BOARD OF INQUIRY INTO THE COVID-19 HOTEL QUARANTINE PROGRAM

WITNESS STATEMENT OF PROFESSOR EUAN WALLACE AM

Name: Euan Wallace

Address: Level 1, 50 Lonsdale Street, Melbourne, Vic, 3000

Occupation: CEO, Safer Care Victoria

Date: 2 September 2020

1. I make this statement to the Board of Inquiry in response to **NTP- 119,** the Notice to produce a statement in writing (**Notice**). This statement has been prepared with the assistance of lawyers.

ROLES AND RESPONSIBILITIES

1. Please describe your relevant professional experience and qualifications.

2. I hold the following qualifications:

   (a) Bachelor of Medicine and Bachelor of Surgery (MBChB);

   (b) Doctor of Medicine (MD);

   (c) Fellow of the Royal College of Obstetricians and Gynaecologists;

   (d) Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists; and

   (e) Fellow of the Australian Academy of Health and Medical Sciences.

3. My relevant professional experience includes:

   (a) since 2017, Chief Executive Officer of Safer Care Victoria (subject to my present secondment referred to in paragraph 5);

   (b) 2006-2016, Director of Women's Health Services at Monash Health. In that role I oversaw the growth of Monash's services to become Victoria's largest maternity service and introduced advanced clinical governance structures and functions for maternity services;

   (c) at Monash University, I am a senior clinical academic, heading Australia's foremost perinatal research cluster and have held the following positions:

(i) since 2013, Head of Department of Obstetrics and Gynaecology;

(ii) 2010-2013, Director of The Ritchie Centre, Monash Institute of Medical Research (now Hudson Institute of Medical Research)

(iii) since 2006, Carl Wood Professor. This is a personal chair named in honour of the inaugural head of department of obstetrics and gynaecology at Monash University;

(iv) 2000 – 2006, Associate Professor in the Department of Obstetrics and Gynaecology;

(v) 1997 – 2000, Senior Lecturer; and

(vi) 1996, Fellow in Maternal-Fetal Medicine.

4. Unrelated to my role at SCV, since 2007, I have been the inaugural and only chair of the Fetal Surveillance Education Program steering committee of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, overseeing provision of training to midwives and doctors across Australia and New Zealand. I have over 370 scientific peer-reviewed publications and, prior to joining SCV, have sat on a number of committees, including ministerial advisory committees related to maternity services.

5. Since 20 July 2020, I have been on secondment to the Department of Health and Human Services (**Department**) as a Deputy Secretary, Case Contact and Outbreak Management in the COVID-19 Public Health Command. My substantive role is CEO, Safer Care Victoria (**SCV**). During my secondment, I am not acting in the position of CEO and an Acting CEO, Associate Professor Ann Maree Keenan, is performing the role.

2. What is Safer Care Victoria and what is its function?

6. SCV was established in January 2017 as an explicit response to a review of hospital safety and quality assurance in Victoria, 'Targeting zero: supporting the Victorian hospital system to eliminate avoidable harm and strengthen quality of care', published in October 2016.

7. SCV is the peak state authority for quality and safety improvement in healthcare. It oversees and supports health services to provide safe, high-quality care to patients.

8. SCV operates as an Administrative Office in relation to the Department under Section 11 of the *Public Administration Act* 2004 (Vic) and in accordance with the statement of expectations of the Minister for Health, that describes the objectives and functions of SCV and that it should perform those functions with independence and accountability.[1]

[1] Letter from Minister for Health, 2 October 2017, SVC.0001.0003.0010.

9. SCV is a quality improvement safety agency.

10. SCV focuses on five priority areas: partnering with patients, families and carers; partnering with clinicians; leadership; review and response; and improvement and innovation in performing the below functions:

    (a) clinical excellence – to identify and implement target improvement projects; develop and implement clinical guidance; provide training and support of leadership for quality and safety;

    (b) patient safety – monitor sentinel events, review system and safety issues, and support independent review of deaths and hospital acquired complications;

    (c) system and safety assurance – to analyse health service data, respond to emerging safety issues and support and train sector leaders; and

    (d) improvement – to advise on healthcare improvement, consumer involvement, and lead major improvement programs.

3. What is your role within Safer Care Victoria and what are you responsible for?

11. I am the Chief Executive Officer of SCV. In that office I am responsible for the overall leadership of SCV, including its strategic and corporate planning, and the planning and implementation of quality and safety improvement priorities across the State's health systems. In collaboration with the Department, I am responsible for leading the ongoing development and implementation of safety and quality systems that inform, report, and improve health service performance.

12. I am also a member of Executive Board of the DHHS, providing leadership and advice to the Secretary across broader health domains. As a member of the Interjurisdictional Committee of The Australian Commission for Safety and Quality in Healthcare (ACSQHC), and of the Clinical Principal Committee of the Australian Health Ministers' Advisory Council (AHMAC), I also represent Victoria in matters relating to health.

13. The Minister for Health appoints me as CEO of SCV and I employ the staff of SCV.

HOTEL QUARANTINE INCIDENT REPORTS

*The following questions relate to "Incident Review Report: Hotel Quarantine Incident One" – DHS.0001.0002.0060 (**Report One**) and "Incident Review Report: Hotel Quarantine Incident Two" – DHS.0001.0002.0032 (**Report Two**)*

4. Why did Safer Care Victoria prepare Report 1 and Report 2? At whose request was each Report prepared?

14. As part of SCV's role in reviewing critical incidents, SCV prepared Report 1 dated 10 June 2020 and Report 2 dated 17 June 2020 because the Secretary of the Department requested us to do so.

15. SCV can conduct such reviews at the request of the Minister for Health or the Secretary to the Department.

5. Pursuant to which policy/policies, guidelines and/or directives are reports such as Report 1 and Report 2 prepared? Please provide copies of any such documents.

16. SCV does not have policies or guidelines for conduct of the reviews *per se*. Rather, we develop a scope of work and employ relevant methodologies that are tailored and relevant to a particular review. Safer Care Victoria has established processes for undertaking incident reviews that are based on best practice in safety science.

17. In relation to Reports 1 and 2, Accimap was the systems analysis method by which the reviews were conducted. Accimap is a widely recognised and validated approach to rigorous incident review. It is an accident analysis method that is used to graphically represent the network of contributory factors involved in accidents and incidents. The Accimap method differs from typical accident analysis approaches in that, rather than identifying and apportioning blame, it is used to identify and represent the causal flow of events upstream from the accident and looks at the planning, management and regulatory bodies that may have contributed to the accident. [2]

18. For Reports 1 and 2, the Accimap process was customised to use what is referred to as the London Protocol, which is a framework for undertaking systems reviews. As it states on page 1, "*[t]he protocol outlined a process of incident investigation and analysis developed in a research context, which was adapted for practical use by risk managers and others trained in incident investigation. ...*" [3]

[2] Accimap Guidance, SVC.0001.0003.0001.
[3] Systems Analysis of Clinical Incidents, The London Protocol, SVC.0001.0003.0013 (page 1).

6. What were the relevant qualifications and experience of the "Review Lead" for each investigation?

19. The Review Lead for Report 1 is a member of the SCV Academy. The SCV Academy is a small group (12) of senior clinicians or consumer advocates who have each undergone additional training, by SCV, in advanced review methods. They typically lead or participate in systems reviews.

20. The lead for Report 1 has completed a Bachelor of Science (Physiology) and a Bachelor of Arts (Philosophy) from Monash University, and a Graduate Diploma in Science Communication from the Australian National University. RE has advanced training in incident analysis, human factors concepts and systems thinking through SCV. RE background is in healthcare safety and quality research, with a focus on service improvement and clinical governance. RE has nine years' experience in the field of consumer experiences and perspectives and is a member of multiple health sector boards. In RE current role at SCV, RE has experience in participating in clinical governance reviews, systems safety reviews and incident reviews. In RE role as an advisor on healthcare consumer issues, RE has experience participating in Morbidity and Mortality Reviews in Victorian health services.

21. The Review Lead for Report 2 is also an Academy Member at SCV. RE works as a review specialist for the Patient Safety Review Team within SCV's Centre for Patient Safety and Experience, and is currently Acting Manager for that team, which includes overall management and support to 19 direct reports. RE has coordinated and acted as review lead for both health service system safety reviews and incident reviews. RED is a registered pharmacist with a Master of Clinical Pharmacy degree. RE career includes 20 years of experience working internationally, in Victorian health services and primary health care. RE has held senior positions as a clinician and researcher working in emergency medicine, medication safety and clinical education. RE usual role and responsibilities involve coordination and leadership of complex incident reviews and safety systems reviews, coordination and delivery of the state-wide training program on serious incident review panels, and the development and implementation of the incident response program within SCV.

22. The role of the Review Lead is to head a review team to investigate the incident (by conducting interviews and requesting documents). The Review Lead then prepares a report addressing the incident and makes recommendations that, if implemented, may prevent a similar incident occurring in the future. It is not within the purview of role of the Review Lead, nor the review team, to confirm whether the recommendations have been implemented. Nor does the Review Lead or team review the adequacy of the implementation of recommendations.

23. The Executive Sponsor for each report was The Director of Patient Safety and Experience, Safer Care Victoria. The Executive Sponsor has oversight over the review and provides the final endorsement for the report. All reviews require a Safer Care Victoria Director or clinical

chief (Chief Nurse, Chief Medical Officer etc) to approve the final review, as the Executive Sponsor.

7. Has Safer Care Victoria, or any of its employees, been tasked to investigate any other aspect(s) of the Hotel Quarantine Program save for those covered by Report 1 and Report 2?

Provide details of any such investigation(s) including:

(a) the nature and purpose of the investigation(s);

(b) the incident(s) or concern(s) giving rise to the investigation(s);

(c) a description of the stage(s) at which such investigation(s) are presently at; and

(d) who is undertaking those investigation(s).

24. No. Other than the two reports identified, SCV and its employees have not been asked to investigate any other aspects of the Hotel Quarantine Program.

8. Is Safer Care Victoria aware of any other incidents, deficiencies or concerns, in relation to Victoria's Hotel Quarantine Program, other than those described in Report 1 and Report 2? If so, please provide details and relevant documents.

25. Save for the matters raised in Report 1 and Report 2, and the matters raised in response to Question 10 below, SCV is not aware of any other matters.

PROVISION OF THE REPORT AND FEEDBACK

9. Which individuals or entities (including, but not limited to, Government Ministers and departments) did Safer Care Victoria provide the Reports to, either in draft or final form? Please provide a separate list for each report.

26. Report 1 was provided by SCV:

(a) in draft, on 21 May 2020 to Merrin Bamert, Commander, Operation Soteria, Covid-19 and Director, Emergency Management and Health Protection, South Division of the Department;[4]

[4] Report 1, page 25; Email, 21 May 2020, DHS.5000.0089.2741 attaching draft report DHS.5000.0089.2742.

(b) on 25 May 2020 to Ms Bamert;[5]

(c) on 28 May 2020, a signed version dated 25 May 2020 was provided to:[6]

(i) Andrea Spiteri, Director Emergency Management (DHHS);

(ii) Meena Naidu, Executive Director, Health and Human Services Regulation and Reform (DHHS);

(iii) Pam Williams, COVID-19 Accommodation Commander (DHHS);

(iv) Merrin Bamert, Commander, Operation Soteria, Covid-19 and Director, Emergency Management and Health Protection, South Division of the Department (DHHS);

(v) REDACTED, Deputy Commander Welfare, Accommodation Command COVID 19 (DHHS);

(vi) Anita Morris, Deputy Commander Welfare, Accommodation Command COVID 19 (DHHS);

(vii) Nicole Brady, Deputy Public Health Commander (Strategy & Implementation), COVID-19 Department Incident Management Team (DHHS);

(viii) Melissa Skilbeck, Deputy Secretary, Regulation, Health Protection and Emergency Management (DHHS);

(ix) Jacinda de Witts, Deputy Secretary, Public Health Emergency Operations and Coordination (DHHS).

(d) on or about 28 May 2020 to the Secretary of the Department;

(e) on an unknown date before 3 June 2020 to Andrea Spiteri, Director Emergency Management, Emergency Management Branch of the Department.[7] The report was signed again on 10 June 2020.

27. Report 2 was provided by SCV:

(a) in draft, on 2 June 2020, to Merrin Bamert, Commander, Operation Soteria, Covid-19 and Director, Emergency Management and Health Protection, South Division of the Department;[8]

(b) in draft, on 2 June 2020, to Pam Williams, COVID-19 Accommodation Commander;[9]

[5] Report 1, page 25; email, 25 May 2020, DHS.5000.0096.3757.
[6] Email, 28 May 2020, DHS.5000.0016.4996 attaching DHS.5000.0016.4997.
[7] Report 1, page 25.
[8] Report 2, page 26; Email, 2 June 2020, DHS.5000.0089.2145. The marked up draft report was returned on 7 June 2020 by Merrin Bamert, DHS.5000.0095.3485 attaching DHS.5000.0095.3487.
[9] Email, 2 June 2020, DHS.5000.0076.7858.

(c) on 16 June 2020, to Merrin Bamert;[10]

(d) on 19 June 2020, to[11]

(i) Andrea Spiteri, Director Emergency Management (DHHS);

(ii) Pam Williams, COVID-19 Accommodation Commander (DHHS);

(iii) Merrin Bamert Commander, Operation Soteria, Covid-19 and Director, Emergency Management and Health Protection, South Division of the Department (DHHS);

(iv) REDACTED Deputy Commander Welfare, Accommodation Command COVID 19 (DHHS);

(v) Anita Morris, Deputy Commander Welfare, Accommodation Command COVID 19 (DHHS);

(vi) Nicole Brady, Deputy Public Health Commander (Strategy & Implementation), COVID-19 Department Incident Management Team (DHHS);

(vii) Melissa Skilbeck, Deputy Secretary, Regulation, Health Protection and Emergency Management (DHHS);

(viii) Jacinda de Witts, Deputy Secretary, Public Health Emergency Operations and Coordination (DHHS);

(ix) Leanne Hughson, Commander, COVID 19 Enforcement and Compliance, Regulation, Health Protection and Emergency Management Division (DHHS);

(x) Murray Smith, Commander, COVID-19 Enforcement and Compliance (DHHS);

(xi) Vanessa Brotto, Deputy Commander Welfare | Operation Soteria Emergency Operations Centre (DHHS).

(e) on or about 17 June 2020, to the Secretary of the Department.

[10] Email, 16 June 2020, DHS.5000.0089.5770.
[11] Email, 19 June 2020, DHS.0001.0012.0941.

10. Before each Report was provided, whether in draft or final form, did Safer Care Victoria make any recommendations or suggestions or raise any issues based on its investigations (either formally or informally)? If so, please provide details, including the person or entity to whom that communication was made and copies of any relevant document(s).

28. It is our normal practice to highlight issues that the reviewers consider may require attention ahead of finalising a formal review report. In this case, the Review Leads for Report 1 and Report 2 escalated such issues to the Review Project Manager, Human Factors / Methodology Lead, and Director System Safety, Safer Care Victoria. This was done via a videoconference meeting on 29 April 2020.

29. The Executive Sponsor escalated these issues to me via a written summary, the 'Operation Soteria Incident Review Escalation Points' (**Escalation Points**), emailed to me on 30 April 2020.[12] The review team and the review leads prepared these points based on anecdotal and other material presented to them in conducting the review. They were not tasked with investigating the matters raised in the Escalation Points and were not aware of whether or how those matters were being addressed at the time or subsequently.

30. On 1 May 2020, I approved the distribution of the Escalation Points to Merrin Bamert, Commander, Operation Soteria, COVID-19, Director Emergency Management. I met with Merrin Bamert via videoconference on 1 May 2020 at 9:30am to discuss the issues raised. The Escalation Points were discussed noting improvements had been made since the review. It was agreed to raise the following items at the Operation Soteria working group:

    (a) daily checks;

    (b) welfare checks; and

    (c) PPE provision.

31. I cannot recall the detail of precise improvements that had occurred subsequent to the reviews, but I was satisfied that the improvements completed or underway addressed the majority of the issues raised by the Escalation Points. The residual issues reflected those to be addressed at the next Operation Soteria working group.

32. It is also our normal process to send draft versions of a report to key stakeholders, as a fact checking exercise to correct any factual inaccuracies in a draft report. If we receive responses, we then check those factual matters to ascertain their accuracy and, if necessary, make corrections to matters of fact.

33. A draft of Report 1 was provided to Merrin Bamert on 21 May 2020 for a fact check. Ms Bamert provided some observations in response on 21 May 2020 about roles and operational structure.[13] I also understand that before 3 June 2020, Report 1 was provided to Andrea Spiteri,

[12] Soteria Review Escalation Points April 2020, SVC.0001.0002.0356.
[13] Email from Merrin Bamert, 21 May 2020, SVC.0001.0002.0056.

Director Emergency Management, Emergency Management Branch of the Department and a role description under finding five was updated as a consequence.[14]

34. I understand that Report 2 was provided to Merrin Bamert and Pam Williams on 2 June 2020 for a fact check. Merrin Bamert provided a marked up draft report to SCV on 7 June 2020.[15] A revised draft of Report 2 was provided back to Merrin Bamert on 16 June 2020 which incorporated responses to her comments, most of which related to the Accimap diagram and rostering fact-checking.[16]

35. I otherwise recall the reviewers raising the issue of certain witnesses being unwilling to be interviewed, including a mental health nurse in respect of Report 1, and a nurse and an Ambulance Victoria paramedic in respect of Report 2.

36. I understand from my discussions with the Executive Sponsor that access to a document (which was unavailable), and the interviews with the three persons who had refused to be interviewed, would have assisted the reviewers in providing a more complete picture in each report, as is explained on page 6 of each of Report 1 and Report 2.

37. Given the reviewers did not have the power to compel witness cooperation, I was satisfied that reasonable attempts had been made by Review Lead 1 to locate the relevant document and that the absence of the information did not critically compromise the reviews. I confirmed with the Executive Sponsor that the reports should be finalised in the absence of this information.

11. If any such recommendations or suggestions were made, insofar as you are aware of what, if any, changes or amendments were made to the Hotel Quarantine Program as a result? Please provide details of each such change, including when they were implemented.

38. SCV was advised by the Hotel Quarantine operational team that continuous improvements were being implemented. The review team were not involved in monitoring the implementation of the reports' recommendations.

39. I was aware of the following specific changes made to the Hotel Quarantine Program as a result of issues and recommendations raised in the reports:

    (a) Entry screening and welfare/health screening processes during the passenger stay were discussed. It was noted that review and updates to the care pathways specified in the Operation Soteria documentation had been undertaken by Public Health. This included reviewing suggestions made by SCV. Public Health noted they were updating the

[14] Report 1, Page 25.
[15] Email from Merrin Bamert, 7 June 2020, DHS.5000.0095.3485 attaching DHS.5000.0095.3487.
[16] Email, 16 June 2020, DHS.5000.0089.5770 attaching DHS.5000.0089.5772.

Operation Soteria combined documents (including by updating the Operation Soteria Plan).

(b) PPE usage by staff at the hotels (safety, risk and impact on care). SCV suggested that nursing staff at the hotels be allowed to use P2/N95 masks for swabbing, mindful that the workforce was anxious about testing. The Deputy Chief Health Officer advised that the state PPE guidance did not require P2/N95 masks for swab taking and that the nursing staff at the hotels should therefore not use P2/N95 masks.

(c) Care escalation pathways were improved and clarified, allowing for more timely provision of urgent care for either physical or mental health emergencies.

(d) A clinical governance lead position was created and appointed.

(e) Specialist mental health expertise was added to the Operation Soteria working group.

40. I was also aware of the steps being taken as described in paragraphs 30 and 31 above.

12. What feedback did Safer Care Victoria receive, in relation to the content of each Report, from:

(a) those involved in the planning, operation and oversight of the Hotel Quarantine Program; and/or

(b) any other individual or entity (including, but not limited to, Government Ministers and departments).

41. I address this in paragraphs 33 and 33 above.

PLEASE PROVIDE DETAILS OF AND RELEVANT DOCUMENTS EVIDENCING SUCH FEEDBACK.

13. Did Safer Care Victoria amend Report 1 or Report 2, or earlier drafts of either Report, in response to feedback from any person outside Safer Care Victoria? If so, please provide details, including any documents evidencing the feedback and amendments (for example, marked-up drafts tracking amendments).

42. The final version of Report 1 took into account the information provided by Merrin Bamert (referred to in paragraph 33), but no amendments were made to lessons or recommendations because of that feedback. Some amendments were made to the background section of Report 1 to take into account Ms Bamert's feedback.[17] I am informed by the Review Lead that those amendments were accepted by the Review Lead because those amendments were

[17] The amendments made are summarised in an email to Merrin Bamert, 25 May 2020, DHS.5000.0096.3757.

uncontroversial and because she agreed that they accurately expressed her existing views in any event. The amendments made following Ms Bamert's feedback are:

(a) Background section – to insert the underlined words in a sentence that reads in part: "… mandatory detention as part of the initiative that would later become known as Operation Soteria.";

(b) Method section – to amend the heading from 'Methodology' to 'Method' and to address that the incident was unexpected for all involved, the review did not have the purpose to determine cause of the incident or the relevant individual's state of mind and to identify that the report did not seek to draw conclusions about fault or blame;

(c) Incident review section – to remove a sub-heading: 'Analysis, findings and learnings';

(d) Timeline of events – to consolidate the last three entries of the timeline;

(e) Actor Map – to remove three roles; and

(f) Reasoning section – to clarify that the Operation Soteria Plan was not completed prior to the incident but is indicative of intentions for running the hotel quarantine system at the time.

43. On 3 June 2020, the role and description under finding five of Report 1 was updated in response to feedback received from Andrea Spiteri Director Emergency Management, Emergency Management Branch of the Department.[18]

44. The final version of Report 2 took into account certain comments provided by Merrin Bamert (referred to in paragraph 34), but no amendments were made to lessons or recommendations because of that feedback. Some amendments were made to the background section of Report 2 to take into account Ms Bamert's feedback.[19] I am informed by the Review Lead that those amendments were accepted by the Review Lead because those amendments were uncontroversial and because they were minor and mainly stylistic.

45. As far as I am aware, the reports were not otherwise amended between the drafts and the final version.

[18] Report 1, page 25.
[19] The amendments made are summarised in an email to Merrin Bamert, 16 June 2020, DHS.5000.0089.5770.

14. To the extent that you are aware, which of the recommendations from Report One and Report Two (if any) were implemented?

Please provide details of and relevant documents evidencing such implementation.

46. I partly address this is paragraph 39, above.

47. SCV will monitor the implementation of recommendations, usually with a check in at 1 month, 3 months and 6 months. In SCV's view, it is for Operation Soteria to evidence the implementation of SCV's recommendations.

48. The action plans for each report provide the due date for the recommendations. The urgent recommendations are closed (ie they have been implemented and are considered complete). The other recommendations have due dates of 14 August 2020 or 28 August 2020. Since my secondment from SCV in late July, I have not been involved in the follow-up of how the recommendations are being implemented.

FURTHER INFORMATION

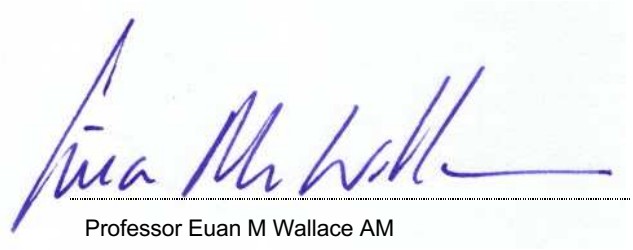
15. If you wish to include any additional information in your witness statement, please set it out below.

No.

Signed at Melbourne

in the State of Victoria

on 2 September 2020



Professor Euan M Wallace AM