2020.

11. In the period 16 March to 27 March 2020 were you in possession of any information or advice that the self-isolating directions were not operating effectively? If so, please give details.

38. On 16 March 2020, only two cases were recorded in Victoria as having an unknown source. By 27 March 2020, that number had risen to 16.
39. In my view, the existence of diagnosed cases in the community at this time from people who had not themselves returned from overseas suggested either that there was an unreasonable delay to shut our international borders or that some travellers were not complying with isolation requirements, or both. My view in this regard was supported by media reports from around 26 March 2020 that some returned travellers were not at home when Victoria Police performed 'spot checks' to ensure that they were complying with their isolation requirements. Further, I believe (but I cannot presently recall with certainty) that around this time I was also advised by my department officials of particular cases where individuals who were meant to be self-isolating were found not to be at home. By 27 March 2020, I perceived that there was a risk of non-compliance by returned travellers with self-isolation requirements.

12. In the period from 16 March to 27 March 2020 was any consideration given by you or, to your knowledge, others within government to strengthening the enforcement regime of self-quarantining at suitable residential premises?

12.1. If yes, please provide details.

12.2. If no, why did you not give consideration to that option?

40. I refer to my response to question 11, above. I believe (but I cannot presently recall) that I raised the need for more police checks to occur at the homes of people who were self-isolating to ensure that they were complying with self-isolation requirements in my discussions with my department officials during this time.
41. Insofar as the enforcement of self-quarantining is concerned, I understood that the CHO had formally requested the assistance of Victoria Police in enforcing the self-isolation regime.
42. Insofar as the enforcement of self-quarantining is concerned, I understood that in March 2020, the CHO formally requested the assistance of Victoria Police in enforcing the self-isolation

regime. The formal request to this effect dated 29 March 2020 is produced under cover of this statement as **MIK.0144.0004.0001**.

13. As at 27 March 2020 did you consider a hotel-based quarantine program was necessary to meet the threat posed by the pandemic?

43. On 27 March 2020, the National Cabinet announced that by no later than 11:59 pm on Saturday 29 March 2020, all travellers arriving in Australia would be required to undertake their mandatory 14-day self-isolation at "designated facilities" such as hotels.
44. On 28 March 2020, the Deputy CHO issued a direction requiring overseas travellers arriving at a Victorian airport or port to be detained at an assigned hotel room for a period of up to 14 days.
45. By this time, although I was not involved in the National Cabinet decision itself, I believed that the risk to the community posed by the COVID-19 pandemic necessitated the HQP being put in place. The increasing number of returned travellers to Victoria in March 2020 together with the increasing number of diagnosed cases recorded in Victoria during this period (referred to in my response to question 11 above), clearly suggested that some travellers were not complying with the need to self-isolate.

14. If yes, what if anything changed from 16 March to 27 March 2020 to make a hotel quarantine program the necessary path to meet the challenge?

46. As stated above, the decision ultimately taken on 27 March 2020 was by the National Cabinet. I am not a member of the National Cabinet. There was no discussion about the establishment of the HQP by the Victorian Cabinet prior to it being announced. However, the relevant change in circumstances that occurred between about 16 March and 27 March 2020 is set out in my responses to questions 11 and 13 above.

15. As at 27 March 2020, to your knowledge did Victoria have any existing plans for the mass quarantine of returning travellers in hotels? If so, what were those plans?

47. Not that I was aware of. I refer to my answer to question 9 above.

16. At any time after 27 March 2020 did you consult with counterparts in other States about how a hotel based quarantine program might be set up? If so:

16.1. what information or advice did you receive from your counterparts; and

16.2. what if any changes did you make or cause to be made to the Victorian model in light of that information or advice?

48. During the COVID-19 pandemic, I have had regular informal meetings with my State, Territory and federal counterparts. At present, these meetings occur fortnightly, but previously they occurred weekly (typically in advance of the National Cabinet meetings).
49. Ordinarily, during these meetings, Australia's Chief Medical Officer provides a report from the AHPPC, the federal Minister for Health provides a report, and each State and Territory Minister for Health is also given an opportunity to report on their jurisdiction.
50. Prior to July 2020, I do not recall specific consultations with other State or Territory health ministers regarding a HQP, other than the initial discussion on 26 March 2020 to which I refer in my response to question 2 above. In about July 2020, the Chief Medical Officer briefed the State and Territory health ministers about a national review into Australia's hotel quarantine arrangements during the COVID-19 pandemic to be conducted by Jane Halton.

Establishment of the Hotel Quarantine Program

17. Did you attend meetings and/or receive briefings in the period 27 to 29 March 2020 at which the proposal for a HQP or its proposed structure and lines of accountability were discussed? If so:

17.1. What were those meetings, and who was present?

17.2. Who gave you the briefings?

51. No. During the period 27 to 29 March 2020, I was not part of any meeting nor did I receive any briefing, on the proposed structure or lines of accountability for the HQP.

18. Did you yourself play any role in the initial decision making regarding the structure and lines of accountability for the HQP? If so, please give details.

52. No. I did not play any role in the initial decision-making regarding the structure and lines of accountability for the HQP.

19. Were you consulted or involved in the decision to establish the Department of Health and Human Services (DHHS) as the control agency for Operation Soteria? Did you agree that the designation of DHHS as the control agency was appropriate?

53. No, I was not consulted about the structure of or operational plan for Operation Soteria prior to its establishment.
54. Separately, under the *Emergency Management Act 2013* (Vic), the COVID-19 pandemic as a whole is a 'Class 2' public health emergency. The COVID Pandemic Plan to which I refer in my response to question 9 above relevantly states, on page 3:

> *The Victorian Government Department of Health and Human Services (DHHS) is the control agency for this Class 2 public health emergency[1] and will take urgent action under legislation including the Public Health and Wellbeing Act 2008, Emergency Management Act 2013 and Commonwealth Biosecurity Act 2015 to safeguard the health and wellbeing of all Victorians.*

55. Footnote 1 to this paragraph states (emphasis added):

> *A Class 2 emergency is a major emergency that is not a Class 1 emergency or a warlike act or act of terrorism. (Class 1 emergencies are either major fires or emergencies with MFB, CFA or SES as control agency).* ***The response in a Class 2 emergency is a collaboration across the health sector, government agencies and the community.***

56. Accordingly, whilst the DHHS was designated as the control agency for the overall COVID-19 pandemic response in Victoria, this meant it had a coordinating role across numerous government departments and agencies in responding to the health emergency. This is because COVID-19 is a complex public health emergency that has required collaboration between departments and agencies, and shared accountability. The fact that the DHHS is designated as the control agency for the pandemic response as a whole did not mean that the DHHS was running Operation Soteria.

20. Pursuant to the Emergency Management Act 2013 (Vic) and the Emergency Management Manual Victoria, DHHS is constituted as the Control Agency (being the agency with primary responsibility for responding to the emergency) for human disease emergencies.

20.1. Did you understand DHHS to be the control agency in a Class 2 health emergency such as COVID-19?

20.2. What did you understand that role of control agency to involve?

20.3. How did you understand DHHS' role as the control agency under emergency management structures to relate to yours and the Chief Health Officer's roles under the Public Health and Wellbeing Act 2008 (Vic)?

57. In respect of questions 20.1 and 20.2, I refer to my response to question 19, above.
58. In response to question 20.3, my role under the PHW Act is principally concerned with the power to declare a state of emergency under s 198 (as referred to in my response to question 10 above). I receive advice from (among others) the CHO as a pre-requisite to making any such declaration.
59. The CHO has a designated statutory function under the PHW Act. As referred to in my response to question 10 above, I do not direct the CHO in the exercise or enforcement of his statutory powers.
60. The role of the DHHS and my role as the Minister responsible for the Coordination of Health and Human Services – COVID-19 has been to work across government to secure a $1.9 billion investment for health system preparedness, and then to work with health services to implement that investment. For example, this has involved expanding the DHHS public health team, securing more ICU beds through necessary infrastructure projects, securing much sought-after medical equipment such as ventilators and PPE for hospitals and entering into arrangements with the private hospital system to utilise their beds and workforce.

21. Questions asked and submissions made on behalf of DHHS in the Board's public hearings suggest a view that DHHS was not in fact the control agency or that control was shared:

21.1. Is that a view you hold or of which you are aware?

21.2. If you hold that view, why?

61. In response to this question, I refer to my responses to questions 3, 19 and 20 above.
62. Specifically in respect of the HQP, I understood it to be a multi-agency response with shared accountability. Whilst the DHHS was designated as the control agency for the overall COVID-19 pandemic response in Victoria, this meant it had a coordinating role across government departments and agencies in responding to the health emergency and this did not mean that the DHHS was running the HQP.

22. Was any consideration given to the use of hospitals or health facilities to accommodate travellers who tested positive to COVID-19? If not, why not? If so, why was the decision taken not to transfer COVID-19 positive travellers to such a health facility?

63. Early in the COVID-19 pandemic (after the State's first diagnosed cases in January and February 2020), I was initially keen to ensure that any affected patients were hospitalised. However, I recall receiving verbal advice at around that time from my DHHS officials to the effect that hospitalisation should occur only if there was a clear clinical need to do so, as we would soon be unable to hospitalise every diagnosed case when numbers increased.
64. To this end, the advice that I received from the CHO dated 15 March 2020 (referred to in paragraph 34 above, MIK.0144.0003.0001) stated, at paragraphs 29 to 30 on page 4 (.0004), that:

    Current modelling suggests that at the peak of a moderate severity epidemic over 120,000 infections will be occurring in the Victorian community daily, with approximately 13,000 people seeking healthcare daily, 580 requiring hospitalisation daily, and of those, 145 requiring Intensive Care Unit admission daily.

    At the peak of a moderate severity epidemic, modelling estimates that 5,112 people will be admitted to hospital and, of these, 1,273 people will be admitted to Victoria's Intensive Care Units for 2019-nCoV cases […]
65. That document further stated, at paragraph 39 on page 5 (.0005), that:

    The current best available international evidence and modelling indicates that throughout Victoria, in a severe scenario, if the mitigating steps are not taken, in the next four months 54,939 people will require hospitalisation across the epidemic, with 12,552 in hospital at peak and 1,556 daily hospital admissions at the peak […]
66. Accordingly, a key focus for me at that time was on planning for more intensive care beds, and negotiating an agreement to utilise the beds and staff of our State's private hospitals. Further, I was advised at that time that it was clinically unnecessary to hospitalise every diagnosed case, as most people experienced only mild symptoms which made it suitable for them to recover at home (with appropriate medical support, where required).

23. When were you first aware of a decision to engage private security contractors as part of the HQP?

67. I was not part of any decision-making process to use private security contractors as part of the HQP.
68. I believe I first became aware of the use of private security guards contracted by DJPR in the HQP after the Rydges outbreak occurred in late May 2020. In particular, at around that time, I was advised by the DHHS public health team that the private security contractors engaged to participate in the HQP had the contractual responsibility to provide personal protective equipment (**PPE**) and infection prevention and control training to their staff.

24. Who made the decision to engage private security contractors?

69. I was not part of any decision-making process to use private security contractors in the HQP. I do not know who made this decision.

25. What was the rationale for that decision as you understood it?

70. I refer to my answer to question 24 above. I do not have any direct knowledge of the rationale for that decision.

26. Did you yourself have a view as at 27-29 March 2020 on the appropriateness of using private security as the front line of security in the HQP? If so, what was that view and what if any steps did you take to have that view taken into account in the establishment of the program? If your view was that it was not appropriate, why was the decision nevertheless taken that private security should be engaged?

71. I refer to my answer to question 23 above.

27. Knowing what you know now, do you support the engagement of private security contractors in any future iteration of a Hotel Quarantine Program? Please give reasons for your view.

72. No, I would not support the engagement of private security contractors in any future iteration of the HQP. COVID-19 is a highly contagious virus that has challenged many workforces. I am aware of healthcare workers in hospitals with years of experience in IPC, and wearing higher levels of PPE, nevertheless becoming infected, as have clinicians from the ADF working at testing sites wearing PPE, as have members of Victoria Police wearing PPE.
73. In my view, there is no “silver bullet” workforce to respond to the risk of a highly-contagious virus but there is an unacceptable risk in using a largely unskilled and casualised workforce, as we have seen recently also in the private aged care sector.

28. The Board understands that a view was reached in late June 2020 within DHHS that the private security guards being used in the HQP should be replaced.

28.1. Did you hold that view?

28.2. Were you briefed or otherwise involved in discussions regarding that view?

74. As stated in response to question 4 above, following the Stamford outbreak in mid-June, I communicated to Kym Peake and other officials within the DHHS that it was my very strong view that the private security contractors in the HQP needed to be replaced as soon as possible with an appropriate alternative workforce. I requested that the DHHS develop options on an alternative workforce to security guards and that it do so in consultation with other relevant agencies involved in the multi-agency HQP response.

75. Also in my response to question 4 above, I refer to the options paper provided to me by Deputy Secretary Melissa Skilbeck on about 24 June 2020 (MIK.0144.0002.0001). I understand that Ms Skilbeck's proposed options were not supported by other parts of government.
76. Ultimately, on 27 June 2020, the CCC decided that full responsibility for the HQP (as well as the "Hotels for Heroes" program and the emergency accommodation program for vulnerable Victorians program) would all be transferred to the DJCS from about July 2020 onwards, and that the role of private security contractors in the HQP would mostly be replaced by Corrections Victoria staff.

29. Were you aware that on 24 June 2020 the Emergency Management Commissioner made a request for 850 Australian Defence Force (ADF) members to perform the security role in the HQP? If so:

29.1. When were you first so aware;

29.2. What discussions did you have and/or briefings did you receive regarding the proposed request; and

29.3. What was your view about the appropriateness of using ADF members in the HQP?

77. I became aware that a request was made by Emergency Management Commissioner Andrew Crisp to the ADF for security support in the HQ program on 25 June 2020, following media reports of this request. I was not involved in this request.
78. Personally, I did not have any concerns about use of the ADF in the HQP. ADF personnel had already been used successfully by the DHHS at testing sites, to train and supervise contact tracers as we were significantly growing the contact tracing team at that time, and in logistics roles at the SCC. I supported the transition of the program to DJCS and the use of Corrections Victoria staff as outlined in paragraph 76 above.

30. The Board is aware that the request referred to in question 29 was later withdrawn on the basis that Victoria Police and Protective Services officers might be available instead. In that context:

30.1. What discussions did you have and/or briefings did you receive regarding the potential use of Victoria Police members and Protective Services Officers to perform the roles being performed by private security;

30.2. What was the content of those discussions; and

30.3. Why were Victoria Police members and Protective Services Officers not ultimately used?

79. I refer to my responses to questions 28 and 29 above.
80. Also in my response to question 4 above, I refer to the options paper provided to me by Deputy Secretary Melissa Skilbeck on about 24 June 2020 (MIK.0144.0002.0001). As stated above in response to question 28, I understand that Ms Skilbeck's proposed options were not supported by other parts of government.

31. Were you party to discussions regarding a proposed and then actual transfer of responsibility for security in the HQP to officers from Corrections Victoria? If so:

31.1. What were those discussions;

31.2. Did you agree with the decision to transfer responsibility to Corrections Victoria?

81. I refer to my response to question 28 above.
82. The decision to use Corrections Victoria staff was made by the CCC on 27 June 2020. I supported this decision, enthusiastically, in the absence of any suitable alternative option.

Reflections in light of events

32. Knowing what you know now, do you continue to support:

32.1. Mass quarantining for all returning travellers?

32.2. Mass quarantining in hotels (as opposed to a different facility or environment)?

83. As a general principle, I continue to support the mass quarantining of returning travellers in some form. This is because I consider the probability that a small minority of returned travellers will not properly comply with a self-isolation direction and will continue to pose an unacceptable risk to Victorians in the context of (a) significant infection levels globally, and (b) the absence of an available safe and effective vaccine for COVID-19.
84. That said, it may not be necessary to quarantine all returning travellers. In addition to the matters to which I refer in my response to question 34, below, it may be possible in future to establish 'bespoke' arrangements for travellers from low-risk nations (namely, with no or low rates of COVID-19 infection), such as New Zealand.
85. It may also be possible to utilise technology to establish alternative approaches. For example, I am aware that Singapore introduced a GPS-enabled wrist-band in mid-August 2020 that allows returned travellers to isolate at home. However, if such alternative approaches are to be considered, returned travellers would need to accept necessary and appropriate intrusions on their privacy to ensure the effectiveness of such an approach (given how highly contagious this virus is, how prevalent it remains internationally and the absence of a safe and effective vaccine).
86. I support an approach to minimise risk as much as possible, understanding that eliminating all risk altogether is probably impossible.

33. If you do, why? If you do not, why not?

87. I refer to my response to question 32 above.

34. Knowing what you know now, would you support mass quarantining for all returning travellers, irrespective of:

34.1. Pre-existing physical and mental health conditions;

34.2. Drug and alcohol dependencies; and

34.3. Other individual vulnerabilities (including vulnerability to family violence)?

88. There are significant challenges associated with screening for relevant pre-existing conditions, dependencies or vulnerabilities in returned travellers prior to their arrival. This might mean the need for at least an initial period of detention to enable that screening to occur prior to alternative arrangements being put in place for specific individuals.
89. Further, I am aware that some exemptions were sought during the period of operation of the HQP by or on behalf of returned travellers with specific health needs or conditions. My knowledge in this regard comes from correspondence that I received from other MPs from time to time, advocating on behalf of a constituent who sought to be exempted from the HQP. Those matters were all referred to the compliance and enforcement team for a decision by an authorised officer (as I do not have any relevant legislative power to grant an exemption or decide on alternative quarantine arrangements under the PHW Act). I am aware that a small number of travellers with health issues, such as people recovering from cancer, were allowed to quarantine at home.
90. However, the purpose of a quarantine program would be undermined if it had so many exemptions to its requirements as to effectively become meaningless. Further, if international travel were to resume in significant volumes in this context, an enormous policy and logistical challenge would be involved in designing and implementing arrangements suitable to meet everyone's individual circumstances. If mass quarantine in some form were used in such circumstances, I would expect there to be a clear process by which travellers could continue to apply for an exemption based on matters such as those referred to in the question, and for that application to be assessed by medical and other decision-makers as appropriate.

35. If you do, why? If you do not, why not?

91. I refer to my answer to question 34 above.

36. Do you consider the current quarantine program being run at the COVID-19 hotel being overseen by Alfred Health is the right model for any future quarantine program for returning travellers?

92. I was very supportive of Alfred Health playing an advisory role for all of the HQP hotels on IPC and a governance role for the "hot hotel", as referred to above. Health services have a daily operational role in dealing with IPC issues, such that they have relevant expertise in this area (and they themselves have faced challenges in this respect given high levels of community

transmission, despite having specialist training and abundant PPE available to them). I support Alfred Health or another health service continuing its current important role in the HQP.

93. However, as COVID-19 infections decline and hospitals seek to resume elective surgery and attend to deferred care by patients, I note that it will be important to ensure that Alfred Health (or any health service) is not being asked to assume significant additional responsibilities, such as running all of the hotels established for the HQP, vulnerable Victorians and infected healthcare workers, that might otherwise interfere with their increasing non-COVID-19 workload.

37. What are the key differences between the model referred to in the previous question and that adopted at quarantine hotels prior to the implementation of this model?

94. I refer to my response to question 36, above. In my view, a critical difference is that Alfred Health has brought well-established and in-depth IPC expertise to their role in the HQP.

38. The Board understands that there was a transfer of responsibility for the Hotel Quarantine Program to the Department of Justice and Community Safety on and from 1 July 2020.

38.1. What were the reasons for this transfer?

38.2. Was the transfer appropriate in your view? Why or why not?

95. I refer to my responses to questions 3 to 4 and 28 to 31 above.

39. In your view, was DHHS, as the department with health expertise, the appropriate department to have control responsibilities for the HQP? Why or why not?

96. I refer to my responses to questions 19 and 20.

Legislative change

40. Information available to the Board suggests that some elements of the HQP were driven or influenced by the particular legislative arrangements in place in Victoria. To the extent that is the case, what is your view about possible legislative changes to:

40.1. Expand the range of persons who can act as authorised officers under the Public Health and Wellbeing Act 2008 (Vic) (for instance, to include Victoria Police members, Protective Service Officers, or ADF members);

40.2. Amend the process and preconditions for compulsory testing for infectious diseases under the Public Health and Wellbeing Act 2008 (Vic);

40.3. Deal with any other limitation imposed by present legislation on how the Hotel Quarantine Program was able to be established and run?

97. Any legislative change following this Inquiry would ultimately have to come before Cabinet, of which I am a member. I feel it would be inappropriate for me to pre-empt that Cabinet process (or the outcome of this Inquiry, which has had the benefit of hearing from many different stakeholders) by expressing any personal view about these matters now.
98. However, I make the following observations:
    a. I understand that recruiting sufficiently large numbers of suitable people to act as authorised officers has been a challenge during the COVID-19 pandemic. The Victorian government is currently considering legislative amendments to address this issue. In the interim, it has been necessary to rely upon measures available upon the declaration of a 'state of disaster' under the *Emergency Management Act 1986* (Vic) in order to expand the range of persons who can act as authorised officers to include members of Victoria Police, PSOs and ADF members.
    b. I would also support making it easier to mandate compulsory testing for infectious diseases for particular groups of people where it is determined to be appropriate to do so.
    c. Finally, my personal view is that after this pandemic, there should be a wide-ranging review of the adequacy of the PHW Act to respond to global pandemics on this scale.

Additional information

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

99. The COVID-19 pandemic is a global health emergency that is unprecedented in our lifetimes. I acknowledge that this second wave has inflicted great suffering on Victorians. I am grateful for, and humbled by, their steadfastness and resilience.

Signed at Melbourne

in the State of Victoria

on 17 September 2020

The Honourable Jenny Mikakos MP