COVID-19 Hotel Quarantine Inquiry

Submissions of the Department of Health and Human Services (DHHS)

1. As acknowledged by counsel assisting in closing, the operation of the Victorian hotel quarantine program placed an enormous, immediate unenviable burden on those in public service.[1] The magnitude and scale of getting the program established and running would have been unheard of in almost any other context.[2] Notwithstanding that burden, as gratefully acknowledged by the Secretary to the DHHS and by the Commander, Operation Soteria, hundreds of public servants and other workers faced the many challenges to work tirelessly on the hotel quarantine program.[3] The Secretary accepted her accountability for the work of those in DHHS,[4] and the evidence shows that she and senior representatives of DHHS worked assiduously to address issues as they arose in the hotel quarantine program, seeking to engage in continuous improvement as the extraordinary demands of the program continued to grow.[5]

2. The structure of these submissions is to give an overview of the factual and regulatory context of the program and its introduction, and the essential elements of its operation. DHHS then addresses the findings that counsel assisting has recommended the Board should make. The submissions of counsel assisting covered a very broad range of matters and suggested findings. It is understood that the only findings that are sought by counsel assisting are those summarised by Mr Neal QC at the close of the submissions.[6] However, it is also noted that there are a range of other matters raised in the submissions of counsel assisting that differ significantly from that summary and make observations of a potentially adverse, and in many cases serious, nature with respect to DHHS or its officers. These submissions attempt in the space available to address the most serious of those matters, as best they can be understood. However, noting the requirements of procedural fairness, and of s 76 of the *Inquiries Act 2014*, should any of the matters canvassed by counsel assisting which were not identified by Mr Neal QC be intended to be the subject of findings or comment in the Board's report, DHHS would respectfully seek an opportunity to respond on those matters before such finding or comment is made.

3. The Department seeks to draw to the Board's attention in these submissions to the following matters:

   (a) that procedural fairness was not afforded in relation to some of the proposed adverse findings;

   (b) that some of the proposed findings were not supported by the evidence adduced in the evidentiary phase of the inquiry;

   (c) that DHHS delivered on the appropriate role of the control agency in a complex emergency, and was focussed and dedicated in the manner in which it delivered on that role;

   (d) the public health team was directly involved, including the Chief Health Officer, Public Health Commander and Deputy Chief Health Officer, in providing expert guidance on the Hotel Quarantine program;

   (e) there was very regular and appropriate briefing of Ministers, their offices, the Premier, his office and the Crisis Council of Cabinet on all matters to do with the pandemic, including the operation of the hotel quarantine program;

   (f) it is impossible to link the downstream impacts of COVID-19 to a specific transmission event in the Rydges Hotel, given the wide range of other actors and circumstances involved, the lack of definitive evidence about the nature of the transmission event, and the capricious and unpredictable nature of the virus;

   (g) guest health and wellbeing was centrally important in everything that was done in the hotel quarantine program, and extraordinary personal and professional efforts were involved in meeting these needs;

   (h) there is a wide range of evidence before the inquiry regarding the effective and responsive management and leadership of the program; and

   (i) there was a dedicated commitment to continuous improvement by the Department.

---

[1] T2196:32-37 (Neal).
[2] T2196: 15-18 (Neal); T2196: 20-26 (Neal); T2196: 27-30 (Neal); T2263: 45-T2264:4 (Neal).
[3] See statement of Kym Peake, Ex 186, [337]. Statement of Pam Williams, Ex 130, [116].
[4] T1813.26-28 (Peake).
[5] T1994.18-24 (Peake) T2029.35-44 (Peake). See also par 163 below.
[6] Which he described as intended to "collect and place on he record in terms those findings which [counsel assisting] submit the Board should make": T2263.22-23.

4. These submissions seek to address the proposed findings and various matters raised in the submissions of counsel assisting the Board. Given that the Board, in the very limited time available to it, has in the hearings only heard a small proportion of the evidence provided by the Department about its work in the hotel quarantine program, these submissions address the significant volume of evidence in witness statements, policies, plans, and contemporary communications, showing the effective and responsive management and leadership of this program. The evidence also shows the dedication of Departmental staff to continuous improvement as the very real challenges of the program arose and were responded to with changes in practices and additional resources. Importantly it also shows the central importance that was afforded by Departmental staff, facing constant difficult choices involving balancing of risks arising from the unpredictable nature of a novel and extraordinarily infectious virus, with the health and wellbeing needs of the quarantined population.

The hotel quarantine program – the context

5. As recognised by counsel assisting, the establishment of a quarantine program in response to the threat posed by COVID-19 was required to take place extraordinarily rapidly, within 36 hours of communication of the 27 March 2020 National Cabinet decision determining that all travellers arriving in Australia will be required to undertake mandatory 14 day self-isolation at designated facilities such as a hotel.[7] The National Cabinet announcement came at a time of increasing cases in Victoria – 106 cases on the day of announcement.[8] The rate of transmission had been observed by the Deputy Chief Health Officer to be increasing from early in 2020 with a risk of exponential growth in cases.[9] It was a novel virus, the understanding of which was (and still is) developing.[10]

6. The National Cabinet announcement came at a time when government agencies were focussed on a range of emergency responses to the pandemic, including in the case of the DHHS attention to the implementation of physical distancing measures, growing contact tracing capacity, and negotiating the in extraordinary measures needed to ensure hospital capacity for an anticipated influx of cases.[11] As observed by the Chief Health Officer "countries like Italy were going through thousands of cases and were facing a catastrophic epidemic that ultimately killed tens of thousands of people".[12] Having seen this exponential growth of cases and rationing of health services overseas, hospitals, with the DHHS, were involved in detailed capital planning work including the governance arrangements for capacity for up to 4,000 emergency beds; for example, the DHHS was leading planning, with Alfred Health, a contingent facility for an intensive care unit at the Melbourne Convention Centre.[13] As observed by counsel assisting, the circumstances facing Victoria were anything but ordinary.[14]

7. It was against this factual background that the hotel quarantine program went from concept to operational in two days.[15] As the operation unfolded, these pressures on the health system and on the operations of government and other agencies did not abate: and hotel quarantine was not the only program that required attention, resources, and skilled and experienced staff.[16] There is no immediately available surge workforce for an urgent program of this kind and magnitude, and appropriately qualified staff, as well as including those from the DHHS willing to undertake new roles in an uncertain environment, needed to be sourced from a number of other sources including local government.[17] As Prof Wallace observed, the complex operation including systems for health and welfare had to be set up "incredibly quickly" noting that in his many years of prior experience working in health services that it ordinarily takes many months to set up the components of health services, and "we would never ask a health service to set up … a program of this complexity in two days".[18]

8. As the program progressed, the returning traveller demographic profile changed significantly, bringing into hotel quarantine families and people who had been away from Australia for a very long time, with diverse languages and limited local supports, after long journeys from often distressing situations in their country of departure.[19] There was a significant increase in returning children and infants – at one point reaching 600 children and young people under 18 years of age in hotel

[7] T.2916.22-23.
[8] Chronology 28, 29. It was the peak of the first wave (but of course was not known to be the peak for some time).
[9] See also senior counsel assisting closing T2193.34-47.
[10] Statement of Simon Crouch, [37]; Statement of Dr McGuinness [24]-[27]; [101] noting that "PPE and IPC that were regarded as being appropriate in May 2020 are not necessarily the same as would be recommended now"; Statement of Merrin Bamert [92]; Statement of The Infection Control Consultant, [139]; Note to the evidence of Prof Grayson as to degree to which certain aspects of the SARS-CoV-2 virus were still in the process of being understood even at the time: see eg [19]; [20] [32], [34], [44]-[46].
[11] Statement of Kym Peake, 14 August 2020, [101]; see also [55]-[56]. T1900.46-T1901.4 (Kym Peake).
[12] T1478.17-20.
[13] T2005.37-44 (Kym Peake).
[14] T.2916.28-29 (Neal).
[15] Statement of Pam Williams at [112].
[16] Statement of Pam Williams, [112].
[17] Statement of Kym Peake [180]; Statement of Pam Williams [112].
[18] T1153.42 to T1154. 24 (Euan Wallace).
[19] T1270 28-38 (Pam Williams). Statement of Pam Williams at [15], [22].

quarantine – which significantly increased the complexity of the health and wellbeing issues experienced.[20] To implement an operation of such a magnitude and scale, as counsel assisting acknowledged, "would have been unheard of in almost any other context".[21]

9. All of this context is relevant to many aspects of the observations and recommended findings of counsel assisting.[22] In particular it is critically relevant to the consideration of the options that were open for the management and operation of the hotel quarantine program.

10. These submissions summarise below the evidence (which perhaps understandably in the limited time available to counsel assisting was not explored in the oral evidence of DHHS's witnesses[23]) that public health advice was at all times sought and embedded into the hotel quarantine program, and that health and wellbeing services including nurses, doctors and mental health services - were rapidly stood up and available to returned travellers at all times consistent with that advice. However, it is accepted that if other pressures on health related human and other resources did not exist, it would have been desirable to have stronger Health Service engagement in the management of hotel quarantine, as was later possible with the engagement of Alfred Health in relation to the Brady Hotel at a time when cases in Victoria had significantly declined, restrictions had eased,[24] and the anticipated demands on hospitals and the health system had not yet materialised.

11. It is respectfully submitted that it will be critical for the Board to assess every finding it is considering carefully against the contemporary prevailing factual situation in which it was made: the extent at any given time of the evolving knowledge about the COVID-19 virus; the other prevailing serious demands on public resources;[25] and the fact that the hotel quarantine program was one part of a State-wide emergency response to the pandemic.[26]

12. It is also submitted, with a respectful understanding of the enormity of the task of the Board and those assisting it, that the time constraints on the Board in conducting the Inquiry has necessarily meant that only a sample of witnesses was called on certain issues, in particular from returned travellers. The evidence from those closely involved with the program is that of the over 20,000 guests in the hotel quarantine program the majority of them, while making a significant sacrifice for the Victorian and Australian community, completed their quarantine without serious difficulties.[27] The Board has, understandably, heard evidence from witnesses who experienced problems in hotel quarantine; however it is respectfully submitted that the Board should be cautious about concluding from that evidence that their experience was representative, rather than individual.[28] DHHS placed a high priority on providing for the health and wellbeing of guests in hotel quarantine and in managing the guests who did experience significant issues while in quarantine, tried to address sometimes intensely complex needs[29] while maintaining their privacy and protecting their dignity.[30]

The legislative framework relevant to the pandemic response and hotel quarantine program

13. Victoria's response to the COVID-19 pandemic is managed primarily under the *Public Health and Wellbeing Act 2008* (**PHW Act**); and the *Emergency Management Act 2013* (**EM Act 2013**). Part 2 of the PHW Act sets out the objectives of the Act, relevantly recognising the State has a role in assisting in responses to public health concerns of national and international significance.[31]

[20] Statement of Andrea Spiteri [58]; T1270 28-38 (Pam Williams).
[21] T.2916.16-18; (Neal).
[22] See also the observations of the Chair of the Board, as to the rapidity of setup, with the consequence that "A certain amount of reality needs to be put into the context.": T673.4-6.
[23] Nor through calling members of the DHHS Welfare team.
[24] Chronology item 54. See also Statement of Simone Alexander at [30]-[34]. Negotiations with Alfred Health commenced in late May (Alexander statement at [29]), and Alfred Health commenced in mid -June (Alexander statement at [30]).
[25] Statement of Kym Peake at [80], [112]; T1217 23 – 41 (Peake); T1365.40 – 44 (Crisp); T1893.5 – 12 (Peake) re the 14 operations running under the SCC at the time of her evidence. The Department's heal h emergency mission plan, pursuant to which the Department was implementing a whole of health system response, including to introduce a range of public health measures including testing and broader containment measures, maximising system capacity to absorb demand, including integrating private hospital resources, and expanding the workforce, skills, and physical system capacity of health services: See Health Mission Plan attached to Statement of Christopher Eccles dated 8 September 2020, at [74], footnote 46]; see attached document DPC.0001.0002.0003 at 0018.
[26] Statement of Kym Peake at [111]-[113]; Statement of Andrea Spiteri [29]. T1587.22-40 (Helps, noting challenges with critical infrastructure, essential services).
[27] Statement of Merrin Bamert [93]; Statement of Pam Williams at [116].
[28] As set out further below, several of the returned travellers, although noting significant difficulties they experienced in hotel quarantine, had positive things to say about the staff and the services provided.
[29] See, for example, the Statement of Merrin Bamert at 15(g).
[30] Statement of Pam Williams at [116].
[31] PHW Act s 4.

14. The Secretary is responsible for the appointment of the Chief Health Officer (**CHO**),[32] who has certain functions and powers under the Act,[33] and for the appointment of authorised officers (**AOs**),[34] who exercise certain functions and powers under the PHW Act.[35]

15. First, the CHO has general functions and powers, under s 21 of the PHW Act, including, relevantly to develop and implement strategies to promote and protect public health and wellbeing and to provide advice to the Minister or the Secretary on matters relating to public health and wellbeing.

16. Second, the CHO may make examination, testing and public health orders with respect to infectious diseases, micro-organisms and medical conditions if they pose a *serious* risk to public health.[36]

17. Third, the CHO has under s 189 powers to investigate, eliminate or reduce public health risks. For that purpose, the CHO may:

    (a) authorise AOs appointed by the Secretary to exercise the public health risk powers; and

    (b) if specified in that authorisation, authorise a specified class or classes of AOs appointed by a specified Council or Councils, to exercise any of the public health risk powers.

18. These public health risk powers are set out in s 190 of the PHW Act and may be exercised at any time. Unlike the emergency powers they are not dependent on a declaration of a state of emergency; and operate with respect to a risk to public health (in contrast to the emergency powers discussed below, with operate with respect to a *serious* risk to public health). The public health risk powers allow an AO to, for example, direct a person or group of persons to enter, not to enter, to remain at, or to leave, any particular premises for the period of time reasonably necessary to investigate, eliminate or reduce the risk to public health. This power would be unsuitable for hotel quarantine as it is subject to a specified time limit of no more than 4 hours, which may be extended as reasonably necessary but not exceeding 12 continuous hours.[37]

19. Other coercive powers of the CHO include the power under s 113 for the making of an examination and testing order of a person in certain quite narrow circumstances. Prof Sutton was asked about whether he considered using any of these powers and explained that he did not consider using them because they historically have been used infrequently and in the context of individuals.[38] He was not specifically asked to address whether the legal conditions would have been satisfied for any specific persons, such as the class of persons subject to hotel quarantine.[39] It is relevant here to note certain of these relevant circumstances:

    (a) a person has an infectious disease or *has been exposed to* an infectious disease in circumstances where a person is *likely* to contract the disease (s 113(1)(a)). There is no evidence to suggest that it would have been possible to ascertain in any rapid time frame whether returning travellers would fall into this category, given that few would know if they had got COVID-19 or been exposed to it;

    (b) if infected with that infectious disease, the person is likely to transmit it (s 113(1)(b)), a matter which, given the evidence as to the infectious nature of COVID-19 could contrary to the first requirement, be readily assumed; and

    (c) if infected with that infectious disease, a serious risk to public health is constituted by –

        (i) the infectious disease; or

        (ii) the combination of the infectious disease and the likely behaviour of that person: s 113(1)(c) –

    It unlikely to be possible to make determinations about the likely behaviour of large numbers of returning travellers, so whether this requirement, properly construed, is satisfied would depend on whether the fact that a person has COVID-19 of itself constitutes a serious risk to public health.

20. Any examination and testing order may only be made if there is no equally effective measure in minimising the risk to public health which is less restrictive of the rights of the person: s 112. While Prof Sutton was asked about whether he considered using the compulsory testing powers, the

[32] PHW Act s 20.
[33] PHW Act s 21.
[34] PHW Act s 30. Councils may also appoint AOs: PHW Act (s 31) and also environmental health officers who also have the status of AO (PHW Act s 3(1), definition of 'authorised officer'; s 29).
[35] PHW Act s 31.
[36] PHW Act Part 8.
[37] PHW Act, s 190(1)(b) and s 190(5).
[38] T1461.47 – T1462.16 (Sutton).
[39] T1461.11-14; T1461.

question was not asked of him or other witnesses such as Mr de Kretser,[40] nor other returning travellers as to whether compulsory testing (which has its own practical and public health difficulties given that it necessitates a forced naseo-pharangeal swab) would be less restrictive than other measures such as quarantine. However, Prof Sutton did give evidence that "for a class of persons across an entire State, the use of those individual public health orders is impractical".[41]

Emergency powers under the PHWA

21. The powers which were used to require returning travellers to remain in hotel quarantine were the emergency powers in s 200(1)(a). Section 198 provides for the Minister, on the advice of the CHO and after consultation with the Minister and the Emergency Management Commissioner under the *Emergency Management Act 2013*, to declare a state of emergency. Where a state of emergency exists s 199 of the Act permits the CHO may then, if believing "that it is necessary to grant an authorisation … to eliminate or reduce a serious risk to public health", authorise AOs appointed by the Secretary[42] or appointed by a Council[43] to exercise any of the public health risk powers and the emergency powers.

22. Prof Sutton gave formal advice to the Minister on 15 March 2020 that the COVID-19 pandemic constituted a serious risk to public health for the purposes of the exercise of the Minister's power to declare a state of emergency under the PHWA.[44] The Minister, after consulting the Minister for Police and Emergency Services and the Emergency Management Commissioner,[45] declared a state of emergency effect from 16 March 2020.[46] The state of emergency was subsequently extended, relevantly on 12 April 2020;[47] 11 May 2020;[48] 31 May 2020;[49] 21 June 2020;[50] and 19 July 2020.[51]

Exercise of the PHWA powers in response to the wider COVID-19 emergency

23. In addition to directions which were given by the DCHO in the context of the hotel quarantine program, the CHO and DCHO had significant other roles in DHHS's response to the wider State wide COVID-19 emergency. Specifically, with respect to the PHWA emergency powers, this included the issuing of directions relating to state-wide physical distancing and other health related emergency management issues: for example, directions about closure of non-essential businesses, visitors to hospitals and aged care, restriction of public activity, and about requirements for persons diagnosed with COVID-10 and their close contacts.[52]

24. The CHO or delegate also has a specific role of Public Health Commander in the emergency management framework, as discussed further below.

Roles of Chief Health Officer and Deputy Chief Health Officer and delegates in emergency management framework

25. In the context of the management of public health emergencies, the emergency management arrangements provide specifically for the engagement of public health expertise in the control arrangements. For reasons addressed extensively in the evidence the CHO was not appointed State Controller, despite the presumption in the *State Health Emergency Response Plan*[53] (**SHERP**); this may have distracted attention from the evidence that there remains in the Emergency Management policy framework, and there was in practice, a public health expertise was deeply engaged in the emergency management response.

26. First, the role of Public Health Commander is a role within the emergency management of public health activities.[54] The PHC is responsible for commanding the public health functions of a health emergency response.[55] This includes investigating, eliminating or reducing a serious risk to public

[40] T123 33-36; T187.29-36. As shown in his statement and transcript, Mr De Kretser is a lawyer experienced in human rights.
[41] T1462.28-29 (Prof Sutton).
[42] Pursuant to the Secretary's power under s 30 of the PHWA.
[43] Pursuant to the powers of Councils under ss 29 or 31.
[44] Statement of Prof Sutton, 13 August 2020, par [81]. Statement of The Honourable Jenny Mikakos MP, 17 September 2020, at [34] and advice at MIK.0144 0003.0001.
[45] Statement of the Honourable Jenny Mikakos MP, 17 September 2020, at [35].
[46] Victoria, *Gazette: Special*, No S129, 16 March 2020.
[47] Victoria, *Gazette: Special*, No S193, 12 April 2020.
[48] Victoria, *Gazette: Special* No S231, 12 May 2020.
[49] Victoria, *Gazette: Special* No S267, 1 June 2020.
[50] Victoria, *Gazette: Special* No S297, 22 June 2020.
[51] Victoria, *Gazette: Special* No S361, 20 July 2020.
[52] The full list of directions are set out in the attachment to the Statement of Prof Sutton "List of Directions to 3 August 2020", Exhibit 154.
[53] Exhibit 161, State Health Emergency Response Plan, Edition 4, DHS.0001.0027.0883.
[54] van Diemen Statement at [15].
[55] Sutton Statement at [170].

health.[56] The SHERP identifies the CHO as the Public Health Commander, but is a role that can be delegated.[57]

27. Dr van Diemen, the Deputy Chief Health Officer, was delegated the role of PHC in mid-February 2020 as part of the incident response to COVID-19,[58] and on the declaration of the state of emergency, she became the PHC. Under SHERP,[59] the function of the PHC involves be:

> The Public Health Commander reports to the State Controller and is responsible for commanding the public health functions of a health emergency response (including investigating, eliminating or reducing a serious risk to public health).
>
> Performing the function of Public Health Commander does not alter in any way the management, control and emergency powers of the Chief Health Officer under the Public Health and Wellbeing Act 2008.
>
> In performing this function, the Public Health Commander will liaise directly with the State Health Commander and State Health Coordinator.
>
> For emergencies where the Public Health Commander is not appointed the State Controller, the Chief Health Officer's authority under the Public Health and Wellbeing Act 2008 remains unaffected, and their decisions on matters of public health should not be overridden by a State Controller.[60]

28. The PHC also leads the Public Health Incident Management Team (**PH-IMT**).[61] In this way, the PHC sits between the emergency and public health teams and provided direct input into decision making as a member of the State Control Team[62] . The PHC or delegate or representative also attended at some State Control Centre meetings.[63] She acknowledged that while in an ideal would there would have been multiple health positions in both the EOC and the SCC, "the reality was there weren't enough to go around and we needed to determine where people would sit and many – most of the public health positions in the response were covering more than one role at any given time".[64]

29. In the context of the hotel quarantine program, Dr van Diemen's evidence was that her functions as PHC related to:

    (a) issuing guidance and advice relating to COVID-19 and setting policies and procedures to address the health and wellbeing of returned travellers in hotel quarantine;[65]

    (b) liaising directly with the State Health Commander and the State Health Coordinator, with a focus on the public health functions of the program;[66] and

    (c) directing requests on different issues sent to the CHO and her to the appropriate decision-makers.[67]

The Emergency Management Framework

30. The EM Act 2013 operates in conjunction with residual provisions contained in the *Emergency Management Act 1986* (**EM Act 1986**).[68] The EM Act 1986 provides that the Minister is to ensure that satisfactory emergency managements arrangements are in place to facilitate the mitigation of, response to and recovery from emergencies, but is not responsible for operational matters in relation to emergency management.[69] The 'Minister' is the Minister for Police and Emergency Services.[70]

31. The EM Act 2013 created Emergency Management Victoria (**EMV**),[71] responsible for developing whole-of-government policy for emergency management in Victoria.[72] EMV was created in response

[56] van Diemen Statement at [21].
[57] Exhibit 161, State Health Emergency Response Plan, Edition 4, DHS.0001.0027.0883 at page 24.
[58] van Diemen Statement at [18].
[59] See also the *Concept of Operations, Department of Health and Human Services as a Control Agency and as a Support Agency in Emergencies, November 2019*, (the Concept of Opera ions document). Exhibit 161, Concept of Operations, Department of Health and Human Services as a Control Agency and as a Support Agency in Emergencies, DHHS, 25 November 2019, DHS.0001.0001.0004.
[60] Exhibit 161, State Health Emergency Response Plan, Edition 4, DHS.0001.0027.0883 at page 24.
[61] Sutton Statement at [170].
[62] Statement of Anneliese van Diemen, [22]; see also State Health Emergency Response Plan, Edition 4, attached to van Diemen Statement (Ex 161). DHS.0001.0027.0883 at page 22.
[63] Statement of Anneliese van Diemen [70].
[64] T1531.9 – 11 (van Diemen).
[65] van Diemen Statement at [21].
[66] van Diemen Statement at [22].
[67] van Diemen Statement at [24].
[68] EM Act 2013 s 4.
[69] EM Act 1986 s 5.
[70] Pursuant to General Order dated 1 January 2000, https://www.vic.gov.au/general-order-dated-1-january-2020#minister-for-police-and-emergency-services. See also Witness Statement of the Honourable Lisa Neville MP, at [4]. LMN.0001.0001.0001.
[71] EM Act 2013 s 14.
[72] EM Act 2013 s 17.

to the Black Saturday bushfires in 2009, and Victorian floods in 2010, and consequent Green and White papers.[73]

32. The Act also created an Emergency Management Commissioner (**EMC**) whose functions under the EM Act 2013 include, relevantly for present purposes, 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, managing the State's primary control centre on behalf of, and in collaboration with, all agencies that may use the primary control centre for emergencies, and consequences management for a major emergency.[74]

33. The cross-agency nature of the emergency management arrangements for the EM Act it provides are reflected in the Act's statutory objectives of the EM Act, including to

    (a) Establish efficient governance arrangements that—

        (i) clarify the roles and responsibilities of agencies; and

        (ii) facilitate cooperation between agencies; and

        (iii) ensure the coordination of emergency management reform within the emergency management sector; and

    (b) implement an "all communities—all emergencies" approach to emergency management; and

    (c) establish integrated arrangements for emergency management planning in Victoria at the State level.[75]

34. The EM Act defines emergencies as either Class 1 (major fires or other major emergency for which fire agencies or the Victoria State Emergency Service Authority are the control agency) or Class 2, meaning a major emergency which is not: a Class 1 emergency; a warlike act or act of terrorism; or a hi-jack, siege or riot.[76] The Act also defines an 'emergency' and 'major emergency'. Under this taxonomy, the COVID-19 pandemic was and is categorised as a Class 2 major emergency.[77]

35. In order to discharge the responsibilities under the legislation at the time,[78] State responses to emergencies, including health emergencies, are guided by a number of planning documents:

    (a) Emergency Management Manual Victoria (**EMMV**), 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;[79]

    (b) State Emergency Response Plan (**SERP**), which outlines the arrangements for a coordinated response to emergencies by all agencies with a role or responsibility in emergency response;[80]

    (c) State Health Emergency Response Plan (**SHERP**), a sub-plan of the SERP, used by people working in emergency services, such as paramedics, doctors, nurses and people working in public health, to help them effectively coordinate health services for the community during emergencies;[81] and

    (d) Victorian action plan for pandemic influenza, prepared by Emergency Management Victoria to guide the pandemic preparation of each government department and agency to address the possible impacts and consequences of pandemic influenza on their organisations, and their responsibilities to communities.[82]

36. The SERP contemplated sub-plans providing guidance for particular types of emergencies to support multi-agency involvement in complex emergencies.[83] That is, the SERP and broader emergency management system anticipates that some emergencies cannot be addressed by a single government agency, and it would be necessary to control and coordinate the actions across them.

[73] Ex 140, statement of Craig Lapsley, [4], WIT.0001.0049.0001; T1351.7 – 19 (Crisp).
[74] EM Act 2013, ss 24, 32, 45.
[75] EM Act s 5; Ex 140, see also statement of Craig Lapsley [4], WIT.0001.0049.0001.
[76] EM Act 2013, s 3(1), definition of 'Class 1 emergency' and 'Class 2 emergency'.
[77] Ex 153, statement of Brett Sutton [162]. Statement of Andrea Spiteri at [13], [26].
[78] As of 30 September 2020 the SERP and the EMMV have been replaced by the Statement Emergency Management Plan.
[79] Ex 145, (Emergency Management Manual Victoria) DOJ.600.001 0501.
[80] Ex 145, (State Emergency Response Plan), DOJ.600.001.0271.
[81] Ex to 126, State Health Emergency Response Plan, DHS.0001.0027.0883 (annexure to Skillbeck statement).
[82] DHHS Initial response to Board of Inquiry, DHHS, 17 July 2020, 2.
[83] Ex 140, statement of Craig Lapsley, 7 September 2020 at [22], WIT.0001.0049.0001.

State Control Centre set up and roles

37. The government considered that Operation Soteria specifically, like the government response to the COVID-19 emergency generally, was a "multi-agency operation, overseen and coordinated by the State Control Centre" (**SCC**).[84] The primary function of the SCC is coordination across government agencies.[85] The SCC had been earlier activated by the EMC for the purpose of managing the COVID-19 emergency on 11 March 2020 at the request of DHHS.[86] The SCC when activated is the apparatus or architecture through which the planning and responses involved in the multiagency response to an emergency occurs.[87]

38. Consistent with the EM Act 2013 and the EMMV/SERP framework, responsibilities for the emergency response management were:

    (a) coordination, undertaken by the Emergency Management Commissioner (EMC);

    (b) control, performed by DHHS as control agency;

    (c) command, by each agency – control and support agencies - of their respective responsibilities and personnel;

    (d) consequence management, managed by the EMC; and

    (e) communication, coordinated by the EMC.[88]

39. Consistent with the EMMV and SERP, DHHS was the nominated control agency for the COVID-19 emergency.[89] The Class 2 State Controllers – Health were two people within significant emergency management experience appointed from the DHHS, Andrea Spiteri and Jason Helps.[90]

40. Operation Soteria became one aspect of the SCC emergency response, although as discussed below, with an unusual commencement in that it was not initiated under the SCC but by allocation of functions to the DJPR in relation to setting up hotel quarantine had been done prior to the program being transitioned to the emergency management framework.

41. The EMMV distinguishes between:

    (a) coordination (bringing together agencies and resources to ensure effective response to and recovery from emergencies);

    (b) control (the overall direction of response activities in an emergency, operating horizontally across agencies); and

    (c) command (the internal direction of personnel and resources, operating vertically within an agency).[91]

42. This established understanding of emergency management roles was adopted and reflected in a Concept of Operations document prepared in November 2019 by the CHO and the DHHS Director, Emergency Management[92] to address DHHS's role in range public health emergencies generally.[93] The Concept of Operations was the foundation for what became the State Control Arrangements COVID-19.[94]

43. The witnesses gave evidence about the nature of the concepts of coordination, control and command within the established emergency management framework.

44. The Emergency Management Commissioner Andrew Crisp explained that, for example, the concepts of command and control "are two very different parts of an emergency"[95] and that:

---

[84] Ex 217, statement of the Honourable Daniel Andrews MP [1], PREM.0001.0001.0001; Ex 164, statement of Jason Helps [29], [32] – [55], DHS.9999.0024.0001. See also Ex 196, Statement of the Honourable Lisa Neville MP, with respect to the role of DJPR in standing up the HQP (at [21]) and the role of the EMC, Commissioner Crisp and the DJPR working as support agency to support DHHS to opera ionalise Operation Soteria and the ongoing operation of the hotel quarantine program: at [23].
[85] Ibid.
[86] Ex 144, statement of Andrew Crisp [12.c].
[87] T1892. 38-40 (Kym Peake).
[88] Ex 144, statement of Andrew Crisp [11]; Statement of Andrea Spiteri [21].
[89] Ex 144, Andrew Crisp [11]; Statement of Andrea Spiteri [18].
[90] Statement of Andrea Spiteri at [7]: her appointment was 1 February. Mr Helps was appointed 7 February. Note response of Prof Sutton to a question whether the State Controller should have health expertise "Andrea Spiteri has some health expertise. She's an excellent leader in the emergency management space within DHHS." T1486.4-6. Mr Helps has extensive police and emergency management experience including in the health sector: Helps Statement [3]-[17].
[91] EMMV 3.2.1 Overview; T1354.45 – T1355.24, T1356.42 – T1357.6 (Crisp).
[92] Exhibit 153, statement of Brett Sutton [54], DHS.9999.0002.0001. T1484.28 – T1485.11 (Sutton).
[93] Ex 155, (Concept of Operations, Department of Health and Human Services as a Control Agency and as a Support Agency in Emergencies), DHS.0001.0001.0004, p 4, referred to in Exhibit 153, statement of Brett Sutton, [54] – [56], DHS.9999.0002.0001.
[94] DHS.500.0032.1850; Ex 164, Statement of Jason Helps [31]-[40]; DHS.5000.0131.5853; Ex 162 Spiteri Statement [31]-[39].
[95] T1354.1 – T1355.24 (Crisp).

> So control is --- if we want to use this current example, so with the Department of Health and Human Services being the control agency, they are responsible for the response to this particular emergency. … So that's control and that can operate across a number of agencies because they could be in support of the Department of Health and Human Services in relation to control.
>
> Coordination is bringing together all those resources and those agencies and departments to work in support of the control agency.
>
> And then command is that line of command that sits within a particular --- within a control agency, so DHHS will have their own command structure, as will other --- Victoria Police will have its own command structure in relation to how it will support the control agency. [96]

45. Mr Eagle, the Deputy Chief Fire Officer, DELWP, was appointed and held the role of Deputy State Controller – Health until 1 May 2020 and has extensive training and experience in emergency and incident management.[97] He described the control function as having the "overall direction" of the incident and agreed with the observations of Mr Crisp that control in emergency management is to be understood as a level of horizontal control across an incident or across and emergency.[98] Ms Bamert, the Director of Emergency Management, Health Protection and Population, South Division, also agreed.[99]

46. Other witnesses with experience in emergency management gave evidence about the meaning of these concepts in the established emergency management context. Melissa Skilbeck, Deputy Secretary — Regulation, Health Protection and Emergency Management, DHHS gave evidence that:

> The key role in the control agency in something as big as this particular emergency, "control agency" becomes something of a misnomer where really most of the activity is coordinating across the array of agencies and departments that have come together to respond as fulsomely as the Victorian public sector can to this emergency. So it is both control in a very specific sense of the word, the public health response to a novel coronavirus; and the coordination role --- little c "coordination", to make the distinction, because I think "Coordination" is defined in the SERP as well --- but coordination across the many agencies that have come to support the response.[100]

47. Kym Peake, Secretary to the DHHS, gave evidence that:

> … the State Controller is our lead person within the State Control Centre, to ensure that for any threat that requires multiagency response under the health emergency, that appropriate arrangements are put in place, so that there is a clear definition of the purpose of an operation, that there is a clear plan for who needs to be involved, what their roles and responsibilities are and who the key contacts are for each part of the multiagency response.[101]

48. Ms Peake also gave evidence about the way the emergency management arrangements in this complex emergency intersected with other aspects of the response which drew on existing arrangements and expertise:

> … the scale and complexity of this operation means that there have had to be capabilities and skills and legal powers and resources from every Department that have been brought to bear, some of which fit within the scope of this manual and an emergency multiagency response, some of which are just relevant to the normal functions of each Department administered under the Public Administration Act and Financial Management Act, and for parts of the response, the role of the control agency has been to determine who should be the appropriate lead.[102]

49. The Class 2 State Controllers – Health appointed in February with respect to the COVID-19 emergency,[103] testified on the different concepts of command, coordination and control, Mr Helps noting that "there was a lot of coordination in the role. But as Andrea said, there was elements of their operation --- of various operations where we exercised control functions as well". Ms Spiteri

[96] T1354.1 – T1355.24 (Crisp).
[97] Statement of Christopher Eagle dated 11 September 2020, [11]-[13].
[98] T1432.40 – T1433.9 (Eagle).
[99] T1307.31-T1307.35 (Bamert).
[100] T1210.30 – T1211.46 (Skilbeck).
[101] T1892.40-45 (Peake).
[102] T1990-T1991 (Peake).
[103] Statement of Andrea Spiteri dated 9 September 2020 at [7]: her appointment was 1 February to 3 July. Mr Helps was appointed 7 February.

gave evidence that the role of the State Controller – Health role for this Class 2 emergency "became one of overall coordination of the implementation of both Chief Health Officer and government decisions and directions across government and agencies, through the operational arrangements for COVID-19, utilising the structures and resources of the State Control Centre".[104]

50. When asked about this, Ms Spiteri explained:

> …the role of the State Controller in leading the State Control Team, was coordinating across the different Government Departments, the agencies that are reflected in the State Emergency Management Team and ensuring that there was good coordination of public health information and advice into those other areas of Government and agencies, sectors and communities, to make sure that any of their planning and responses to what might be the effects of the emergency were well informed by the public health responses. So that was a key role.
>
> … the Emergency Management Manual Victoria also envisages, for very large and complex emergencies, where there are multiple accountabilities by different Government Departments and agencies, that the control agency may see itself as a lead agency in coordinating as part of its control function..[105]

51. The passage in Part 7 of the EMMV to which Ms Spiteri referred is 7-1 and states:

> There are complex emergencies where a shared accountability across a number of agencies occurs. In these cases there is a need for a single agency to be responsible for the collaborative response of all the agencies. For the purposes of consistency the term control agency will be used to describe this lead agency role.[106]

52. All witnesses with whom the issue was raised agreed that this was a complex emergency within the meaning of the EMMV.[107] Witnesses agreed that the support agency of which they were part had responsibility for the performance of the designated functions of that agency in the emergency response, as did Commissioner Crisp.[108]

53. The overall effect of this evidence from those people experienced and involved in the emergency management framework is to emphasise the importance of emergency management arrangements to facilitate a multi-agency response to complex emergencies, for which no one agency has the resources or expertise and experience to respond alone. Every agency, including DHHS, responded by meeting the urgent and complex challenges in a committed way, with the individual dedication of many hundreds of staff.

54. DHHS rejects the submission that it did not properly understand the role and importance of a control agency.[109] While suggestions were raised in the course of the hearing that the control agency must have control in the purely literal sense, as well as command and responsibility for every task undertaken across an entire emergency, this does not reflect the reality of emergency management; nor is it a desirable, feasible or sustainable approach to future emergency management. It is not an appropriate role for a control agency is to supplant the proper functions of every government department and agency, cabinet and parliament in responding and oversighting the response to the pandemic. It would neither be feasible nor practicable for the Department to assume responsibility for directing or administering functions such as tax relief and cashflow support for businesses, OHS regulation for all industries or managing changes to the public transport network to make it safe for commuters.

55. Furthermore, it is customary for departments to directly deliver and contract services under an emergency – in line with the best utilisation of government resources and capacities. For example, the DELWP contracts a range of fire-fighting resources to support EMV in fighting wildfires– and remains responsible and accountable for those functions.

56. This is why the EMMV envisages models of shared accountability for complex emergencies, and details operational command structures for all agencies involved in the emergency response. It is why the infrastructure of the SCC is available to facilitate sharing of intelligence, enable scenario

---

[104] Statement of Andrea Spiteri 9 September 2020, at [31].
[105] T1585.45 – 1587.8 (Spiteri). Ms Spiteri noted that she was referring to Part 7 of the EMMV: T1587.1-18.
[106] Ex 145, (Emergency Management Manual Victoria) DOJ.600.001.0501.
[107] T989.22 – T991.21 (Rachaele May, DJPR); T1429.11-40 (Commissioner Andrew Crisp); T 1593.31 and T1631.40-44: (Jason Helps, DHHS, State Controller); T1892.35 – 45 (Kym Peake): "The Emergency Management Manual is really clear that for complex emergencies here will be shared accountability for tackling that emergency, and I think it is very fair to say that COVID-19 is the most complex emergency that we've ever experienced, health or otherwise."
[108] T426.4 -T427-11 (Febey, DJPR); T989.22 – T991.21 (May, DJPR); see also Statement of Rachaele May dated 12 August 2020 at [23] as to her understanding of the designated functions; T1417.44—T1418.1 (Andrew Crisp).
[109] T2205: 1-2 (Ellyard).

planning and identification of enterprise-level risks for the Victorian government, and support multi-agency operations to tackle specific threats and consequences associated with a complex emergency. It is also why the crisis structures of government at a federal and state level were established to enable whole of government leadership and decision-making on overall strategic directions for the COVID response.

57. In any complex emergency, but particularly an emergency that impacts on the operation of every portfolio of government, every sector of the economy, and every household in the state – the response, while under the control agency, will not only have support agencies with specific and potentially significant functions to perform which align with the agencies' areas of expertise, but may also have multiple lead agencies addressing particular matters arising through the emergency.[110]

58. In addition to the role of DHHS as the control agency for Victoria's COVID-19 response, the DJPR, Department of Transport (**DoT**),[111] and Victoria Police[112] all had roles within their areas of expertise and experience as support agencies both in the wider emergency response and in the Operation Soteria response (as well, in the case of DJPR, as a shared function with DHHS relating to hotel quarantine under the Missions structure).[113] All agencies – both control agency and also the support agencies - also had command responsibility within their own agency, involving the reporting lines in place in that agency in discharging or their response activities, contractual, or legislative obligations.[114]

59. The State control arrangements were set out in the State Strategic Operations Plan[115] and the State Operational Arrangements- COVID-19 which was approved by the EMC on 21 May 2020 and by the State Controller Health on 22 May 2020[116]

60. The complex nature of the emergency – and the intersection of the legislative powers required to manage it, in particular the fact that directions were made under the PHW rather than under the Emergency Management legislation – necessarily involved some complexity in the organisational structure to address the operation.[117]

61. Following the establishment of a specific operation – Operation Soteria – for hotel quarantine under the State Control framework, specific plans for Operation Soteria were successively developed. On 27 March 2020, the EMC advised the State Controller and the State Consequence Manager of the need to develop an operational plan for the program.[118] That plan developed in the SCC by DHHS with the assistance of the ADF became the Operation Soteria Plan which was approved by the EMC and became operational at 11.59pm on 28 March 2020[119]. Further versions of the plan were developed and progressed in response to evolving operational needs: the Operation Soteria Plan version 1.1 was developed on 29 March 2020, Operation Soteria Plan version 2.0, which was reviewed by, among others, the Public Health Commander and approved and authorised for release by the EMC, became operational on 29 April 2020,[120] and Operation Soteria Plan v 2.1 was also reviewed by the PHC authorised for release by the EMC on 8 May 2020.[121] The final version of the Plan, v3, was authorised for release by the EMC 26 May 2020 again after review by the PHC.[122]

62. The Operation Soteria Plans set out the roles of the various agencies in the program: the DHHS as control agency,[123] the Australian Border Force, AFP and Department of Foreign Affairs and Trade[124] and the DoT, Ambulance Victoria, Victoria Police and Department of Jobs, Precincts and Regions (**DJPR**).[125] For example, under Operation Soteria Plan, DJPR was identified as responsible for the following:

---

[110] **T1893**.5-13 **(**Kym Peake**) -** noting that DHHS while the control agency for the COVID-19 pandemic emergency is, out of the 14 opera ions running through the State Control Centre, the lead agency for 4 of them, and is not, for example, the lead agency "for the management of roadblocks for ensuring that there isn't movement between metropolitan Melbourne and regional Victoria" notwithstanding the relationship to the public health response. This is because the expertise as well as necessary legislative powers and a command structure lie with Victoria Police.
T1210.44 **– T1211.**30 (Melissa Skilbeck on the distinction between control agency and lead agency).
[111] T1217.18- 23 (Skilbeck).
[112] The witness statement of the Honourable Lisa Neville sets out the responsibilities of Victoria Police in Operation Soteria at [25]. LMN.0001.0001.0003.
[113] Statement of Christopher Eccles dated 8 September 2020, at [74], footnote 46]; see attached DPC.0001.0002.0003 at 0018.
[114] Exhibit 162, statement of Andrea Spiteri [22]. T1354.1 – T1355.24 (Crisp).
[115] Statement of Andrea Spiteri dated 9 September 2020, [32] and attached document DHS.5000.0131.5853: State Strategic operations Plan for the weekly period 30 March 2020 to 12 April 2020.
[116] Exhibit 167: State Operational Environment COVID-19 DHS.5000.0032.1850_R. See also statement of Commissioner Andrew Crisp at [12](b)].
[117] T 1593.31 (Helps).
[118] Ex 144, statement of Andrew Crisp [34].
[119] Ex 144, statement of Andrew Crisp [40]. For all plans see statement of Pam Williams, [20] and attachments. Pan v1 is DHHS.0001.0001.1475.
[120] Ex 144, statement of Andrew Crisp [41]. For plan see statement of Pam Williams and attached documents (Exhibit 131) DHHS.5000.0079.0864l See first page for review and authorisation details.
[121] Statement of Pam Williams, Exhibit 130 and attachments exhibit 131, DHHS.0001.0008.0517.
[122] Statement of Pam Williams, Exhibit 130 and attachments exhibit 131, DHHS.0001.0001.2245.
[123] Taking v2.1 of the Plan, effective 8 May (DHHS. 0001.0008.0517, exhibit 131) see part 2.4, pages 7-9.
[124] Taking v2.1 of the Plan, effective 8 May (DHHS. 0001.0008.0517, exhibit 131) see parts 2.5-2.7, page 9.
[125] Taking v2.1 of the Plan, effective 8 May (DHHS. 0001.0008.0517, exhibit 131) see parts 2.8 to 2.11, pages 9-10.

(a) manage accommodation contracts; [126]

(b) manage transport arrangements and contracts for deliveries;

(c) manage private security contracts to enforce quarantine requirements at accommodation;[127]

(d) establish reception parties to coordinate passenger movement from transport to accommodation in conjunction with DHHS;

(e) establish reception parties at accommodation in conjunction with DHHS;

(f) prepare for incoming passenger accommodation registration at accommodation in conjunction with DHHS;

(g) reconcile passenger data with airside entry data;

(h) identify in detail, capture and manage the welfare needs of detainees, with DHHS;

(i) identify in detail, capture and manage special or social needs of detainees, with DHHS;

(j) manage services for all passengers including food, amenities and transport for deliveries.[128]

National Cabinet and Crisis Council of Cabinet

63. In addition to the emergency management arrangements, Victoria's COVID-19 response involved national and state Cabinet governance structures. This overlay was unique to this emergency and undoubtedly increased the complexity of the response and was not a matter directly considered by the Emergency management framework. A National Cabinet was instituted on 15 March 2020, drawing on advice of the Australian Health Protection Principal Committee (**AHPPC**). The AHPPC is a decision-making committee for national health emergencies comprising all state and territory chief health officers or their equivalents, chaired by the Australian Chief Medical Officer. It provides advice to whole-of-government bodies, the National Cabinet and the National Coordination Mechanism. The AHPPC also produces public advice on relevant issues it considers.[129]

64. A Crisis Council of Cabinet (**CCC**) and Mission Coordination Committee (**MCC**) 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.[130] The CCC replaced all Cabinet committees and functions as the core decision-making forum for the COVID-19 emergency.

65. The MCC, chaired by the Secretary to the Department of Premier and Cabinet (**DPC**), consisted of:

(a) senior leadership from the Premier and Treasurer's Private Offices;

(b) Mission Lead Secretaries; and

(c) DPC Deputy Secretaries with responsibilities for economic, social, corporate matters..

66. The functions of the Missions were considered and approved at CCC and set out in a document discussed and endorsed by the MCC on 17 April 2020, which Mr Eccles notes in his statement referred to quarantine for international arrivals,[131] and which reflect the shared accountability between the DHHS and the DJPR for the hotel quarantine program, by reference to each Departments' areas of expertise.

67. The Consolidated Mission Plans identify Ms Peake as Mission lead for the Health Emergency Mission, and refers to a range of health related responsibilities in response to the pandemic including responsibility for

> Implementing and managing emergency accommodation to support safe quarantining and isolation (bringing on supply, triaging demand, and developing wrap around supports.[132]

[126] And in prac ice, see T960.6 (May). See also Ex 41, statement of Shane D'Cruz [11] – [16], CML.0001.0014.0001; Ex 80, statement of Rachael May [23], DJP.050.002.0001. See also T558.30-35 (Menezes).
[127] And in prac ice see Ex 49 statement of Unni Menon [12] – [15], [34] – [35], DJP.050.006.0001; Ex 36, statement of Katrina Currie DJP.050.005.0001; Ex 59, statement of Principal Policy Officer, DJP.050.004.0001; Ex 61, statement of Gregory Watson, [59] – [65], WILS.0001.0015.0001; Ex 65, statement of Jamie Adams, [6], no Doc ID; Ex 63, statement of Shaun Hogan [11] – [12], WILS.0001.0010.0001; Ex 80, statement of Rachael May [82], DJP.050.002.0001.
[128] Ex 163, Operation Soteria v 2.0 at 10, DHS.5000.0079.0864.
[129] Exhibit 153, statement of Brett Sutton, 13 August 2020 at [15], DHS.9999 0002.0001.
[130] See DHHS initial response to Board, DHS.0001.0114.000; Ex 164, statement of Jason Helps [28].
[131] Statement of Christopher Barcroft Eccles dated 8 September 2020, at [74], footnote [46]; see attached document DPC.0001.0002.0003 at 0018.
[132] DPC.0001.0002.0003 at .0013.

68. The Mission 3: Economic Program Deliver, Supply, Logistics and Procurement Mission is identified in the Mission Plans as having Mr Simon Phemister as the Lead, and Minister Pakula as the CCC Minister. The Mission Plan for that mission refers on the first page to "Key priorities", including:

    (a) Supply and logistics lead for response effort

    (b) **Medical equipment and PPE**: Whole of Victorian Government supply and logistics for health and non-health medical equipment and personal protective equipment (PPE) requirements

    (c) **Accommodation**: Secure suitable accommodation stock for health and non-health response effort requirements

    (d) **Quarantine of international arrivals**: Working with DHHS, house arrivals in hotels and provide services throughout their stay.[133]

69. MCC was established as the main forum to support the delivery of the missions, including strategic decisions taken by National Cabinet and the CCC, and consider a range of policy matters. Reporting and submissions to the CCC with respect to the hotel quarantine program was done jointly by DHHS and DJPR: see submissions to the CCC noted by the Secretary to the DPC, Chris Eccles, as relating to the hotel quarantine program, on the following dates:

    (a) 8 April 2020,[134], noting at [20] and [21] that

        > Roles and responsibilities for the hotel quarantine program have been shared by DJPR, SCC, DHHS and Victoria Police.
        >
        > As the emergency accommodation program expands to cater to other cohorts, DJPR should continue to retain its responsibility for sourcing accommodation and managing industry and accommodation provider relationships, while DHHS will retain its responsibility for the specific needs of different cohorts in its remit, and health advice around COVID-19 precautions.

    (b) 24 April 2020,[135] and

    (c) 4 June 2020.[136]

70. Both the CCC and the MCC were supported by a Mission Coordination Unit within DPC.[137]

The initial set up: implementation of hotels, security and supporting services

71. The evidence is relatively uncontroversial as to the initial implementation of the hotel quarantine program after the announcement of the National Cabinet decision to require all travellers arriving in Australia to undertake mandatory 14 day quarantine.[138] Mr Eccles left the National Cabinet meeting which was taking place at about midday to call Mr Phemister, Secretary to the DJPR, to inform him of the decision, advising that there was a priority of sourcing accommodation.[139] DJPR had already been tasked and had undertaken considerable work in securing hotel rooms for latent capacity in relation to the pandemic, and for which it had been given an $80 million budget allocation by the Expenditure Review Committee on 20 March 2020.[140]

72. Mr Phemister also called Jeroen Weimar, from the Department of Transport.[141] Ms Peake, learnt about the program shortly afterwards from staff who had attended a debrief on the National Cabinet conducted by DPC staff.[142] From that point Mr Phemister understood that DJPR had lead responsibility for delivering the Program and that he needed to identify each of the building blocks to implement the program.[143] This was also the understanding of others involved in the program.[144]

73. On the afternoon of 27 March there was a meeting of the Victorian Secretaries Board at which the hotel quarantine program was discussed. The discussion at the meeting was the effect that DJPR

[133] DPC.0001.0002.0003 at .0018.
[134] Statement of Christopher Barcroft Eccles dated 8 September 2020, at [51](a) see attached document DPC.0001.0001.0733; noting at 1 on page 1 that DHHS.
[135] Statement of Christopher Barcroft Eccles, at [51](b) attached document DPC.0001.0001.6565.
[136] Statement of Christopher Barcroft Eccles, at [51](c) see attached document DPC.0001.0001.0357.
[137] Ex 186, statement of Kym Peake [256] – [260], DHS.9999.0009.0001.
[138] Board chronology item 28, DPC 0001.0001.6617.
[139] Statement of Christopher Barcroft Eccles, [22](a) and [77]-[78]. DPC.0017.0001.0001 (exhibit 177). See also T1757 10-42.
[140] Statement of Christopher Barcroft Eccles, [79]. DPC.0017.0001.0001 (exhibit 177). See also as to the budget allocation the 8 April 2020 CCC submission exhibited to Mr Eccles statement: DPC.0012.0001.0733 (referred to at par 51(a) of the Statement).
[141] Statement of Christopher Barcroft Eccles, [78]. DPC.0017.0001.0001 (exhibit 177).
[142] Statement of Kym Peake [107]-[108].
[143] Statement of Simon Phemister [26].
[144] See eg Statement of Commissioner Andrew crisp [45].

was leading the implementation of the program.[145] The Secretary for the Department of Justice and Community Services noted that it was necessary to be cognisant of the fact that the SCC had been stood up which was acknowledged by Mr Phemister and Mr Eccles.[146] There was then a SCC teleconference attended by representatives of DJPR, DHHS, Victoria Police, and the EMC.

74. Mr Phemister appointed Ms Febey as the DJPR lead for the program from 27 March to 14 April, and subsequently Rachaele May.[147] Other DJPR staff were tasked with putting in place contracts for key aspects of the hotel quarantine program: Mr Unni Mennon being tasked with hotels, Ms Currie with identifying security firms and Principal Policy Officer for being contract manager. Ms May had responsibility with respect to cleaning contracts for COVID positive rooms.[148]

Hotels

75. Work on the initial identification and contracting of hotels was undertaken prior to the Hotel Quarantine program, as part of the Hotels for Heroes program.[149] Mr Unni Mennon explained that he had been tasked by Mr Phemister to contract hotels to accommodate vulnerable people who required accommodation to self-isolate,[150] and was then given primary responsibility for identifying and procuring hotels for the purpose of the Program as an extension of that role.[151] He was contacted by Mr Phemister on 27 March 2020 and was tasked "to then swiftly secure an appropriate pipeline of accommodation to allow the mandatory quarantining to take effect as of 29 March."[152] The DJPR were responsible for Hotels effectively for the program from inception until transferring the Hotels to DHHS from 1 July 2020.[153]

76. Mr Mennon was well placed for this role as he not only had been contracting hotel services from 22 March 2002, prior to the hotel quarantine program but that more generally he "had a fair amount of experience and exposure in contracting third party services for a variety of functions, both in the private and in the public sector."[154] He had also prior to 27 March 2020, been involved in discussions with "major peak bodies representing accommodation providers in Victoria, the Australian Hotels Association and Accommodation Association of Australia"[155] specifically regarding sourcing accommodation for people positive for COVID-19.

77. The contracts required by clause 2.1(d) that each Hotel must

> …subject to clause 2.1(e) ensure that each Room is thoroughly cleaned and disinfected at minimum:
>
> (i) prior to the commencement of each Department's Nominee's stay; and
>
> (ii) as soon as practicable following the conclusion of each Department Nominee's stay,
>
> to a standard consistent with the most recent recommended public health standards in respect of COVID-19.[156]

78. Clause 2.1(e) stated that the hotel must:

> if there is a confirmed case of COVID-19 … allow the Department's representatives to enter the Supplier's premises in order to undertake specialised cleaning of the relevant Room. For the avoidance of doubt, these specialised cleaning services will be at the cost of the Department.[157]

---

[145] Notes of VSB Meeting 27 March 2020, DPC.0013.0001.0001 at 0004. Notes attached to the statement of Christopher Barcroft Eccles, DPC.0017.0001.0001 (exhibit 177)at [59], fn 36.
[146] Notes of VSB Meeting 27 March 2020, DPC.0013.0001.0001 at 0004. Notes attached to the statement of Christopher Barcroft Eccles, DPC.0017.0001.0001 (exhibit 177)at [59], fn 36.
[147] Statement of Simon Phemister par [32].
[148] Statement of Rachaele May 12 August 2020 at [86]; Second Statement of Rachaele May dated 28 August 2020.
[149] Statement of Simon Phemister [28]; [48].
[150] Ex 49, Witness Statement of Unni Menon, DJP.050.006.0001 [13].
[151] Statement of Simon Phemister, [48].
[152] T631.17-19.
[153] T631.4.
[154] T631.44-46.
[155] T633.21-22.
[156] Ex 49, Statement of Unni Menon [18]. For the relevant hotel contracts see, Rydges: Ex 45, Statement of Rosswyn Menezes, [11], referring to Ex 46, Agreement for the Provision of Accommodation between DJPR and Charlor Pty Ltd, 27 March 2020, RYD.0001.0010.0018 (see also RYD.0001.0010.0003 for full contract). Stamford: Ex 47, Statement of Karl Unterfrauner, [9], referring to Ex 48, Agreement for he Provision of Accommoda ion between DJPR and SPM (1994) Pty Ltd, 12 April 2020, STAM.0001.0004.0304.
[157] Ex 49, Statement of Unni Menon [18]. As to the implementation of this division of cleaning responsibility and DJPR's responsibility for implementation of the specialist COVID-19 positive cleaning, see: Ex 41, statement of Shane D'Cruz [54] – [55], CML.0001.0014.0001; Ex 49, statement of Unni Menon, 24 August 2020 at [18], DJP.050.006.0001; Ex 82, statement of Rachael May [5], DJP.050.002.0032; T520.2-15 (Cruz); T521.39–44 (Ferrigno); T605.4 (Unterfrauner).

79. Clause 2.1(h) required that the relevant hotel was:

> …responsible for, ensuring that before its officers, employees, agents, contractors and sub-contractors perform the Services, they receive:
>
> (i) adequate training in security, workplace health and safety, customer service and risk management; and
>
> (ii) are provided with personal protective equipment in accordance with the relevant public health standard, including but not limited to in relation to COVID-19….[158]

80. All of these requirements were reasonable and prudent and were consistent with the pre-existing legal obligations with respect to cleaning of premises for hotels and other accommodation.[159] There is no evidence that there was a suggestion by the Hotels at the time – or after the event – that they were unable to comply with the conditions required or that they were unreasonable, and in fact the evidence of the hotels was (as discussed below at paragraphs 212 to 223) that comprehensive training was provided by them to their staff.

The decision to engage private security

81. Noting the attention given in the Inquiry to the issue of who made the decision to use private security firms, it is clear that it was not a decision made, participated in or sought by any DHHS representative.[160] The evidence is to the effect the Chief Commissioner of Police (**CCP**), the EMC, and the Minister for Police and Emergency Services were all aware of the decision prior to the 27 March SCC meeting[161]. Mr Crisp gave evidence that he had "already been informed that the DJPR had been allocated responsibility by the DPC for sourcing accommodation and private security … before 4.30pm meeting."[162] At that meeting it was expressed to all parties that the preference of the CCP was to use private security, this exchange was recorded and played to the Board in evidence[163].

82. The CCP and his command had the relevant expertise with respect to use of private security in the program. The CCP is responsible for licensing and regulation of the security industry in Victoria under the *Private Security Act* 2004 (Vic) including the granting of security licences[164] renewing security licences[165] variation and cancellation of security licences[166] and conducting disciplinary inquiries into security licences or security businesses.[167] There was no basis on which at that time it was incumbent on DHHS to oppose the use of private security, the engagement of which was in any event well in train by the time the program came within the emergency management arrangements. Prof Sutton, for example, explained that he "wouldn't have had sufficient familiarity with [the industry] to have made some of the conclusions that [he] can make now by virtue of having seen some of those complexities play out."[168] It was only later that specific difficulties in the security guard workforce became evident.[169] It is in retrospect that the interplay of a casualised workforce and the dependency on work was identified as involving difficulties, predominantly in the context of contact tracing.[170]. There is no evidence that any person had, or should have been on notice of, those concerns when security was engaged.

The engagement of security and the management of security contracts

83. The DJPR was tasked to identify and contract private security prior to the 27 March 2020 SCC Meeting. The process by which that occurred was detailed in the evidence of Katrina Currie. Ms Currie was tasked by email at 12.17pm on 27 March by DJPR Deputy Secretary Alex Kamenev to nominate a person at DJPR to obtain work with Unni Menon to obtain a "cleaning and security workforce" for the Hotel Quarantine program.[171] At 10.17pm on 27 March, an email was sent to Unni

[158] Ex 49, Statement of Unni Menon [18]; see also T562-563 (Menon).
[159] *Public Health and Wellbeing Prescribed Accommodation Regulations 2009*, regulation 18(b) (A proprietor of prescribed accommodation must maintain the prescribed accommodation and all bedrooms, toilets, bathrooms, laundries, kitchens, living rooms and any common areas provided with the accommodation – …. (b) in a clean, sanitary and hygienic condition …").
[160] See the evidence of the two State Controllers which was clear that they did not make any decision relating to private security: T1631.5-9 (Spiteri) and T1630.42-T1631.3 (Helps).
[161] T1666.5-47 and T1668.4-8.
[162] T1401.25-27.
[163] Ex 145, Recording of State Control Centre Meeting 27 March 2020, DOJ 511.001.0001, played to Board of Inquiry T1379.10- 30.
[164] Division 2 *Private Security Act* 2004.
[165] Division 3 *Private Security Act* 2004.
[166] Division 4 *Private Security Act* 2004.
[167] Division 5 *Private Security Act* 2004.
[168] T1504.45-47.
[169] T15304.37 – 47 (Sutton). Statement of Dr Looker, [95]l Statement of Dr Crouch at [88]-[89]; Statement of Dr McGuinness at [97]-[99].
[170] T1494.35 -T1496.9 (Sutton).
[171] Ex 36, statement of Katrina Currie, DJP.050.005.0001 [11], Email Ex 37 DJP.104.008.6765.

Menon nominating Katrina Currie as that person.[172] Ms Currie was involved with other DJPR staff in determining the roles and responsibilities for security prior to contracting with the agencies.[173]

84. Rachaele May explained the DJPR role as being "responsible for ensuring the provision of security, and held and managed those contracts. Over time the role of security changed and numbers were scaled up as policies changed."[174] A principal policy officer at the DJPR explained that "Due to the urgency of request, the main priority at the beginning of the program was to get security contactors onsite and ready for return travellers to arrive"[175].

85. On 28 March 2020, Ms Currie advised Mr Phemister that she had identified Unified Security and Wilson Security as licensed security providers that had trained staff, could supply PPE and were ready to stand up in the program.[176] MSS Security were also engaged as security providers in the program but on the basis of existing state purchase documentation[177]. Mr Phemister directed Ms Currie to proceed in procuring those security providers on behalf of DJPR.[178]

86. Ms Currie gave evidence that even prior to the contractual requirements being finalised she advised the security providers verbally in initial discussions that they would be required to provide their staff appropriate PPE and that all staff would be required to undertake Commonwealth's COVID-19 training and she "subsequently requested that this requirement be included in the written agreements with each private security company."[179]

87. Ms Currie's subordinate, the Principal Policy Officer who was made the departmental representative for the security contracts, and who gave evidence that the DJPR was in charge of ensuring compliance with the security contracts[180] explained that the substance of the contractual requirements that related to risk, predominantly PPE, staff training and risk assessments/preplanning were specifically considered and communicated with the contracting parties in advance.[181]

88. The terms of the service contracts drafted by DJPR legal[182] include a clause by which the security company:

> …acknowledges and agrees that it and its Personnel, while delivering the Security Services, are likely to come into contact with people who have or may potentially have COVID-19.

89. The terms also provided for provision of training by the security company:

> The Service Provider must (at its cost) and will be responsible for ensuring that before the Service Provider's Personnel perform the Security Services they receive:
>
> a) adequate training in security, workplace health and safety, customer service and risk management as applicable for the provision of security services and, including but not limited to, in relation to COVID-19;
>
> b) meet all relevant safety induction requirements …and
>
> c) in addition to the above, have undertaken the Australian Government Department of Health COVID-19 infection control training module, or any and all other COVID-19 awareness training as directed by the Purchaser….[183]

90. The firms were also required to wear and provide PPE[184] and there is in any event no evidence of a shortage of PPE. The basis on which the firms were contracting – including obligations as to training

[172] Ex 36, statement of Katrina Currie, DJP.050.005.0001 [12], Email Ex 37 DJP.101.002.1076.
[173] Ex 36, statement of Katrina Currie, DJP.050.005.0001 [17] –[20], Emails Ex 37 DJP.105.004.0936 and DJP.105.004.0936.
[174] Ex 80, Statement of Rachaele May, DJP.050.002.0001, [82].
[175] Ex 130, statement of Principal Policy Officer (DJPR), DJP.050.004.0003, [21].
[176] Ex 36, statement of Katrina Currie, DJP.050.005.0001 [23], Minutes Ex 37 DJP. DJP.201.002.0002.
[177] Ex 36, statement of Katrina Currie, DJP.050.005.0001 [24].
[178] Ex 36, statement of Katrina Currie, DJP.050.005.0001 [23].
[179] Ex 36, statement of Katrina Currie, DJP.050.005.0001 [36] – [37].
[180] Ex 130, statement of Principal Policy Officer (DJPR), DJP.050.004.0003, [55].
[181] Ex 130, statement of Principal Policy Officer (DJPR), DJP.050.004.0003, [24]: "On 1 April 2020, I was instructed by Ms Currie to make arrangements for the drafting of contracts … In hat email, Katrina asked me to consider a number of issues as part of the procurement process: Key questions to check on: - Access to PPE – if not available they will need to let us know so we can negotiate via Claire Febey and her team to source - Staff training – ensure they have done online COVID awareness training available from the Commonwealth - Capacity to scale up quickly – ensuring they have access to a staff pool that can be deployed fairly quickly when required - Site walk throughs prior to assess staffing needs – access/entry points - Evacuation protocols for each site."
[182] Ex 130, statement of Principal Policy Officer (DJPR), DJP.050.004.0003, [23].
[183] See for MSS: Statement of Jamie Adams, exhibit 65; at [80], referring to the signed Purchase Order Contract, MSSS.0001.0002.0050, see Specifications at 3, page .0065 (in exh 66); Wilson: Statement of Gregory Robert Watson Exh 61 WILS.0001.0010.0057 at [93], referring WILS.0001.0001.8812 (in exh 62). See clauses 3.12, 6, Specifications, and Schedule 14 Special Conditions. Unified: Statement of David Millward, USG.0001.0001.3941 (exh 69); contracts USG.0001.90991.2688 and USG.0001.0001.2688 (exh 70). Note latter document is missing the second part but that both documents are referenced at the statement of Simon Phemister, [104] DJP.105.003 0793 (the missing one from Mr Nagi's statement) DJP.105,003.0817 (the one Mr Nagi references).
[184] See Clause 2 of the Specifications in the MSS and Wilson contracts, and clause 3.12 of the contract relating to the Service Provider's obligation to provide equipment, in combination with the Special Condition in Schedule 14 that this obligation extended to "all necessary personal protective equipment

and PPE - was acknowledged by the senior security firm representatives in their evidence,[185] and the evidence showed the significant training and safety assessments undertaken by them to ensure the safety of their staff, as discussed further below at paragraphs 225 to 230. PPE guidance was provided to the firms by DHHS on 12 May.[186]

RESPONSES TO SPECIFIC FINDINGS INVITED BY COUNSEL ASSISTING

A. Pandemic planning

"Assumption" of risk and suggested failure adequately to mitigate

91. Counsel assisting's submission that "in setting up the Hotel Quarantine Program in response to the infection risk posed by returned travellers, the State created a program which carried within it its own infection risks [and] In doing so, the State assumed responsibility itself for identifying and managing those risks[187]" does not, with respect, start at the appropriate premise as established on the evidence. The fact is that the original and subsequently the predominant source of COVID-19 infections was from people entering Australia from overseas.[188] If returned travellers were to return to Australia, as agreed by National Cabinet, it was the entry into Victoria of travellers potentially infected with COVID-19 which created the risk. The issue then was in fact an assessment of whether having returned travellers from overseas isolate at home was a greater risk of transmission of COVID-19 within the community than if those travellers were detained in a hotel quarantine program. This is exactly what the CHO and DHCO considered:

> …on balance, at that particular time, the most appropriate thing was to require people to undertake their quarantine in a hotel scenario so that we could be absolutely certain that incoming importations were being contained in the hotel environment rather than having an opportunity to spread into the community with less control.[189]

92. They were far from alone in that assessment; all other states instituted hotel quarantine measures and by 26 June 2020 the AHPPC remained of the view that all international travellers should "continue to undertake 14 days quarantine in a supervised hotel".[190]

93. There was no complete mechanism to ensure observance of quarantine in the home environment – which does not simply involve ensuring that persons do not leave the home but that no one enters and any contact with persons delivering goods or providing services does not involve a transmission event.[191] The police and the public health officers already had information as to returned travellers not properly isolating.[192] The uncontested evidence was there were very real practical difficulties in supervision of several thousand people spread across the state rather than across a smaller number of locations that are proximate to one another.[193]

94. It is not, therefore, consistent with the evidence and the reality of the pandemic and the State of Emergency in March to find that the State "assumed responsibility" for a risk of transmission of COVID-19: that risk was created by the virus itself, and any decision to permit persons to enter Victoria from overseas. There were then choices to be made as to how to deal with this risk but the hotel quarantine program did not create it.

95. The reality of the risk of significant community transmission arising from the return of overseas travellers is not only made clear in the uncontested evidence to the Board as to the transmission risks from overseas arrivals,[194] but from the public findings of the Special Commission of Inquiry into the Ruby Princess in New South Wales.[195] Further, it is clear that even in established environments such as hospitals which (unlike hotel quarantine) are designed from the infrastructure down with

---

to be worn by Service Provider Personnel in accordance with the relevant public health standards including but not limited to in relation to COVID-19": see eg MSS contract at MSSS.0001.0002.0050 at 0081.

[185] Mr Adams gave evidence that he had the expectation that all guards would at all times treat any person they came into contact with as if they did have COVID-19 in terms of the safety precautions: T 840.36-T841.1.

[186] See eg Statement of David Millward at [65]-[66] (Exhibit 69, USG.9999.0001.0001. Bamert statement at [24](b) and [40]; Exhibit 136.

[187] T2263.36-38 (Neal QC).

[188] Van Diemen Statement at [37].

[189] T1541.37-41 (Van Diemen). Note also the evidence of Dr van Diemen at T1157.37-1156 that "there were a number of discussions around potential alternative mechanisms for hotel quarantine … It became apparent very quickly that an entire a complete home-based quarantine system would not be feasible simply by virtue of the fact that we were receiving large numbers of interstate arrivals, and again a number of arrivals of individuals or families who had been out of Australia for a long ime and therefore didn't have a home to go to. So it became apparent that there would always need to be a degree of hotel quaran ine."

[190] Sutton at [182] referring to AHPPC Statement, 26 June 2020 published at https://www.health gov.au/news/australian-health-protection-principal-committee-ahppc-statement-on-hotel-quarantine.

[191] T1656: 18-22; T1566.24-35 (Van Diemen); T1481.27-44 (Sutton).

[192] T1682.24-.28, T1682.46 (Ashton), T1512.7 (Sutton) T1540.12 (van Diemen). See also par 403 below.

[193] T1564.38- T1564.1

[194] T1542.7-20 (Van Diemen).

[195] Report of the Special Commission, 14 August 2020, available at https://www.dpc.nsw.gov.au/assets/dpc-nsw-gov-au/publications/The-Special-Commission-of-Inquiry-into- he-Ruby-Princess-Listing-1628/Report-of-the-Special-Commission-of-Inquiry-into-the-Ruby-Princess.pdf.

infection control in mind and have highly trained workforces whose expertise involves infection control, it is not possible to create environments free of the risk of transmission.[196]

96. It is also important to recognise that the evidence available to the Inquiry was limited in scope, and does not provide a basis on which to make any reliable findings as to the mechanism of transmission from hotel guests at Rydges and Stamford to staff in the program nor as to what occurred after there was transmission and the chain of events which led to spread in the community. As noted further below, there is a range of evidence which could bear upon the transmission events which – understandably in the time available – was not called. There was also very limited evidence about what occurred after staff involved in the program contracted the virus. What is known is that Outbreak Management Teams were faced with difficulties including the failure of persons contacted in the contact tracing efforts to disclose honestly their movements and their contacts;[197] or accept alternative accommodation,[198] or to cease work while symptomatic.[199] These are just examples of the various matters which contributed to community spread; the task of considering what occurred after the immediate outbreak would be a very significant one, requiring a very significant range of other evidence to be considered before any conclusions could be drawn as to why these transmission events spread in the way that they did, when other such events have not had that result. As noted by Dr van Diemen "there is no single cause of the current second wave", but "hundreds of micro-decisions and actions … none of which would have individually been enough to cause the end result."[200] The complexity of the situation and the limits on the evidence before the Board are such that it would be unsafe to make the finding that "the movement of the virus through the barriers of quarantining is responsible for some 99 percent of the recent COVID-19 infections in Victoria"[201] nor indeed any reliable finding as to the relationship of the events examined in the hotel quarantine program, and subsequent ultimate consequences in the community.

Pandemic planning

97. Pandemic response planning and emergency exercises are a central tenant of emergency management in Australia with "planning for pandemics well entrenched in all health services across Australia.[202]" Prof Grayson explained that "since 1917 flu pandemic, influenza … has been a dominant focus of those pandemic plans[203]." Prior to COVID-19 Victoria had two pandemic response plans, the Health Management Plan for Pandemic Influenza[204] 2014 (**VHMPPI**) and the Victorian Action Plan for Pandemic Influenza 2015[205] (the EMV pandemic plan). Kym Peake explained that the purpose of the plan as set out in the VHMPPI "is to provide an effective health response framework to minimise transmissibility, morbidity and mortality associated with an influenza pandemic and its impacts on the health sector and community".[206]

98. Prof Grayson gave evidence as to the appropriateness of influenza pandemic plans to the COVID-19 response as being "perfectly fine in terms of coronavirus because it is just another respiratory virus" and "that many components of the pandemic plans, whether it is Federal or State are equally applicable to coronavirus".[207]"

99. As the threat of the Covid-19 pandemic materialised across the world and infections rose in Victoria the DHHS amended the VHMPPI to create the specific COVID -19 Pandemic Plan for the Victorian Health Sector.[208] Kym Peake explained that this plan "also informed the development of sector specific plans within DHHS's portfolio responsibilities, including disability services, aged care and community services"[209].

100. Counsel assisting took both Kym Peake and Prof Sutton to the 2009 Commonwealth Government review of the national response to the H1N1 Pandemic.[210] As they were not asked in the Notices requiring their respective statements about this Report which predated their roles at the DHHS by so

[196] See, for example, exhibit 200, "Protecting our healthcare workers", 25 August 2020, at page 2, no ing the numbers of COVID-19 infections acquired in healthcare set ings. See also the evidence of Ms Skilbeck on the impossibility of a risk free environment where coronavirus exists as shown in the experience of hotel quarantine in other jurisdictions: T1227.13-14; T1226.43-47.
[197] See Statement of Sarah McGuinness, Ex 106, at [96]-[101]; Statement of Clare Looker, Ex 97 at [86]; Statement of Simon Crouch, Ex 103, [87]-[89]. This included persons who were working as security staff: T.
[198] Statement of Clare Looker, Exhibit 97 at [89] and [95].
[199] T1555.38- T1556.20 (van Diemen, identifying the person referred to in DHS.5000 0034.6968 as a security guard).
[200] Statement of Anneliese van Diemen [150].
[201] T2267.26-28 (counsel assisting).
[202] T45.47.
[203] T41.41.
[204] Ex 145 (Annexure to Crisp Statement), VHMPPI, Department of Health, October 2014, DOJ.600.001.0325.
[205] Ex186, statement of Kym Peake [27].
[206] Ex 145, VHMPPI, Department of Health, October 2014, p.4.
[207] T41.45.
[208] Ex 186, statement of Kym Peake [28].
[209] Ex 186, statement of Kym Peake [29].
[210] Ex 156, Review of Australia's Health Sector Response to pandemic (H1N10 2009 – Lessons Iden ified, Australian Government, Department of Health and Ageing, (2009), HQI.001.0003.0001.

many years[211] (which advance request would have enabled enquiries to be made about contemporary responses to the report), it is unsurprising that when asked about the Report for the first time in cross examination, [212] they were unable to provide substantive information about it. While the report refers to a need for clarification of the roles and responsibilities of all governments for the management of people in quarantine during a pandemic, no witnesses from the Commonwealth or any Victorian or other State officials who may have been in relevant roles in 2009 and in a position to discuss the responses to the 2009 Report were called to give evidence.

101. In any event, on the face of the review it is clear that there is no reference to or consideration of mandatory mass quarantining. The one reference in the report to planning for "contact tracing and quarantining of large numbers of people after arrival in Australia" was put to Prof Sutton who explained that no formal quarantining of large numbers of people occurred at that time, but that "some individuals who were identified as close contacts of known cases would have been told to quarantine for a time".[213]

102. There is no evidence before the Board that Victorian pandemic planning was inadequate relative to any planning in any other State or Territory (or internationally). There is also no evidence before the Board of any more advanced or detailed planning for mass quarantine in any other national or international jurisdiction. Accordingly, it is respectfully submitted that no adverse finding can be made by the Board as to any inadequacy of the pandemic response planning in Victoria.

103. As to future planning, there is an existing system of review and oversight which is available to assist government planning for future pandemic responses including quarantine requirements. Given the potentially complex demands of emergency responses, the EMA does not contemplate departmental emergency management planning in isolation but provides a cross government framework for this purpose. The EMA requires the State Crisis Resilience Council (SCRC, consisting of the Department head of each Department, the CCP, the Chief Executive, Emergency Management Victoria and the EMC),[214] to develop a rolling 3 year Strategic Management Action Plan[215] which includes a work program for each agency[216]. Performance against this strategic action plan by each responding agency or department is monitored and reported on by the Inspector General of Emergency Management who has the role under the EMA has the function to "evaluate state-wide training and exercising arrangements to maintain and strengthen emergency management capability".[217] The role is described in the EMMV[218] as including "to provide assurance to the government and community in relation to Victoria's emergency management arrangements and [foster] continuous improvement of emergency management."

B. Emergency Management and DHHS as Control Agency

DHHS as control agency

104. Counsel assisting submitted that DHHS did not bring health and welfare expertise to the program and, in particular, the decision in February 2020 to appoint persons without public health expertise as the State Controllers for a public health emergency detrimentally influenced the way in which DHHS managed the hotel quarantine program.[219] The Board should not so find, for the following reasons, each of which are explained below. In summary they are as follows.

    (a) First, the evidence before the Board explains the rationale for the appointment of persons other than the CHO as State Controllers.

    (b) Second, the Public Health Commander fulfilled a role under the SHERP as part of the emergency management response.

    (c) Third, public health leadership, advice and expertise was sought by and operationalised in Operation Soteria, including through the CHO and Public Health Commander. This is found in the evidence from Dr van Diemen, Ms de Witts, and witness "Infection Control Consultant", as well as from Ms Williams and Ms Bamert.[220] While Dr Romanes expressed concerns about the consequences of the decision, the evidence shows that his policy work was implemented.

[211] Prof Sutton was working in East Timor at the time of the report: T1470.35-44.
[212] T1468.32-T1468.38 (Sutton).
[213] T1470.41-44.
[214] *Emergency Management Act* (2013) Vic s 8.
[215] *Emergency Management Act* (2013) Vic s 12(1).
[216] *Emergency Management Act* (2013) Vic s 12(3).
[217] *Emergency management Act* (2013) Vic s 64(1)(d).
[218] Ex 145, (Emergency Management Manual Victoria) DOJ.600.001.0501 at DOJ.600.001.0789.
[219] T2264: 25-36 (Neal); T2203: 35-39 (Ellyard); see also T2203: 41-43 (Ellyard).
[220] Evidence of Ms Williams, T1269: 25-28; T1271: 11-12; Evidence of Ms Bamert, T1311: 9-12; T1334: 19-28.

105. The submission of counsel assisting has not appreciated the full scope and practical operation of the SCC and Operation Soteria roles, including those of the PHC and Deputy PHCs. In closing it was submitted to the Board that "the structures show that the Chief Health Officer and the Public Health Commander weren't in the line of hierarchy in Operation Soteria, they were off to one side.[221]" This is, with respect an over-simplification and does not take into account the enormous contribution that the CHO, DCHO and delegates have made to the pandemic response in the exercise of powers under the PHWA across the State and through his and his Public Health Commanders in the hotel quarantine program. This Inquiry has, by definition and terms of reference, been solely focussed on the hotel quarantine program. This has meant that understandably, it has not had in sight the immense task that the CHO and the Public Health Command have undertaken throughout this pandemic.

106. Public health expertise had a significant role in the Victorian hotel quarantine program, not only through the exercise by the CHO and delegates of his powers in the PHW Act and but also the valuable involvement of the Public Health Command staff including Dr Van Diemen and Deputy Public Health Commander Dr Finn Romanes.

107. Counsel assisting urges the Board to find that the appointment of State Controllers who did not have public health experience was a failing of the hotel quarantine program. Respectfully, this submission is not sustainable. If it that was the case, then each other State or Territory that has hotel quarantine (most of which have had transmission events but mercifully have not led to major outbreaks), would also be controlled by a person with public health experience. They are not.

108. Counsel assisting in closing submissions noted that contrary to the evidence of some DHHS witnesses, the program was not under the absolute control of the CHO.[222] This was not the position of the DHHS and the evidence to which this refers[223] should be considered in context of the witnesses' explanation of the CHO's powers under the PHWA which were central to the control response to the emergency across the State, including in the Public Health Commander's role in hotel quarantine. The comments should not be misinterpreted as an attempt to step away from the emergency management framework but instead an acknowledgement of the significant impact that the CHO and delegates had on the overall pandemic response and a genuine and a considered attempt to assist the Board to understand the multiple influences on the emergency response. Mr Helps' explanation was that "the State Controller-Health role was to complement the public health response."[224] These comments are supported by Mr Crisp's evidence as to the primacy of the powers under the PHWA and the "clear roles and responsibilities for the Chief Health Officer under the *Public Health and Wellbeing Act* and then once a State of Emergency is enacted…how we ensure that works, and the *Emergency Management Act* supports the overall health emergency."[225]

Appointment of State Controller

109. Kym Peake appointed the Director of Emergency Management in DHHS the State Controller Covid-19 on 1 February 2020.[226] This appointment was made on the advice of Deputy Secretary Melissa Skilbeck.[227] It is accepted that the appointment was not the default appointment considered in the SHERP, however, the SHERP identifies that an appointment needs to consider the "nature of the emergency and response"[228] and the Concept of Operations document prepared by the CHO and the Director, Emergency Management Branch, takes into account that there may be circumstances where the CHO is not appointed.[229]

110. Ms Skilbeck discussed her proposed recommendation of Ms Spiteri with the EMC prior to making the recommendation to Ms Peake, and he was also supportive of it.[230] Commissioner Crisp gave evidence that the CHO did not perform the role of State Controller "[b]ecause of the significant demands on his in responding to the public health emergency".[231] He was not cross examined on this evidence or at all with respect to the CHO not being appointed State Controller.

111. Any consideration of the whether the CHO should have been appointed the State Controller needs to be put in the context of the enormous task that the CHO has undertaken in this pandemic response. An examination of his already substantial commitment and involvement to addressing the pandemic

[221] T2206.22-24.
[222] T2264.38-40. (Neal QC).
[223] T1583.41 – T1584.5.
[224] T1583.47.
[225] T1352.7-10.
[226] Ex 186, statement of Kym Peake [52].
[227] Ex 186, statement of Kym Peake [52].
[228] Ex 161, State Health Emergency Response Plan, Edition 4, DHS.0001.0027.0883 at page 24.
[229] Ex 187; Concept of Operations – Department of Health and Human Services as a Control Agency and as a Support Agency in emergencies, Version 1.0, 25 November 2019. See Part 4: Principles. DHS.0001.0001.0004.
[230] Ex126, Instrument of appointment and brief signed by Kym Peake, DHS.0001.0001.0839.
[231] Statement of Andrew Crisp[16](a) DOJ.600 002.0008. Exhibit.

highlights the reasons that an alternative State Controller was considered appropriate. During this period the CHO had direct involvement in the management of the Public Health Command overseeing pathology, infection prevention and control, case contact and outbreak management and intelligence[232], contact tracing and legal directions[233], as well as his commitments to AHPPC, community education[234] and daily briefings to government and the media, and supervision of the Public Health Commander as his delegate.[235] If he were to have been State Controller another person would have had to have fulfilled some or all of these other vital roles, many of which involve engaging public confidence in the health response, a responsibility best discharged in an emergency of this kind by the most senior public health officer of the State.

112. It is accepted that Prof Sutton and others did not agree that he should not have been appointed. Dr Romanes said in his witness statement tendered to the Board that had the CHO been appointed it was "possible… [that] public health expertise [would] have been more embedded in the governance of the hotel quarantine program."[236] Dr Romanes ceased his involvement in Operation Soteria after 18 April 2020,[237] and Dr van Diemen as Public Health Commander in her continuing role had an overview of how his policy advice was in fact implemented.[238]

113. The basis for Prof Sutton's disagreement was that it was appropriate that he have a line of sight of operational elements for matters he was accountable for under the PHWA, to have a line of sight of the application of the controls and to be aware of the situational awareness of those activities.[239] As set out below, the Public Health Commander role, filled by Dr van Diemen, did have a significant role even if it was not exactly in the way the CHO envisaged.[240]

114. Contrary to counsel assisting submission's to the effect that there was a failure to engage public health experts in the operational aspect of the program, public health experts – including the CHO – were actively engaged in key operational decisions, including testing (see paragraphs 246 and 248), cohorting of positive travellers in a "hot hotel" (see paragraph **Error! Reference source not found.**-276), considering and granting exemptions (see paragraphs 369 and 376) and temporary leave (see paragraph 382) as well as providing ongoing IPC advice (see for instance paragraph 174). The Operation Soteria Commanders (or COVID Accommodation Commanders) gave evidence of working closely with DHHS's public health experts to implement public health policies and advice on the ground (see, for example, paragraph 144).

115. The evidence before the Board is also that the public health advice, including the very significant body of work by Dr Romanes on the State Physical distancing plan, was in fact:

(a) provided to participants in the hotel quarantine program through the SCC (see paragraphs 133 to 135 below); and

(b) embedded in the implementation of Operation Soteria, including through the Operation Soteria Plans in version 2 and 3. Attachment A to these submissions explains how Dr Romanes' public health policy advice was incorporated into the Operation Soteria plans.

116. The advice provided by Melissa Skilbeck to appoint Ms Spiteri to the State Controller – Health role directly contemplated the complexity of the role extending beyond matters of public health expertise. Relevantly Ms Skilbeck advised:

> I recommended the State Health Coordinator as controller for the 2019-nCov outbreak to manage the growing social and economic impacts of the virus across government and provide access to the needed logistics and communications support rather than hazard (virus) control[241].

117. Ms Skilbeck explained in cross examination the complex matters that were considered in proffering her advice including the demands on Prof Sutton's expertise and the "sheer scale of responsibilities of the Chief Health Officer", including his role in the AHPPC, State decision making and his vital role public communications. [242] Ms Peake agreed with the recommendation based on her understanding

[232] Ex 153, statement of Brett Sutton [34] [35]; T1218.39-T1219.19.
[233] Ex 186 statement of Kym Peake [62].
[234] AS to CHO's involvement in AHPPC and extensive communications involvement/community education T1218.39-T1219.19.
[235] T1453.22-23.
[236] Ex 113, statement of Dr Finn Romanes [82].
[237] Ex 113, statement of Dr Finn Romanes, [40].
[238] T1528.25-T1528.35 (van Diemen)
[239] T1485-35.
[240] T1493.23 (Sutton).
[241] Ex126, Instrument of appointment and brief signed by Kym Peake, DHS.0001.0001.0839.
[242] T1218.5-18 (Skilbeck).

of the "very significant operational responsibilities the CHO was already undertaking in response to the pandemic both at state and national level".[243]

118. While Prof Sutton disagreed with the decision to not appoint him, he gave evidence that he agreed that due to the current complexity it was appropriate that the CHO was now not the State Controller.[244] Dr van Diemen did not express disagreement with the appointment decision, and acknowledged the difficulty of the decision. In cross examination she explained:

> I would also, I think, agree with the sentiment that there was enormous requirements being made of everybody's time, and --- and can understand the reasoning that was given behind the appointment of the State Controllers. I have, I think, remained somewhat conflicted and on the fence about that, because I understand both --- both sets of logic and I'm not sure that there is an entirely correct decision in either respect at this point in time.[245]

119. It is clear that the question of the appointment raised a range of issues of real complexity, on which reasonable judgments could differ by reference to the prevailing circumstances, including an environment of constrained human resources at the time. The Board has heard of the making of many complex decisions, by senior public officials who were then able to explain the logic and reasoning for their decision-making. That an alternative decision may be regarded in retrospect as having been possible does not, by itself, call the original decision into question, Nor does the appointment of Ms Spiteri and Mr Helps support a finding that "DHHS didn't understand its control agency function and didn't properly perform it", as was put by counsel assisting.[246]

120. Whilst Ms Spiteri is not a Public Health Physician, she is an extremely experienced Emergency Management expert with significant experience in both health and emergency management.[247] Similarly, Mr Helps, having worked in emergency management with Victoria Police, Hospitals and the Department of Health and (immediately before the COVID-19 response), with significant duties in the multi-agency response to the bushfire emergency,[248] was extremely well placed to contribute his significant expertise to this emergency response as State Controller.

Interstate comparative analysis

121. Due to the constrained time and terms of reference of this Board of Inquiry, there has understandably been no focus on the response of other States or the Commonwealth, but as acknowledged by the Chair, "it can obviously often prove helpful to understand, even with the various legislative differences and structures, the use to which or the way in which various resources are being used."[249] While there has been no examination of the individual programs, a consideration of the legislative framework in other States[250] highlights that the pandemic responses of New South Wales, Western Australia or South Australia were implemented through emergency management frameworks which did not involve the Chief Health Officer (or public health expert equivalent) in "control" of the State's pandemic response.

Equivalent interstate emergency management schemes

State	State Controller or equivalent	Who issues quarantine directions	Who enforces quarantine directions
NSW	**State Emergency Operations Controller (Commissioner of Police).** *State Emergency and Rescue Management Act 1989 (NSW)* s 18.	**Minister for Health.** *Public Health Act 2010 (NSW)* s 7.	**Police** *Police Act 1990 (NSW)* s 30; *Public Health (COVID-19 Air Transportation Quarantine) Order (No 3) 2020 (NSW)*; **Enforcement officers.** *Public Health (COVID-19 Border Control) Order (No 2) 2020 (NSW)* cl 3(1), definition of 'enforcement officer'.
Qld	**State Disaster Coordinator (Deputy Commissioner of Police).** *Disaster Management Act 2003 (Qld)* s 21B.	**Chief Executive, Qld Health Chief Health Officer (during COVID-19 emergency).** *Public Health Act 2005 (Qld)* s 332.	**Emergency officers (includes police).** *Public Health Act 2005* s 315, definition of 'emergency officer, s 333, s 362G; *Police Service Administration Act 1990*

[243] Statement of Kym Peake, Ex 186, [53].
[244] T1486.23-29.
[245] T1533.29-34.
[246] T2207: 6-10.
[247] Ex 162, statement of Andrea Spiteri [3] – [6] as acknowledged by Prof Sutton who noted: "Andrea Spiteri has some health expertise. She's an excellent leader in the emergency management space within DHHS" T1486.4 -6.
[248] Helps Statement, [11]-[12]; [14].
[249] T1963.40-43.
[250] Ordinarily, *Evidence Act 2008* s 154 provides it is not necessary to prove legislation and subordinate legislation. In any event, *Inquiries Act 2014* s 61 provides that a Board of Inquiry is not bound by the rules of evidence and may inform itself on any matter it sees fit.

			(Qld) s 5.15 "Officer as employee of the Crown".
SA	**State Coordinator (Commissioner of Police).** *Emergency Management Act 2004 (SA)* s 14.	**Chief Executive of the Department of Health.** *South Australian Public Health Act 2011 (SA)* s 90(1) and *Emergency Management Act 2004 (SA)* s 25(2)(fb)	**Authorised Officers (includes police).** *Emergency Management Act 2004 (SA)* s 17.
Tas	**State Emergency Management Controller AKA State Controller (Commissioner of Police).** *Emergency Management Act 2006 (Tas)* s 10.	**State Controller.** *Emergency Management Act 2006 (Tas)* s 40.	**Police.** *Emergency Management Act 2006 (Tas)* s 40, Sch 1; Tasmania, *Gazette*, No 21954, 23 Mar 2020, 145. Authorised officers. *Emergency Management Act 2006 (Tas)* ss 33, 40.
W A	**State Emergency Coordinator (Commissioner of Police).** *Emergency Management Act 2005 (WA)* s 10.	**State Emergency Coordinator**	**Authorised Officers (includes police).** *Emergency Management Act 2005 (WA)* s 61.

122. The submissions of counsel assisting that it was preferable for Victoria's COVID-19 emergency response to have been managed by its CHO appears implicitly based on a view that if the CHO had been appointed State Controller – Health, the resurgence of COVID-19 in Victoria would, or at least, could have been avoided is contradicted by the approach of other States which focus on police and emergency management officers in the senior roles.

123. Importantly, counsel assisting also did not identify any way in which the CHO not being appointed State Controller is causally related to any particular outcome in hotel quarantine, much less the outbreak of COVID-19 in the community. There is insufficient evidence to find that there was any link between a failure to embed public health command in Operation Soteria and the transmission events. The Board did not examine the counter factual – which is purely hypothetical - in any detail. When it was put to Prof Sutton, he also resisted making any observations of the way in which the program may have operated differently.[251] On the contrary, the evidence that has been led as to the significant multi agency response and the utilisation of the Emergency framework, highlights the difficulties that a State Controller who did not have significant emergency management experience would have had in that role. The evidence is that public health command and advice was clearly and significantly embedded in the hotel quarantine program.

Public Health involvement in Operation Soteria

124. Counsel assisting also suggest that the appointment of health professionals as State Controller or otherwise involve them in the control arrangements (which, DHHS submits, is in fact what was done as the evidence discussed above establishes) would have increased the focus not only on health issues, including infection prevention and control (**IPC**). It is submitted that while the evidence shows some different views as to who was appropriately in the role of State Controller at the time, having regard to what actually occurred in practice there is no evidence –- that there was insufficient public health expertise involved in setting the policies and guidance for the program, or a lack of health and welfare services provided to returned travellers. In this respect the Board must be cautious to consider the evidence of what actually was done (rather than the concerns expressed by some – but not all – about not appointing a health expert in the State Controller role).

125. Public health advice and expertise were deployed in the operation of the hotel program in the following ways:

(a) the Public Health Commander role, fulfilled by the DCHO, had a role in the emergency management framework under the SHERP, discussed above at paragraphs 26 to 28.

(b) public health advice and expertise, in relation to IPC, PPE and cleaning was made available to[252] and was then implemented by Operation Soteria;

(c) development and implementation of policies relevant to health and welfare and exemptions[253]

(d) external public health advice was sought from both IPA and Alfred Health, in relation to, respectively, the standing up of Rydges as a hot hotel and then to run the quarantine hotels from June;

[251] T1488.3.
[252] Ex 203, Statement of Infec ion Control Consultant, DHHS.
[253] Statements of Dr Romanes and Statement of Dr van Diemen.

(e) through the working groups chaired by Prof Wallace on a daily to every few days basis from 14 April 2020 throughout the program, with representatives from Public Health Command, EOC, Compliance and State Control to discuss and agree on the approach to matters affecting health and wellbeing of travellers.[254]

126. In addition to the evidence as to the provision of advice and direction of the policy framework by the public health, there is a very large volume of evidence – not explored in the hearing, but provided in the statements of many DHHS and other witnesses – of the health and wellbeing services actually implemented, as discussed at Part G below.

127. DHHS also expanded two relevant IPC functions, both of which assisted in the hotel quarantine program. First, Dr van Diemen and the Infection Control Consultant gave evidence of the establishment of the IPC cell in DHHS in late March, to generate and provide COVID-19 IPC advice.[255] The cell is led by a Deputy Public Health Commander. The Board did not call her. Second, DHHS established a team of IPC outreach nurses (**IPCON**) to undertake outbreak visits across the state including to Rydges and Stamford.[256]

128. Further, the Board did not call evidence of and so did not hear of the considerable public health advice deployed through DHHS in its state-wide response to COVID-19,[257] in addition to its usual, ongoing public health work. By way of example, by 7 August 2020, 122 directions under the PHWA had been issued in relation to COVID-19 under the authorisation of the CHO,[258] each of which provided for the legal control of measures to address transmission risks.

COVID-19 Physical Distancing Plan

129. At the end of March 2020, and in her capacity as PHC, Dr van Diemen required that there be a clear plan for the whole detention process including clear exemptions protocols and pathways, and a centralised record for detainee information.[259] Dr van Diemen set this in motion by asking the Physical Distancing Lead and Deputy Public Health Commander – Planning, Dr Romanes, to advance the preparation of this single policy.[260]

130. At about that time, Dr Romanes had been preparing a policy document called the draft *COVID-19 – DHHS Physical Distancing and Public Health Compliance and Enforcement Plan dated 4 April 2020* (the **Physical Distancing Plan**).[261] The original focus of the document addressed state-wide public health control measures for COVID-19.[262] The then draft document was updated to address the mandatory detention of returned travellers to address their healthcare and welfare as well as the protocols applicable to AOs. Dr Romanes' evidence was that he did this with the objective of having a single policy and procedure document addressing the mandatory detention of returned travellers.[263] Public health colleagues responsible for welfare contributed relevant to welfare checks.[264]

131. The completed draft described a strategy and recorded the protocols for the physical distancing response to COVID-19 and also described many aspects of the compliance and enforcement policy for directions issued by the DCHO including the mandatory detention policy. It also included:

(a) policy and procedures to address the health and wellbeing of people in mandatory quarantine by identifying risks;[265]

(b) hotel quarantine matters and draft protocols, including about health and welfare and compliance;[266]

(c) the process for assessing and managing exemption requests.[267]

132. Dr Romanes explained in his evidence that careful management of all persons in hotel quarantine needed to be expressed clearly,[268] that this was important to him and that there needed to be a link

[254] Exhibit 118, second statement of Euan Wallace [6]; Ex 117, Working group minutes DHS.0001.0002.0093; Evidence of Wallace T1169.6-8.
[255] See van Diemen at [97] and Ex 203, Statement of Infection Control Consultant, DHHS at [18]-[24].
[256] de Witts, [11] and [15(a)], [31]-[32].
[257] For example, the Department staffed a hotline to provide COVID-19 advice to the community and clinicians: Peake second statement, [13(c) and (e) and Annexure A]; worked to provide state wide COVID-19 testing and determine tes ing criteria: Peake [262.4]; Sutton [22]; purchased PPE through Health Purchasing Victoria; COVID-19 Pandemic Plan, p20; developed new data systems such as the COVID-19 Compliance Application: Smitth, [53]-[65], T906.11-.20, T907.14-27 (Cleaves).
[258] Peake Statement at [22].
[259] van Diemen Statement at [25].
[260] van Diemen Statement at [26].
[261] Romanes Statement at [24] and [46]; Exhibit 114, COVID-19 – DHHS Physical Distancing and Public Health Compliance and Enforcement Plan, 4 April 2020, DHS.5000.0123.3241.
[262] Romanes Statement at [24].
[263] Romanes Statement at [25].
[264] Romanes Statement at [46].
[265] Romanes Statement at [46].
[266] Romanes Statement at [47].
[267] Romanes Statement at [47].
[268] Romanes Statement at [46] and [47].

between the policies for the public health control of COVID-19 and the controls and means to implement those controls, in addition to agreement on how compliance was then managed.[269]

Provision of COVID-19 Physical Distancing Plan to the implementing agencies and companies

133. On 4 April 2020, Dr Romanes emailed the Physical Distancing Plan to the DCHO and CHO for endorsement, and copied that correspondence others, including those within the Department with responsibility for operating the hotel quarantine program including the State Controller, Ms Spiteri.[270]

134. Around this time, the Physical Distancing Plan was provided through the State Emergency Management Centre (**SEMC**) to DJPR for provision to hotels and security in relation to, for example fresh air breaks and wellbeing and DJPR then providing it to security companies in relation to how those breaks should be managed from a public health perspective.[271] DJPR then distributed relevant instructions from the Health and Welfare Policy (the document that developed from the Physical Distancing Policy) on 9 April 2020 to all three security companies, MSS Security[272], Unified Security[273] and Wilson Security.[274] On 18 April, DJPR also sent through to security companies an Exercise and Fresh Air Policy Implementation plan.[275]

135. Dr Romanes also provided advice based on the Physical Distancing Plan on specific issues in response to requests from the SEMC staff, for example an email sent by Dr Romanes on 4 April 2020 in response to a query about the policy around how to manage smoking and fresh air for people. Dr Romanes provided the Physical Distancing Policy and extracted the relevant text of the detailed procedure for residents to leave their room for exercising or smoking into an email to explain how the procedure should be applied, taking into account IPC considerations.[276] This was provided to and implemented by Operation Soteria.[277]

Dr Romanes' 9 April 2020 email and actions taken in response

136. Dr Romanes, with the agreement of the PHC Dr van Diemen and the CHO made a formal request to the State Controller for a more complete operations plan, and also for a plan to be produced to address arrangements for the provision of health and welfare to people in mandatory quarantine.[278] On 9 April 2020, Dr Romanes made this request, on his own behalf and also on behalf of Dr van Diemen[279] and Prof Sutton,[280] who supported the issue being raised.[281] Prof Sutton gave evidence that he accepted Dr Romanes' concerns as his honest, if subjective appraisal of the Operation Soteria governance.[282] Dr Romanes explained the reason for that request as follows:[283]

> In order that public health risks were carefully and consistently managed, in early April, I formed the view that it was important for experienced public health staff to have an opportunity to design and influence the hotel quarantine program and to participate in its governance at the highest level. This was not least because the detention of people was arising through an assessment by public health of the need for the program and that it arose through the authorisation of the DCHO ….

137. The email is properly understood as a call on behalf of the DCHO in the early days of the hotel quarantine program for a cohesive, documented focus on wellbeing and health in the operational structures for hotel quarantine. That these matters were raised speaks positively to the direct involvement of the PHC and the Department's general commitment openness and freedom to raise matters leading to continuous improvement. The evidence demonstrates that it resulted in immediate and ongoing steps to this effect. In particular, Dr van Diemen gave evidence that the email achieved its desired purpose and health principles were incorporated into the program, including through a

[269] Romanes Statement at [47].
[270] Romanes Statement at [48]; Exhibit 114, Email from Dr Romanes, 4 April 2020, DHS.5000.0123.3240 attaching DHS.5000.0123.3241.
[271] While the email to DJPR from Mr Hogan dated 8 April 2020, DHS.5000.0131.0369, referred to by Watson at [129] and [144] was not tendered, the provision of the policy is otherwise referred to in Ex 71, Statement of Mo Nagi dated 24 August 2020, [34]-[35].
[272] Email from DJPR to MSS Security dated 9 April 2020, DJP.110.003.3057; Ex 65, Statement of Jamie Adams, MSS Security, [105] and email from DJPR to Mr Adams dated 9 April 2020, MSSS.0001.0005.0592..
[273] Statement of Principal Policy Officer at [31], Statement of Principal Policy Officer at [31], Email from DJPR to Unified Security dated 9 April 2020, DJP.110.002.8419.
[274] Statement of Principal Policy Officer at [31], Email from DJPR to Wilson Security dated 9 April 2020, DJP.110.002.8529.
[275] Statement of Principal Policy Officer at [31], and documents DJP.110.004.0613; DJP.110.004.2240, and DJP.110.003.9072 (MSS).
[276] Exhibit 114, Email from Dr Romanes, 4 April 2020, DHS.5000.0095.9277.
[277] Bamert statement at [78].
[278] van Diemen Statement at [68]; Exhibit 161, Email from Dr Romanes to State Controller, 9 April 2020, DHS.5000.0053.6652.
[279] van Diemen Statement at [68].
[280] T1491.18 (Sutton).
[281] T1490.8 (Prof Sutton) and T1528.43 (Dr van Diemen), Prof Sutton recognised that he did not have direct experience of the program so his concerns arose from conversations with Dr Romanes, which he accepted to be true T1490.31 and endorsed T1492.5.
[282] T1488.31 (Sutton).
[283] Romanes Statement at [83].

series of subsequent iterations of the Operation Soteria plan and insertions of a large number of other services into the plan.[284]

Public Health Liaison Officer and PHC involvement in preparing Health and Wellbeing policy

138. The email sent by Dr Romanes resulted in an immediate response from the State Controller who requested that a new Public Health Liaison Officer reporting to Dr van Diemen as PHC would be established to work across operational leads and to facilitate appropriate connection and support the PHC in relation to the operation.[285] Dr van Diemen was also provided with a draft version of the Operation Soteria Plan which included the provision of regular welfare calls to all quarantined passengers and support to meet identified needs.[286]

139. Dr van Diemen gave evidence that over the Easter long weekend (following an event that prompted the Safer Care Victoria review), there was a push to finalise the improvements in the documentation of welfare checks and escalation processes[287] including a number of meetings at the State Control Centre to reach an agreement on policy and procedure for health and welfare, as well as the responsibility for implementing it.[288]

140. By 15 April 2020, Dr van Diemen had agreed with the State Controller that the Public Health Incident Management Team would be responsible for the creation of policy and associated procedures for health and welfare of returning travellers while the EOC would be responsible for the operationalising of all policy and procedures – including logistics and rostering at hotels.[289]

141. Following the agreement that the PHIMT would be responsible for preparing policy and the EOC for implementation, further drafting had taken place to the Physical Distancing Plan and it had been renamed Interim Healthcare and Welfare Plan for mandatory quarantine dated 11 April 2020.[290] Dr van Diemen reviewed the document and provided comments and requested that the plan be reviewed to, in effect, focus on healthcare and wellbeing standards and remove operational details, as this was the responsibility of the EOC.[291] On 17 April, Dr van Diemen was provided with a further draft plan, this version called the Mandatory Quarantine Health and Welfare Plan.[292] That plan was approved by Dr van Diemen and on 18 April it was sent to the State Controller for endorsement.[293] Dr van Diemen explains in her evidence that the plan continued to evolve between 18 April to 30 April to articulate health standards which were to be consistent with the nomenclature used in the health and wellbeing standards of care that the Royal Australian College of General Practitioners had developed for caring for people in immigration detention,[294] and to articulate the separation of the policy from the operational aspects of the program.[295]

142. By 30 April 2020, the plan, which was endorsed by Dr van Diemen,[296] had a new name: 'Annex 3 – Health & Wellbeing Standards for healthcare and welfare provision' (being an Annex to the Operation Soteria plan).[297] It was updated from time to time but the underlying policy remained substantially unchanged.[298] On 26 May 2020, version 3 of the Operation Soteria Plan was approved,[299] and included:

    (a) Annex 1 – COVID-19 Compliance Policy and procedures – Detention authorisation outlines the responsibilities of Authorised Officers at ports of arrival and hotels;

    (b) Annex 2 – Health & Wellbeing Standards; and

    (c) Annex 3 - COVID–19 Operational guidelines for mandatory quarantine.

143. See Attachment A to these submissions which identifies how the content of the Operation Soteria Plan and Mandatory Quarantine Health and Welfare Plan were incorporated in the Operation Soteria plans and operationalised.[300]

---

[284] T1530.25-30.
[285] van Diemen Statement at [68]; Exhibit 161, Email from State Controller, 10 April 2020, DHS.5000.0053.6652.
[286] van Diemen Statement at [68]; Email from State Control Centre, 10 April 2020, DHS 5000.0053.6652 attaching DHS.5000.0053.6655.
[287] van Diemen Statement at [69].
[288] van Diemen Statement at [70].
[289] van Diemen Statement at [71]; Exhibit 161, Email from Dr van Diemen, 15 April 2020, DHS.0001 0012.2104.
[290] van Diemen Statement at [72]; Exhibit 161, Interim Healthcare and Welfare Plan for mandatory quarantine dated 11 April 2020, DHS.5000.0126.1658. Romanes Statement at [23], Footnote [2].
[291] van Diemen Statement at [72].
[292] Exhibit 161, Mandatory Quarantine Health and Welfare Plan, 18 April 2020, DHS.5000.0110.7943.
[293] van Diemen Statement at [79]; Exhibit 161, Email from Dr Romanes, 18 April 2020, DHS.5000.0110.7942 attaching DHS.5000.0110.7943.
[294] Exhibit 161, RACGP, The Standards for health services in Australian immigration detention centres, DHS.0001.0106.0028.
[295] van Diemen Statement at [80].
[296] van Diemen Statement at [81].
[297] Exhibit 161, 'Annex 3 – Health & Wellbeing Standards for healthcare and welfare provision, DHS.5000.0118.2852.
[298] van Diemen Statement at [82].
[299] van Diemen Statement at [113]. Exhibit 161, Opera ion Soteria Plan v3.0 with annexes v2.0, 1 June 2020, DHS.0001.0001.1053.
[300] For example, Ms Williams confirmed that onsite medical services, including nursing and mental health nursing, were provided in accordance with the clinical governance framework established by public health command: Williams statement at [19(c).]

144. As discussed below at pars 164 to 168, Public Health command also provided IPC advice both through the PHC, the Deputy PHC,[301] its internal consultant and through the recommendation of external IPC experts, which was used to guide various aspect of hotel quarantine operations.

C. Private Security and AOs

145. The way in which private security was engaged by DJPR at the commencement of the hotel quarantine program is discussed at paragraphs 71 - 74 and 81 - 90 above. The Department had no involvement in that decision, and there was no reason for it to oppose the use of private security at the outset, as it was only later that vulnerabilities associated with the security workforce cohort, came to light predominantly in the context of contact tracing following the outbreaks.[302]

146. Counsel assisting has proposed a finding that security staff 'should have been under the direct supervision of [AOs]" and that it was a 'failure of the system' that AOs did not appear to understand that they were 'in charge'.[303] The use of the concept "in charge" creates some difficulty in identifying exactly what is meant, given that other terms such as "oversight" and "supervision of the contracts"[304] are also used by counsel assisting in this context. Noting the range of legal powers and obligations involved – the scope of the employment, OH&S and contractual obligations of the security companies for their employees;[305] the security contract management by the DJPR;[306] and what powers the AOs had under the PHWA Act to give to security guards directions directly associated with the implementation of detention – it is critical that findings not be based on any generalised or oversimplified concepts. Further, the submission risks, with respect, conflating two issues: first whether AOs *should* have been "in charge" of security in some way (a matter involving consideration of the legal limitations on AO powers), and secondly, what *in fact* were the arrangements put in place by all parties for supervision of security. The fact is that while AOs could give directions to security on very limited matters (such as permitting leave from their identified place of detention, their rooms, for fresh air)[307] they were not under the arrangements in place "in charge" of security and it would be inappropriate to criticise AOs or those to whom they reported because they did not believe that they were.

147. The role of AOs in the hotel quarantine program was to enforce compliance with the Public Health Directions made by the Deputy Chief Health Officer under the PHWA.[308] There were three broad roles for AOs in the hotel quarantine program, exercising powers under the PHWA:

(a) firstly, serving upon persons arriving at the airport or maritime ports a detention notice under the PHWA, directing their detention in hotel quarantine, and explaining that notice;

(b) secondly, during the hotel quarantine period, ensuring compliance with the detention notice and issuing and managing permissions such as temporary leave (including fresh air breaks) and 'exemptions' from quarantine; and

(c) thirdly, approving the release of those persons from the hotels at the end of the hotel quarantine period.[309]

148. These roles were dictated by the legislative framework and the scope of the Direction and Detention Notices that they had been authorised to enforce.

149. AOs did not have responsibility for any other staff working at hotels or have any other staff (including security staff) reporting to them.[310] Giving an enforceable direction other than relating to the detention of guests would have been outside the lawful powers and operational mandate of the AOs.[311] They also did not have responsibility for overseeing infection prevention controls at hotels or for overseeing the use of PPE by others working at quarantine hotels more generally.[312] It is inappropriate to suggest as did counsel assisting in closing,[313] that Senior AO Mr Cleaves had been

[301] Romanes Statement re his preparation of the Physical Distancing Plan which was incorporated into Operation Soteria Plans (as set out in Attachment A). See also par 193 below.
[302] See T1494.35 -T1496.9 (Sutton) and par 82above.
[303] T2265.20-22.
[304] T2265.27 and T2265.40-41.
[305] See paragraphs [88] to [90] above.
[306] See paragraphs [84] to [87] above.
[307] Section 202(1) of the PHWA; Ex 124, Operation Soteria Plan v3, DHS.0001.0001.1053, pages, 40 and 51-54; Ex 122, statement of Murray Smith [16], [99] and [103]-[107].
[308] Exhibit 109, Statement of Authorised Officer, Operations Support at [13].
[309] Exhibit 122, Smith statement at [11], [21]. Fur her details of the roles and responsibilities of AOs are set out in Exhibit 109, Statement of Authorised Officer, Opera ions support at [62] and [64]; Exhibit 110, Operational Instruction entitled "Authorised Officer Handover Notes", dated 14 June 2020 DHS.5000.0008.3881; Unnamed Senior AO statement at [32(c)], [63]-[64], [67]-[69]; and generally in the Smith and Cleaves statements.
[310] Smith statement at [14]; Unnamed Senior AO statement at [76].
[311] Cleaves statement at [68].
[312] Smith statement at [12].
[313] T2207.17.20.

"warned off",[314] given that the effect of the Mr Cleaves' evidence was that he understood that he was to focus on the matters for which he was accountable.[315] This was an entirely appropriate instruction in light of the role of AOs having a regulatory focus, on compliance with the 'legal detention process'.[316]

150. Secondly, as to what was in fact the case in terms of AOs' responsibility on site, the weight of evidence does not support a finding that AOs were or purported to be 'in charge' of security staff at hotels. Ms Febey gave evidence of her view (and the view of members of her team) that security guards 'should' be under the direction of AOs and that she advocated for that to be the case early on in the initial days of the hotel quarantine program.[317] However there was no evidence that she did anything to have any such an arrangement understanding to be implemented in the terms of the DJPR contracts with security firms [318] and in fact the contractual arrangements said nothing about security taking instruction from AOs or include any content at all about the role of AOs.

151. The Policy Officer, DJPR (who prepared the scope of works for security contractors), and gave evidence that "DJPR was in charge of ensuring compliance with the security contracts",[319] did not believe that security staff would be under the direction of AOs,[320] nor was it the understanding of Rachele May.[321] While what may have been conveyed to security companies led to a perception on the part of some that AOs were "in charge of the site"[322] Similarly, Ms Febey's evidence was that AOs were to brief staff and contractors at the start of each shift each day on the appropriate use of PPE and other safe working practices.[323] In fact, the evidence establishes that these daily briefings were in fact undertaken not by AOs but by Department Team Leaders,[324] as well by security supervisors or their own staff.[325]

152. Third, the evidence was that matters relating to the conduct of the security guards including complaints were generally escalated to the DJPR[326] and dealt with by them in conjunction with the relevant security firm.[327] The Operation Coordinator, DJPR who was a Site Manager at the Stamford gave evidence that "complaints would be made directly to the hotel, security companies or other contractors" but that it was his "preference for the complaints to be directed to me because it was my experience that I could most efficiently address and resolve the complaints by reason of the fact that I was on-site".[328]

153. Fourth, the evidence of Departmental witnesses was that staff from the various teams working at hotels (including nursing, security, Department Team Leaders, AOs, hotel management and DJPR staff) generally worked very cooperatively and closely at an operational level, and it was common that requests were made to all members of the teams by members of other teams to assist with a particular task. In most cases, the staff from most teams helped out others wherever they could.[329] This is consistent with the evidence of other witnesses such as hotel manager Shaun D'Cruz, who stated that requests would come from a number of people including nurses or AOs (but that he would seek clarity from his contact in DJPR),[330] and hotel manager Stephen Ferrigno, who stated that the majority of requests would be funnelled through the Department Team Leaders on site but that they also came from AOs or the DJPR site contact.[331] Other witnesses appeared to confuse the roles of AOs, Department Team Leaders and other onsite staff such as DJPR staff.[332]

154. Fifth, it was the clear evidence of Senior AO Noel Cleaves that he and other AOs did not regard themselves as being 'in charge' at hotels, and that he did not tell others this, given they did not have

[314] This was certainly not the language used by Mr Cleaves, whose evidence was that he understood he was being told to be "Focusing on the things for which we were accountable, which was the legal detention process". T915.6-10. Such an instruction was entirely appropriate.
[315] See T898.3-39, T924.25-36 (Noel Cleaves).
[316] T915.1-14 (Noel Cleaves); T926.23-25 (Chair summarising Mr Cleaves' evidence).
[317] T427:13-428:7, T401:23-42, T397:44-398:9 (Claire Febey).
[318] T427.31-36 (Febey).
[319] Exhibit 59, Statement of Principal Policy Officer, DJPR, at [55]; see also [61].
[320] Exhibit 59, Statement of Principal Policy Officer, DJPR at [20]-[21].
[321] See Exhibit 80, May statement at [110], [114]-[115].
[322]T.795.32-34 (Gregory Watson); Ex 30, Wilson Security – Core duties at the hotel, WILS.0001.0003.2697.
[323] Exhibit 32, Statement of Claire Febey, DJP.050.010.0001, [90]-[92].
[324] See Exhibit 205, Statement of Senior Project Officer at [13]; Exhibit 130, Williams statement at [49]; Exhibit 84, statement of CCOC (Operations Coordinator, DJPR) at [15]. Ex 46, Rosswyn Menezes, [27] – [28]; [35].
[325] Ex 205, Senior Project Officer, [13], Ex 65, Jamie Adams, [134], [146] and [150], Ex 62, Gregory Watson, [130], T351.15 and T352. 1-7 (Security Two), T722. 32-39 (Mr Rob Paciocco - Black Tie Security), T723-4. 45-5 (Mr Sorav 'Sam' Aggarwal – Sterling Services Group), T534.39 (Stephen Ferringo); T2021.29 (Kym Peake); T899.40 (Noel Cleaves).
[326] Exhibit 59, Statement of Principal Policy Officer, DJPR, at [72], Ex 71, Mo Nagi, [27]; [37]; [63], Ex 65, Jamie Adams, [75], Ex 62, Greg Watson, [142]
[327] Exhibit 59, Statement of Principal Policy Officer, DJPR, at [73]- [92].
[328] Exhibit 84, Statement of the Operation Coordinator, DJP.050.007.0001 at [19].
[329] Cleaves statement at [38], [151]; Unnamed Senior AO statement at [75]-[76].
[330] T529:39-13 (Shaun D'Cruz).
[331] T530:31-43 (Stephen Ferrigno). See also Exhibit 47, Unterfrauner statement at [29].
[332] See, eg, the evidence of hotel manager Mr Anandampullai (Exhibit 40), who states at [51] that the 'Authorised Officer was a representative from either the DHS or the DJPR who had responsibility for overseeing activities at the hotel related to the quarantine program', and at [61] that AOs were on site to (among other things) 'act as a trouble shooter when issues arose'. See also Exhibit 31, statement of Security 16 – Rydges Hotel, who noted that he did not recall seeing anyone wearing a 'vest with "Authorised Officer" written on it or iden ifying themselves as an "Authorised Officer"': at [64].

management or control over aspects of the hotel quarantine program other than the compliance aspects with the Detention Notices as they applied to people under detention.[333]

155. Finally, there was varying evidence from security staff about the relationship between security staff and AOs. In large part, it reflects that:

(a) Security staff had their own supervisors and reporting lines on site.[334] This included supervision from some of the head contractors of their subcontracting companies.[335]

(b) Issues about security staff behaviour or complaints were to be escalated to and managed by DJPR, which had an oversight role in relation to security.[336]

(c) The role of AOs related primarily to issues relating to guests, particularly where they needed to leave their rooms including for fresh air breaks, [337] were trying to leave their rooms,[338] and in the exit process.[339] Mr Hogan of Wilson Security also gave evidence of security both 'declining to implement' requests from AOs in some circumstances, and responding to directions both from AOs and hotel staff in other circumstances.[340]

156. In summary, it can be accepted that there were differing views among agencies and individuals as to the roles of AOs, and that this uncertainty was undesirable. However, it is also the case that AOs had limited legal powers to exercise in the program, primarily focussed on monitoring the detention of the returned travellers and authorising their movement if necessary, and did not put themselves forward as being in charge of the site. There is no basis for a finding that it was a 'failure of the system' that AOs did not appear to understand that they were 'in charge".

Transfer of private security contracts

157. Counsel assisting submitted that the transfer of contracts for private security and hotels should have been transferred to DHHS much sooner, and that this would have ensured clear lines of accountability and responsibility and supervision and an ongoing review of whether those contracts were suitable.[341] At the outset during the first complex months of the program, given that the DJPR had entered into the contracts, and also held the budget for the hotel accommodation and ancillary services[342] and given all of the matters for which DHHS was responsible in the pandemic response, there was a practical logic in DJPR managing the contracts.[343] This was also plainly the view of the CCC and MCC which continued to identify the logistical and contract management functions as the appropriate responsibility of the DJPR. Ms Peake accepted however, and the Department accepts that as the program progressed and the complexity of the joint operation became apparent, it became evident that a consolidation of responsibilities would be beneficial.[344] From late May Operation Soteria Command began working with Alfred Health to engage them to provide all clinical staff and infection control governance and training at the hotels.[345] Following the introduction of a model for the Brady COVID positive hotel with a range of functions including security, cleaning and customer liaison under the oversight of Alfred Health and DHHS,[346] a broader change to a consolidated model was in fact implemented.[347]

---

[333] T898.17-23, T929.20-33 (Noel Cleaves).
[334] See, eg, T738:9-25 (Mina Attalah); Exhibit 52, Attalah statement at [24], [26], [27], [45], [46]. Sam Krikelis of MSS Security gave evidence that 'particular duties of staff members were … arranged on a shift by shift and site by site basis as determined on each shift by the site supervisor, in accordance with directions that person received from the DJPR representatives when onsite, the DHHS AOs and other onsite stakeholders such as DHHS team leaders and the nurses' Exhibit 67, Krikelis statement at [34].
[335] Exhibit 53, Ishu Gupta statement at [26]-[28]. Mr Gupta of The Security Hub's evidence was that onsite supervision was provided by MSS and Wilsons (or sometimes by Mr Gupta's own senior security staff), taking instructions and guidance from AOs as to decision-making relating to operations, but with overall supervision of hotel operations provided by the head contractor.
[336] Exhibit 67, Krikelis Statement at [54]. Mr Krikelis further stated that the AOs 'made final decisions about site based ques ions' such as 'if a guest was causing issues', however also noted that security personnel would accompany Department Team Leaders or 'DJPR authorised officers' in case things became difficult. See also Ex 69, Millward Statement, at [101] identifying DJPR staff names as is line of communication in connection with the contractual obligations.
[337] Exhibit 53, Gupta statement at [19(c)]. See also Exhibit 71, Nagi statement at [30]-[31].
[338] Exhibit 63, Hogan statement at [35]: security were to ask guests to return to heir rooms if they left them, with guests who attempted to abscond to be escalated to an AO or to Victoria Police by dialling 000.
David Millward of Unified Security gave evidence that if guests attempted to leave their rooms, Unified Security were to ensure that they returned to their rooms and closed their door, with Unified to contact the DHHS Authorised Officer on site regarding any issues of non-compliance: Exhibit 69, Millward statement at [40]-[41].
[339] Ex 71, Nagi Statement at [41].
[340] Exhibit 63, Hogan statement at [59]-[60].
[341] T2228: 5-11 (Ellyard).
[342] Ex 177, Statement of Christopher Eccles, [79].
[343] T2012.8-14.
[344] T2012.8-22.
[345] Williams statement at [51].
[346] Statement of Simon Alexander, exhibit 99, at [30]-32].
[347] Statement of Christopher Eccles, DPC.0017.0001.0013 at [51](d) re briefing on alternative supervision model for COVID-19 hotel; briefing paper of 27 June 2020; subsequent recommendation for transfer of Hotel Quarantine Program to the Attorney-General and DJCS in he 27 July 2020 written brief referred to at par 51(d) of the Statement.

D. IPC and PPE in hotel quarantine program

Counsel Assisting Submissions in relation to IPC and PPE in Operation Soteria

158. Counsel assisting have made various submissions as to the quality and implementation of IPC in hotel quarantine. The first is that the program was operated as a logistical exercise and public health advice and command was not embedded in the program.[348] For the reasons explained above, in relation to the role of PHC and the involvement of public health advice in the operational plans and for the reasons set out in this section as to how IPC advice was created and implemented by Operation Soteria, this submission ought to be rejected. First, it is submitted that the contracts with hotels and security companies should not have placed responsibility for PPE and IPC on those contractors.[349]

(a) The evidence of hotel managers and security companies is go the effect that they accepted their contractual and legal OH&S responsibilities to provide IPC and PPE training and gave evidence as to the training they provided to their staff.[350] The DJPR, as the contracting entity and contract manager, had responsibility for monitoring the performance of contracts.[351]

(b) The submission put by counsel assisting suggests that there is no role for private entities to assist the state. That is unrealistic and inconsistent with the evidence of the hotels and the security companies that they were able to, and in fact did, discharge their obligations.[352]

(c) In summary, the evidence is that the Department, DJPR, hotels and security contractors each provided their staff with IPC and PPE training; that start of shift briefings occurred; that signage was displayed and that appropriate IPC and PPE advice was provided. This part of the submission addresses these issues.

159. Secondly it is submitted that within the Department, there should have been greater IPC and PPE training and supervision and monitoring to ensure adherence to appropriate standards.[353] This is addressed below (in addition, see from paragraphs 204 – incorporation of IPC in program design and 232 – on-site audits and practical instruction).

160. It is also suggested that testing was insufficient.[354] This is addressed below from par 241.

161. It is submitted that cleaning processes were deficient at Rydges and across the program.[355]

(a) DJPR had contractual responsibility for cleaning. See pars 77 to 80 above.

(b) The preparation and provision of DHHS advice on cleaning is addressed in 191 and from 193.

162. It is also submitted that the Department knew from early on that fomite transmission was obvious risk.[356] This is addressed below in paragraph 172.

163. It is put that the program should have been but was not accompanied by intensive ongoing monitoring and auditing and this increased or at least failed to adequately mitigate the risk that the virus would be transmitted into the community.[357] This submission fails to take into account the various reviews that did take place, along with iterative and continuing nature of the improvement process,[358] that Department conducted PPE use audits in May,[359] IPA reviewed and audited IPC in hotels for the Department,[360] and Safer Care Victoria conducted two detailed reviews, that also considered other issues that arose.[361] The Operation Soteria Plan was revised in response to

[348] T 2265-T2266.
[349] T2266: 3-10.
[350] See paras 212 to 223 (hotels) and 224 to 229 (security firms) below.
[351] Ex 59, Statement of Principal Policy Officer, [12], [31]; T960.6-8, T967.6-8, and T991.16-21 (May); Ex 35, Operation Soteria Plan V1, dated 28 March 2020, DOJ.504.101.8483, T.418.8-28 (Feebey).
[352] See paras 212 to 223 (hotels) and 224 to 229 (security firms) below.
[353] T2266: 11-16.
[354] T2266: 20-22.
[355] T2267: 32-35.
[356] T2239.29.
[357] T2263: 45-T2264: 10 (Neal). It is also put that concerns raised and advice provided by the Australian Medical Association in relation to the program were seemingly not acted on and not given any adequate response: T2260: 32-34. There is no evidence that the CHO did not receive these concerns, which were sent not on AMA letterhead nor sent by an AMA email address and were sent to a generic CHO email address.
[358] T1994.20 (Peake).
[359] Williams Statement at [60(b)].
[360] Bamert statement at [28], [40]; Exhibit 136, IPA, Summary of findings – Review of Hotel accommoda ion for OS travellers in quarantine, DHS.0001.0021.0020.
[361] Wallace statement, [14], [28]. Ms Bamert gave evidence of an agreement from 5 May, arising out of the SCV review process, to establish a clinical governance framework and clinical lead: a clinical governance framework was drafted and the clinical governance lead filled by a nurse practitioner in the second week in June, before the move to the Alfred Health model. Bamert statement at [80(a)].

operational need and public health input (see par 61). Following each outbreak, the IPCON Outbreak Nurses conducted audits of both Rydges and Stamford.[362]

List of IPC Advice.

164. As set out above, the Public Health Incident Management Team was responsible for the creation of public health advice, for the EOC and Operation Soteria to then implement. To this end, the IPC Consultant, (the witness referred to as the Infection Control Consultant gave detailed evidence of her involvement in the preparation of IPC policies that were then available to Operation Soteria. Ms de Witts, whose role provided support to the public health team,[363] was aware that the following public health advice and guidance the Infection Control Consultant discusses was then given to Operation Soteria:

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

(b) PPE advice for hotel health care workers for contact with COVID-19 quarantine clients dated 22 April 2020;

(c) Guidelines for managing COVID-19 in mandatory quarantine dated 23 April 2020;

(d) Operation Soteria Plan v2 dated 26 April 2020, which includes section 5 'Health and Welfare' dated 24 April 2020 approved by the Public Health Commander, including the 'Public Health Standards' and refers to the 'Guidelines for managing COVID-19 in mandatory quarantine';

(e) COVID-19 Case and Contact Management Guide (version 11) dated 29 April 2020, which contains sections on hotel quarantine at 5.1.4 and 6.1.4, in the context of broader public health guidance;

(f) Email advice on 27 April 2020 reiterating the applicability of publicly available cleaning and disinfection advice for non-healthcare settings to the hotel quarantine program and providing advice on specific questions raised by DJPR with respect to cleaning hotel rooms;

(g) PPE Advice for Hotel-Based Security Staff & AOs in Contact with Quarantined Clients dated 5 May 2020, which was subsequently updated on 8 June 2020;

(h) Operation Soteria Plan v2.1 dated 8 May 2020, which includes section 5 'Health and Welfare' dated 8 May, including the 'Standards', 'Operational Guidelines' approved by the Public Health Commander;

(i) Operation Soteria Plan v3 dated 26 May 2020, which includes section 5 'Health and Welfare' dated 1 June 2020, including the 'Standards', the 'Public Health Policy for COVID-19 in mandatory quarantine' and the 'Operational Guidelines', approved by the Public Health Commander;

(j) Advice for cleaning requirements for hotels who are accommodating quarantined, close contacts and confirmed COVID-19 guests, last updated 19 June 2020.

165. In addition to these documents, the DHHS' IPC Consultant also gave evidence of preparing cleaning advice in March 2020 (discussed below). The creation and implementation of each of these documents are described below.

IPC – roles and responsibility for creation and implementation of advice

166. As set out, the IPC consultant seconded to the Department prepared advice in relation to IPC and PPE that was available to and applied in the hotel quarantine program.[364] This advice was prepared having regard to national and international guidance.[365] The Public Health team had responsibility for the availability of IPC and PPE advice and guidance. Throughout the program, the IPC cell grew from one consultant to a significant number over April[366] and provided state-wide infection prevention control advice.[367]

[362] McGuiness statement, [73]-[78].
[363] Exhibit 155, de Witts' statement. Document IDs for each document are found in the statement at [28]. Ms De Witts had responsibility for supporting the CHO and the Public Health Command operationally and with logistical support, hereby allowing the public health team to focus on the pandemic: [7], [9]. Her role was to provide oversight and executive input, and was not to provide public health advice: [12]. Ms de Witts was not, contrary to closing submissions made at T2242:15, a Deputy Secretary with responsibility for he program and there is no basis in evidence for such a finding. It is Ms de Witts uncontested evidence that the Regulation, Health Protection and Emergency Management Division would be responsible for the COVID-19 emergency accommodation function (reporting through the Operation Soteria command structure) and enforcement and compliance functions.
[364] T1524.29-47.
[365] van Diemen statement at [98].
[366] Ex 203, Statement of Infec ion Control Consultant, DHHS at [20]-[22].
[367] van Diemen statement at [99].

167. Operation Soteria was responsible for implementation of the advice.[368] Operation Soteria provided the logistical and operational framework to provide the health, human services and wellbeing functions for the purpose of quarantining returned travellers.[369] The COVID-19 Accommodation Commander was responsible for operationalizing the public health policies in each hotel,[370] including through standard operating procedures for team leaders.[371]

168. Throughout April and May, the Department also worked with an IPC consultant from Infection Prevention Australia (**IPA**) to conduct onsite reviews, report on IPC and PPE issues,[372] and develop written guidance in relation to the use of PPE at quarantine hotels (which was provided to nursing staff, security guards and AOs on site at quarantine hotels).[373] Infection prevention measures were reinforced by the use of posters at hotels about infection prevention and PPE use (including donning and doffing of PPE).[374]

169. The contracts between the DJPR and hotels allocated responsibilities between them with respect to standard cleaning and that required for cleaning of COVID positive guest rooms: see pars 77 to 80 above.

Evolving knowledge of means of transmission

170. In the early stages of the COVID-19 pandemic, thinking about the transmission characteristics of COVID-19 was extrapolated from knowledge of similar diseases. As more data became available, the scientific community developed a more specific understanding of the modes of transmission of the SARS-CoV-2 virus.[375] From February 2020 onwards, the knowledge of COVID-19, how it is transmitted and the appropriate IPC measures that should be used, has evolved[376] and continues to develop. This evolving understanding meant that the public health team continued to update its advice and Operation Soteria Command continued to implement the program in the context of that changing knowledge.[377]

171. For example, the use of masks and PPE when swabbing has evolved over time. In April, the national guidance for all hospitals was that airborne/contact precautions were not required for patients with severe coughing.[378] Operation Soteria Command implemented that advice.[379] This has since been modified.[380] It is thus important that the Board assess PPE and IPC practices against the scientific knowledge applied at the time, rather than applying current standards to earlier periods.[381]

172. Dr McGuiness gave evidence that the IPC guidance in the CCOM Guidelines was consistent with the WHO position on the modes of transmission of SARS-CoV-2 as at 1 May 2020.[382] Counsel assisting emphasised that WHO had recognised that fomite transmission was a possibility. Notwithstanding, WHO noted that in that same document that COVID-19 was primarily transmitted through respiratory droplets and contact routes.[383] Dr Crouch gave evidence that he was not convinced that we yet fully understand how it is transmitted.[384] This was uncontested. Thus while fomite transmission was considered possible in late March 2020, the evidence from Dr Crouch, consistent with the position of WHO, is that it was considered secondary (WHO) and rare (Dr Crouch) and droplet transmission was considered more likely.

Department IPC and PPE advice was consistent with national and international standards

173. In late January or early February, AHPPC appointed an expert advisory group to provide nationally consistent infection prevention and control guidance. This group reported directly to AHPPC, however some of its members attended CDNA, a sub-committee of the AHPPC, which prepared the

[368] van Diemen statement at [103] and [132]. T1526.12-15. T1552.27-42.
[369] Sutton, [129].
[370] Statement of Merrin Bamert, dated 9 September 2020, [17(b)]; Evidence of Ms Williams, T1269: 25-28; T1271: 11-12; Evidence of Ms Bamert, T1311: 9-12; Evidence of Ms Bamert, T1334: 19-28.
[371] Bamert statement at [17(b)] and [18].
[372] Bamert statement at [28], [40]; Exhibit 136, IPA, Summary of findings – Review of Hotel accommoda ion for OS travellers in quarantine, DHS.0001.0021.0020.
[373] Bamert statement at [35].
[374] Ex 205, statement of Senior Project Officer at [36], [42]; Exhibit 64, Statement of Jan Curtain,YNA.0001 0001.0001 at [60] and [74]; Exhibit 47, Statement of Karl Unterfrauner, STAM.0001.0004.0009, para 41, page 16]; Statement of Security 1, WIT.0001.0004.0001, [16].
[375] McGuinness statement at [25]. Looker statement at [98].
[376] van Diemen statement at [104].
[377] T1273:20-35 (Pam Williams).
[378] Ex 204, Email chain, 28 April 2020, DHS.5000.0087.2413. Ex 203, Statement of Infection Control Consultant, DHHS at [49].
[379] Bamert statement at [32] and [41].
[380] Ex 203, Statement of Infec ion Control Consultant, DHHS at [65]. P2/N95 respirators are now used in certain settings when caring for suspected or confirmed COVID-19 cases for prolonged periods and this change in PPE use has really only been relevant to Victoria.
[381] McGuinness statement at [101]. This is apparent in comparing the 'Coronavirus disease 2019 (COVID-19), Case and contact management guidelines for health services and general practitioners' (CCOM Guidelines) information on modes of transmission as at 10 July 2020 with the version as at 1 May 2020, which provides a more limited understanding about the mode of transmission in May and states that the mode of transmission "is not yet fully understood although based on the nature of coronavirus infections, transmission is likely through droplet and contact": McGuinness statement at [29].
[382] McGuinness statement at [31].
[383] McGuiness's statement, at [27].
[384] Crouch statement at [37].

Series of National Guideines COVID-19 guidelines (**SoNGs**),[385] semi-regularly. Dr van Diemen was aware of the AHPPC advice (and CDNA guidelines), including because she assisted the CHO on preparing briefings and recommendations for the AHPPC on matters related to COVID-19. She also sat on the CDNA.[386] In her view, which was not challenged, all infection prevention and control advice, including in relation to PPE use by guards and hotel workers and provided in Victoria by the IPC cell, was in line with national advice.[387]

Appropriateness of IPC measures

174. Counsel assisting have put that the IPC measures and PPE measures were insufficient. There is no evidentiary basis to support this. The Department's IPC consultant approved and prepared separate advice on PPE to be worn by hotel workers and for AOs and security guards.[388] Dr van Diemen and the Infection Control Consultant both gave evidence as to the creation of that advice, and were not challenged on their evidence.

PPE Advice for Hotel Workers, AOs and Security Guards

175. Dr van Diemen gave evidence that the PPE Advice for AOs and Security Staff[389] was based on evidence available at the time in relation to COVID-19 and that it was primarily transmitted via droplet and contact transmission. The national and WHO guidance regarding PPE, at that time, was to wear a mask if within 1.5m of suspected/confirmed cases; a mask would not be required if physical distancing could be maintained.[390] This advice was on the understanding that security guards would be present when guests arrived at a hotel and would escort guests to and from their rooms for fresh air breaks, and that this was the limit of their duties and interactions, including that they would not be required to touch people (in performing security duties). The PPE recommendations were based on National guidance and the understanding as to the guard's role in escorting guests on fresh air breaks. [391] For this reason, Dr van Diemen determined that masks were to be used when escorting guests if physical distancing could not be maintained.[392] She was not cross-examined on this.

176. Dr van Diemen also gave evidence that glove use was discouraged with an emphasis to be placed on hand hygiene instead. In making this advice, it was understood that security staff were to open all doors and push lift buttons etc, not guests.[393] This was consistent with Dr Crouch's evidence that in non-clinical settings, regular hand hygiene is preferable to gloves because often people wear the same gloves all day, and so they become contaminated and thus sources of transmission, if not changed after each interaction.[394]

177. The other issues that were considered when making this advice included:[395]

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

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

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

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

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

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

178. In Dr van Diemen's view, it would not have been appropriate to ask security guards to, for example, wear full PPE (including eyewear and a gown) when escorting guests on fresh air breaks. Her evidence was it remains the case that full PPE is not recommended in these circumstances and is

[385] Infection Control Consultant statement, [32]; van Diemen [94].
[386] van Diemen statement at [94].
[387] van Diemen statement at [95].
[388] van Diemen statement at [122]; Bamert statement at [24(a)]; Exhibit 136, "PPE advice for hotel based healthcare worker (HCW) for contact with COVID-19 quarantine clients", DHS.5000.0027.5115.
[389] Ex 203, Statement of Infec ion Control Consultant, DHHS at [48], DHS 5000.0023.1373 found in Exh 204; Bamert statement at [24](b); Exhibit 136, "PPE advice for hotel security personnel for COVID-19 quarantine clients", DHS.5000.0095.9059.
[390] Exhibit 161, WHO guidance, 27 February 2020, Rational use of PPE, DHS.0001.0106.0134. van Diemen statement at [125].
[391] Infection Control Consulant statement, [55]; van Diemen [126].
[392] van Diemen statement at [126].
[393] van Diemen statement at [127].
[394] Crouch statement at [42(e)].
[395] van Diemen statement at [128].

not recommended by national advice.[396] This evidence was consistent with the evidence of the witness known as the "Infection Control Consultant", as set out below.

179. The evidence from the Infection Control Consultant, as to the appropriateness of IPC guidance and PPE measures, was also not tested. It was not put to the Infection Control Consultant that her advice was other than, as she put it, based on internationally and Australian best practice evidence. The Infection control Consultant gave evidence[397] that:

> The use of PPE is another important IPC measure. In advising on PPE or drafting PPE guidelines, it was and is my practice to have regard to and adopt where appropriate relevant national and international guidelines on evidence-based best practice and a review of evidence through literature search. This includes reference to World Health Organisation, Communicable Disease Network of Australia, the USA Centers for Disease Control and Prevention and the Australian National Health and Medical Research Council Australian Guidelines for the Prevention and Control of Infection in Healthcare.[398] I will generally always follow such guidance. The only example I can think of where I have not, was very recently when Victorian PPE guidance has differed from National guidance with respect to use of P2 respirators instead of surgical masks for the care of patients with suspected or confirmed COVID-19 infection in certain circumstances. This was in response to the PPE taskforce's[399] guidance and was not a decision that the IPC Cell made.

180. IPC measures that are appropriate depend on both the user and the setting. For example, advice prepared for healthcare workers will address their heightened risk and their greater health literary and expertise in appropriately using PPE and awareness of IPC.[400]

181. The Infection Control Consultant also gave evidence as to the appropriateness of guidance provided to security guards. It had been put, to Prof Grayson, that the PPE guidance was not appropriate. This was not put to the Infection Control Consultant , who explained the rationale behind her advice. Her evidence was that the information contained in both these PPE documents (for guards and for AOs[401]) was based on evidence at that time that COVID-19 was transmitted primarily via droplet and contact and the then current WHO guidance[402] and the National Guidance which required a mask to be worn if a person was within 1.5m of suspected/confirmed cases and that a mask was not required if physical distancing could be maintained.[403]

182. In summary, the Infection Control Consultant's uncontested evidence was that the PPE advice for Security and AO was based on the above, noting the following matters:

> The advice directed at security and AOs used lay language because I understood that security guards, and also AOs were not a health workforce and would not be as familiar with use of masks or other PPE as health care workers would be.
>
> The emphasis was to try and maintain physical distancing at all times. Masks can provide a false sense of security and create an infection risk for those inexperienced in use of PPE. Use of masks in these circumstances, without adequate training, can increase instances of staff touching their face and thereby increase risk of contamination and transmission. Masks are also better for source control, to stop infected persons from spreading droplets, rather than protecting wearers from infection.
>
> The advice recommended hand hygiene rather than use of gloves. This is because glove use can lead to poor hand hygiene compliance particularly with untrained workers who may feel that they are protected by gloves and then touch lots of surfaces with gloved hands, potentially contaminating them. It is preferable to sanitise hands regularly by washing with soap and water or using an alcohol-based hand rub between touching different surfaces.

---

[396] van Diemen statement at [130].
[397] Ex 203, Statement of Infec ion Control Consultant, DHHS at [41].
[398] Australian National Health and Medical Research Council Australian Guidelines for the Prevention and Control of Infection in Healthcare, DHS.0001.0112.0006, published at https://www.nhmrc.gov.au/about-us/publications/australian-guidelines-prevention-and-control-infection-healthcare-2019#block-views-block-file-attachments-content-block-1.
[399] The PPE Taskforce was established in early April 2020 by Safer Care Victoria and is chaired by the Chief Medical Officer to provide standardised PPE advice to healthcare services and GPs, and to manage PPE stock.
[400] van Diemen statement at [104].
[401] Ex 203, Statement of Infec ion Control Consultant, DHHS at [66].
[402] Ex 161, WHO guidance, 27 February 2020, Rational use of PPE, DHS 0001.0106.0134; WHO Guidance, 6 April 2020, Rational use of personal protective equipment for coronavirus disease (COVID-19) and considerations during severe shortages, DHS.0001.0108.0001.
[403] Ex 203, Statement of Infec ion Control Consultant, DHHS at [54], see also [55], [56].

> An assessment needs to be undertaken for any advice that is given based on the best available evidence at that time as I set out in paragraphs 49 to 51. In my view, the PPE for Security and AOs was an appropriate balance having regard to these considerations.[404]

183. This was consistent with Dr van Diemen's evidence that the emphasis was to try and maintain physical distancing at all times and that masks can provide a false sense of security and create an infection risk for those inexperienced in use of PPE. Use of masks, without adequate training, can increase instances of staff touching their face and thereby increase risk of contamination and transmission. Masks are also better for source control, to stop infected persons from spreading droplets, rather than protecting wearers from infection.[405] This was not challenged. Nor was the proposition that hand hygiene is preferable to use of gloves by untrained workers.[406]

184. Dr McGuinness also gave consistent evidence that in situations where staff were not required to be in close contact with a suspected case, and were able to maintain a distance of 1.5m from the case, it may have been appropriate for them to wear a mask alone, provided that they practiced good hand hygiene and avoided touching their face.[407]

185. A Department team leader gave evidence that a key message in the PPE policy referred was that PPE was not required by hotel quarantine Security Guards or AOs if they could maintain a 1.5 metre distance from a guest. The policy also reinforced the requirement for security staff and AOs to perform hand hygiene before and after every guest contact.[408] PPE was to be used in conjunction with other infection control strategies such as social distancing, hand washing and hygiene, cough etiquette and self-isolation.[409] This evidence was not challenged. The Infection Control Consultant also gave evidence that, with the DPHC's endorsement,[410] she advised IPA on PPE advice,[411] which IPA accepted.[412] There is no evidence that IPA formed the view that the PPE advice was other than appropriate.

186. The advice recommended hand hygiene rather than use of gloves. This is because glove use can lead to poor hand hygiene compliance particularly with untrained workers who may feel that they are protected by gloves and then touch lots of surfaces with gloved hands, potentially contaminating them. It is preferable to sanitise hands regularly by washing with soap and water or using an alcohol-based hand rub between touching different surfaces.[413]

Safety and wellbeing of AOs and other staff

187. Counsel assisting referred to Ms Gavens' evidence to the effect that she was concerned about the safety and wellbeing of DELWP staff working as AOs and set out concerns in an email dated 24 June 2020,[414] which evidence was said by counsel assisting to be 'not the subject of any dispute or challenge'.[415] This disregards the evidence in Mr Smith's statement that he did in fact provide a formal response to Ms Gavens on the issues set out in her email, which also referred to a conversation with Ms Gavens responding to each issue.[416] The email substantively responds to every issue raised by Ms Gavens.[417] By way of example, item 4 of Mr Smith's email states — in response to a complaint about a 'lack of operationally focused process and procedures' — that the complaint is incorrect and that 'a document first released to staff on 29 April 2020 provides great detail in terms of what they are required to do'.[418] This email sets out the measures put in place to

[404] Infection Control Consultant statement, DHHS [56]-[58].
[405] Ex 203, Statement of Infec ion Control Consultant, DHHS at [57].
[406] Ex 203, Statement of Infec ion Control Consultant, DHHS at [58].
[407] McGuinness statement at [37].
[408] Ex 205, statement of Senior Project Officer at [36].
[409] Ex 205, statement of Senior Project Officer at [40].
[410] Ex 203, Statement of Infec ion Control Consultant, DHHS at [46].
[411] Ex 204, Email from "Infection Control Consultant", 21 April 2020, DHS.5000.0087.2463 attaching draft COVID Hotel HCW quarantine PPE advice, DHS.5000.0087.2467.
[412] Ex 204, Email to "Infection Control Consultant", 21 April 2020, DHS.5000.0104.0984 attaching DHS.5000.0104.0989.
[413] Ex 203, Statement of Infec ion Control Consultant, DHHS at [58].
[414] T2257.41-2258.17 (counsel assis ing).
[415] T2257.41-44 (counsel assisting).
[416] Mr Smith did not accept that what Ms Gavens had said was true, but that it was her opinion: T1198 33-1199.2 (Murray Smith). Mr Smith's response email to Ms Gavens was included at Annexure MS2 (Exhibit 123a) to his statement, where he said 'I formally responded by way of email to Kate Gavens (DELWP) on 21 July 2020 which is in (DHS.0001.0052.0001)'. This was specifically referenced by counsel assisting at T1197.10-18 in introducing the questions relating to Ms Gavens.
[417] Exhibit 123a, Annexure MS2 to statement of Murray Smith, DHS.0001.0052.0001. Note also the evidence of Mr Smith as to the training and paper based instruction given to AOs: Smith Statement [33]-[47] and [53]-[59], and the evidence of Mr Ashford about online training at T265, and his awareness that procedures on a range of matters were available to AOs at the work desk: T268.
[418] Counsel assisting also noted in closing Ms Gavens' evidence that she withdrew DELWP staff from he program on 10 July, and stated that Mr Smith 'told the Board he didn't know why all the DELWP staff had been withdrawn from the program' suggesting that he was aware of the withdrawal but not the reasons why. Mr Smith's evidence had in fact been that he was merely aware that there were no DELWP officers in the program and not of the 'withdrawal' T1199.16-21 (Murray Smith).

safeguard staff on site, as is also demonstrated in the evidence of the various ways in which the Department provided IPC and PPE advice to those working in the hotel program.

Provision of guidance to Operation Soteria and staff on site

188. In relation to the PPE guidance for health care workers, IPA provided a draft which the Infection Control Consultant reviewed.[419] The Department then distributed the advice (after 1 May updated and issued as "PPE Advice for Hotel-based Healthcare Workers Contact with COVID-19 Quarantined Clients")[420]:

(a) to Department staff working on site at the hotels on 22 April[421] and via the team leader packs and available in laminated printed form and paper copies on the Hotel Team Leader's desk on site at each hotel.

(b) to the Department's contracted nursing agencies (YNA and Swingshift) to be sent to every nurse ahead of their first shift in a hotel, and to every nurse involved in Day 3/Day 11 COVID19 testing (where face-to-face contact with quarantine guests occurs) every time they are booked on a shift.[422] and

189. In relation to the PPE guidance for security guards and AOs, the advice was issued as "PPE Advice for Hotel-Based Security Staff & AOs in Contact with Quarantined Clients".[423] Security contractors confirmed those guidelines were available on site and provided to them.[424] The guidelines were also made available to AOs;[425] included in the team leader packs and available in laminated printed form and paper copies on the Hotel Team Leader's desk on site at each hotel;[426] and provided to DJPR.[427] The guidelines were updated and provided to staff on 8 June as a revised version of "PPE Advice for Hotel-Based Security Staff & AOs in Contact with Quarantined Clients"[428] including the same instructions on the use of PPE, but with further detail about hand hygiene and how to use a mask properly.[429]

190. From about 3 May, the Department also provided written guidance to team leaders working on site, about social distancing and use of PPE, including donning and doffing PPE appropriately, as part of the onboarding process.[430] A web based training course was also provided by the Department about donning and doffing PPE.[431]

Cleaning advice

191. DJPR was responsible for contracting with hotels for cleaning of guest rooms at the end of their stay and common areas.[432] Over the course of the hotel quarantine program, the Department provided advice to DJPR about the practices, procedures and standards to be expected of cleaning in quarantine hotels, based on public health advice.[433] The Department expected DJPR would provide that advice on to its contracted cleaners and hotel operators.[434]

---

[419] Ex 203, Statement of Infec ion Control Consultant, DHHS at [42], [46], [47].
[420] Bamert statement at [24]; Williams Statement at [57(a)]; Exhibit 131, DHS.5000.0003.9690.
[421] Bamert statement at [24(a)]; Exhibit 136, Email from Operation Soteria EOC to DHHS staff and quarantine hotels, dated 22 April 2020, [DHS.5000.0029.2253] and attachment PPE advice for hotel health care workers (HCW) for contact with COVID-19 quarantine clients dated 22 April 2020 [DHS.5000.0010.1863].
[422] Bamert statement at [24]; see also Ex 205, statement of Senior Project Officer at [31].
[423] Bamert statement at [24](b); Exhibit 136, "PPE Advice for Hotel-Based Security Staff & AOs in Contact with Quaran ined Clients", DHS.5000 0003.9688; Williams Statement at [57(b)]; Exhibit 131, DHS.5000.0023.1373.
[424] Exhibit 69, Witness statement of David Millward USG.9999.0001.0001, para 99, page 16; Exhibit 52, Statement of Mina Attalah, URM.0001.0001 0204_001, para 42, page 9]; Exhibit 71, Witness statement of Mo Nagi, WIT.0001.0036.0001, 62, page 8]; Exhibit 67, Witness statement of Sam Krikelis, MSSS.0001.0014.0001_0001, paras 63 – 66; [Exhibit 63, Statement of Shaun Hogan, WILS.0001.0010.0001, para 83, page 24]; Exhibit 69, Witness statement of David Millward USG.9999.0001.0001, para 121, page 20; Exhibit 42, Witness Statement of Stephen Ferrigno, SHER.0009.0001.0001, para 35, page 9; Menezes statement at [22] and [36].
[425] Ex 109. Statement of Authorised Officer, Operations Support at [33].
[426] Bamert statement at [24](b). See also evidence of Mr Ashford T268.
[427] Bamert statement at [24](b) and [40]; Exhibit 136, Email from [redacted] to Nigel Coppick, copying Rachaele May, DJPR, and o hers "PPE Advice for Hotel-based security staff and AOs" dated 12 May 2020, DHS.5000.0023.1372; Williams Statement at [57(b)]; Exhibit 131, DHS.5000.0023.1372.
[428] Bamert statement at [24](b); Exhibit 136, "PPE Advice for Hotel-Based Security Staff & AOs in Contact with Quaran ined Clients", DHS.5000 0009.1930; Williams Statement at [57(c)]; Exhibit 131, DHS.5000.0001.8212.
[429] Bamert statement at [24](c); Exhibit 136, Email from DHHS OpSoteria EOC dated 10 June 2020, DHS.5000.0008.1681.
[430] Bamert statement at [25]; Exhibit 136, Email dated 26 April 2020 "Deployment Order – Operation Soteria" DHS.5000.0030.6735, "How to put on (don) and take off (doff) your personal protective equipment (PPE)" DHS.5000.0030.6737 and "Hotel Team Leader Onboarding Process" DHS.5000.0028.6288.
[431] Evidence of Cleaves, T901: 5-13.
[432] Williams Statement at [26]. See also T415 and 416 (Ms Febey, DJPR), Statement of Menon, [17] and [18].
[433] Williams Statement at [27]; Evidence of Ms Williams, T1298: 1-10 and T1299: 5-12.
[434] Evidence of Ms Williams, T1298:30-T1299:3, T1280:44-47; Evidence of Ms Bamert, T1319: 11-14, T1320: 4-7.

192. To reduce transmission risk, guests were responsible for cleaning their own rooms (and were given cleaning materials for that purpose) and for bagging and placing rubbish and dirty linen outside their hotel room.[435] Clinical waste was required to be disposed of in clinical waste bins.[436]

193. The Department's IPC consultant prepared cleaning advice, *Cleaning and disinfecting to reduce COVID-19 transmission: Tips for non-healthcare settings*,[437] that was publicly available on the Department's website on 20 March 2020 (**March Cleaning Advice**), with a minor update made on 22 March 2020.[438] The purpose of the guide was to provide advice on cleaning and disinfecting to reduce the risk of COVID-19 transmission in all non-healthcare settings in Victoria.[439] Dr Romanes, DPHC – Strategy and Policy endorsed the document.[440] The information was not developed specifically for hotels, although it was intended to address a range of situations including those where a suspected or confirmed case was in a facility that houses people overnight, for example, a hotel.[441]

194. The Infection Control Consultant prepared the March Cleaning Advice having regard to the AHPPC information for routine cleaning and disinfection in the community and information from the Department Guidelines for the investigation of gastroenteritis to determine appropriate bleach dilutions and steam cleaning information.[442] She also considered the US Centers for Disease Control and Prevention website when drafting the advice.[443] The March cleaning advice was consistent with the evidence Prof Grayson gave at the start of the inquiry as to appropriate cleaning standards:

> … the standard, if we are talking about an analogous situation, both in the coronavirus ward, say, here at the Austin, or if we are talking about superbugs, the standard is to use bleach to clean the area, a combination of detergent and then bleach, usually 1,000 parts per million bleach kills everything. There are some components that can't be cleaned with bleach and they are cleaned with just 40 detergent. But obviously in the example you are giving with the lift, all of those areas could be cleaned with 1,000 parts and indeed at the Austin, everything is cleaned with 1,000 parts per million of bleach, whether it is a COVID ward or not.[444]

195. On 8 April the Department emailed the DJPR about cleaning requirements for rooms once vacated, specifically those that have had confirmed COVID-19 cases, attaching the 20 March cleaning advice and COVID-19 Case and Contact Management Guidelines for Health Services and General Practitioners (**CCOM Guidelines**).[445] Ms Febey of the DJPR gave evidence of receiving the advice, and the CCOM Guidelines on 8 April 2020.[446] The advice was to apply the cleaning requirements in the March Cleaning Advice and the CCOM Guidelines for every space aside from those with COVID positive people in rooms, which were provided with the email.[447] In practice at the Rydges, as there was only one lift for guests, a system was implemented to have the lift cleaned immediately in between guests using it. This was done by using a sign which was flipped to say 'dirty' after the lift had been used by a guest and was waiting to be cleaned and flipped to say 'clean' following disinfection.[448]

196. On 27 April, in response to requests by DJPR for cleaning advice, the Department provided advice to DJPR to refer cleaners to the March Cleaning Advice and subsequently confirmed that the advice was applicable to cleaning for COVID-positive hotel rooms and no period of settling was required unless aerosol generating procedures had been undertaken.[449]

197. It has been put that tailored cleaning advice was not available to hotels until June, referring to the 'Hotel Quarantine Response – Advice for cleaning requirements for hotels who are accommodating quarantined, close contacts and confirmed COVID-19 guests updated', issued 16 June 2020[450] and

---

[435] Williams Statement at [26]; Exhibit 131, COVID-19 – DHHS Physical Distancing and Public Health Compliance and Enforcement Plan dated 4 April 2020, page 35, DHS.0001 0008.0674, and Annex 2 – Health and Wellbeing (v2) dated 1 June 2020 contained within OS Plan (v3) dated 26 May 2020, DHS.0001.0001.2245.
[436] Williams Statement at [39]; Exhibit 131, "Opera ion Soteria Clinical and Waste Related Guidance", DHS.5000.0003.9660.
[437] Exhibit 161, Cleaning and disinfecting to reduce COVID-19 transmission - 20 March 2020, DHS.0001.0015.0323.
[438] Williams statement at [28].
[439] van Diemen statement at [114].
[440] Ex 203, Statement of Infec ion Control Consultant, DHHS at [36].
[441] Ex 203, Statement of Infec ion Control Consultant, DHHS at [37].
[442] Published at https://www2.health.vic.gov.au/public-health/infectious-diseases/infection-control-guidelines/gastrointestinal-illness-investigation-guidelines.
[443] Published at https://www.cdc.gov/coronavirus/2019-ncov/community/clean-disinfect/index.html, as at 18 September 2020 (updated from time to time). Ex 203, Statement of Infection Control Consultant, DHHS at [38].
[444] T61.36-43 (Lindsay Grayson)
[445] Williams statement at [30]. Exhibit 131, DHS.0001.0015.0287, attaching "Coronavirus disease 2019 (COVID-19) Case and contact management guidelines for health services and general practitioners" dated 5 April 2020, DHS.0001.0095.0001 and", Cleaning and disinfecting to reduce COVID-19 transmission: Tips for non-healthcare settings", DHS.0001.0015.0323, DHS.5000.0001.8769 and DHS.5000.0002.1028. See also Exhibit 161, CCOM Guidelines version 17, 5 April 2020, DHS.0001.0060.0034. This document was continuously updated.
[446] Exhibit 131, DHS.0001.0015.0287 Email from Mr Hogan to Ms Febey attaching March Cleaning Advice, see also T430.15 (Febey, confirming receiving March Cleaning Advice), 430.22 (Febey, receiving CCOM Guidelines); T492.8- 495.21 (May)
[447] Williams statement at [30];
[448] Ex 205, statement of Senior Project Officer statement at [16].
[449] Williams Statement at [33]; Exhibit 131, DHS.5000.0001.8769.
[450] DHS.5000.0003.1597.

provided to DJPR on 17 June (**June Cleaning Advice**).[451] Ms May of the DJPR acknowledged that the DJPR had all the information that was required to instruct cleaning contractors by 28 April.[452]

198. In the IPC consultant's view, the substance of the later advice is found in the March Cleaning Advice provided to the DJPR, and provided by them to cleaning companies. While the former contained some more specific advice relevant to hotels, in her view, "the essential substance of the advice is the same in both documents".[453] This view was not challenged, nor was it put to any witness, such as Prof Grayson or hotel managers, that the substance in the March Advice was insufficient.

199. Mr Girgis, from IKON similarly gave evidence that the procedure in the June Cleaning Advice largely reflected the procedure they had been following in the March Cleaning Advice, it also referred to steam cleaning of all soft furnishing and carpets.[454]

200. In addition, the CCOM Guidelines[455] was provided to the DJPR on 8 April and was also publicly available. These guidelines provide for general IPC,[456] and are based on the CDNA Series of National Guidelines – COVID-19 and the WHO guideline, *Infection prevent and control during health care when novel coronavirus (nCoV) infection is suspected: Interim guidance January 2020*. It is the Department's key resource for clinicians and health services. It is regularly updated to ensure that it aligns with the national CDNA Australia guidelines and international best practice.[457]

201. The CCOM Guidelines reflects nationally consistent advice regarding the management of COVID-19 suspected and confirmed cases had evolved as further information regarding the specific risks of transmission became known. The Guidelines noted that further knowledge or advice was incorporated into the Guideline as it became available.[458] In the light of all this evidence it is not open to the Board to find that cleaning advice was not available, or that the cleaning advice was not appropriate.[459]

Implementation of public health advice in Operation Soteria

202. Operation Soteria Command sought and followed public health advice about IPC measures for the hotel quarantine program, and that advice was continuously improved over time, as the understanding of COVID-19 and public health advice evolved.[460]

203. Dr van Diemen gave evidence that she and her team provided a range of public health advice to Operation Soteria, including in relation to welfare.[461] Ms Bamert's evidence confirmed that as Commander she worked closely with Public Health to ensure the policies they established and drafted were operationalised in each hotel, including through the development of standard operating procedures for team leaders that provided instruction on how to implement the public health policies, which were approved by the Public Health Incident Management Team (including, at the start of the program, by Dr Finn Romanes).[462]

Incorporation of IPC into the design of the program

204. Reduction of transmission risk and support of specific infection control measures were built into various aspects of the design of the hotel quarantine program.[463]

205. Upon entry at airports or ports, procedures were established to limit risk, with a clear focus on containment, infection risk and use of social distancing, hand hygiene and PPE by Victorian and Commonwealth staff and contractors. These procedures included the following:[464]

    (a) Special arrangements were put in place for the plane from Uruguay carrying people from the Gregory Mortimer cruise ship (arrival at a separate hangar and all processing airside with no movement through the terminal).

---

[451] Williams Statement at [37] and [38]; Exhibit 131, DHS.5000.0001.8954.
[452] T983.32-T985.21. See in par icular T985.10-21
[453]Ex 203, Statement of Infection Control Consultant, DHHS at [40].
[454] Exhibit 128, Witness statement of Michael Girgis, WIT.0001.0027.0001, [31].
[455] Exhibit 161, CCOM Guidelines version 17, 5 April 2020, DHS.0001.0060.0034. This document was continuously updated.
[456] Exhibit 161, CCOM Guidelines, p 18.
[457] van Diemen statement at [116].
[458] Exhibit 161, CCOM Guideline, p 19; van Diemen statement at [117].
[459] Cf, for example, T2225: 15-22.
[460] Williams statement at [42].
[461] T1254: 39- T1255: 14; T1526: 12-15.
[462] Bamert statement at [17(c)] and [18].
[463] Williams statement at [41].
[464] Williams statement at [41(a)]; see procedures in COVID-19 – DHHS Physical Distancing and Public Health Compliance and Enforcement Plan dated 4 April 2020, pages 18-19 [DHS.0001.0008.0674] as well as in Opera ion Soteria Plan (v1) dated 28 March 2020 [DHS.0001.0001.1475], (v 2) dated 26 April 2020 [DHS.5000.0001.3583] and (v3) dated 26 May 2020 with
Annexures dated 1 June 2020 [DHS.0001.0001.2245].

(b) For all incoming flights, nurses undertook symptom and temperature testing (as described further below) and anyone with COVID-19 symptoms or other significant medical or mental health issues were transported directly to Royal Melbourne Hospital by ambulance.

(c) To limit risk and delay at check-in at the hotels, couples and family groups were identified and the information relayed to the hotel (via DJPR) to enable room allocations to occur while people were being processed at the airport and transferred to the hotel. This became increasingly complex as the numbers of families and related family groups increased over May and June. It was not always possible to allocate rooms according to family preferences, for example it was rarely possible to allocate rooms with balconies when requested since these existed in very few hotels.

(d) To limit transmission risk (and to simplify operations in the hotels), attempts were made to house all arrivals from each plane in the one hotel so that their transit to the hotels was a continuation of any contact with the same people with whom they had shared a flight.

206. During transport of returned travellers to hotels and allocation into rooms, the following procedures were in place:[465]

(a) Skybus were contracted by the Department of Transport for transport and made special arrangements to limit the numbers in the bus for social distancing and to protect drivers. AFP and Victoria Police escorted the buses.

(b) On arrival at hotels, buses were unloaded sequentially to ensure social distancing and guests were allocated rooms. Luggage was unloaded with the help of security and concierge staff. Each hotel varied in its capacity to maintain safe social distancing depending on the size of its foyers and the number of lifts. At entry, all staff wore PPE and guests wore masks and had access to hand sanitiser.

207. Modifications were made to the physical environment of hotels to reduce transmission risk. By way of example, hotel lobbies were cordoned off to encourage swift movement through spaces, hotels were encouraged to remove or limit soft furnishings, and staff on site were separated into specific zones to prevent cross-infection.[466] Ms Williams gave evidence that the hotel process was designed to minimise any time that people spent in common areas; the hotels themselves had limited all sort of access and provided very rapid ingress and egress from the hotels.[467]

208. Procedures in place for face to face interactions between staff and guests in or at rooms were also designed to minimise contact. For example, meals and other items (parcels, linen, etc) were left outside the doors for guests to pick up. Meals were provided in disposable containers which were not re-used. Most interactions with guests were via telephone, and any face to face interactions were at the door where possible. The number of these interactions, increased with the introduction of testing of all guests on Day 3 and Day 11 from early May. This involved clear protocols to reduce infection and transmission risk for the testing teams allocated to each hotel on testing day. The protocols required that the nursing staff wore PPE and undertook the swabbing at the door to the room to reduce infection risk; the nurse performing the swabbing procedure was required to doff PPE after each room, and the whole team changed PPE when they changed floors.[468]

209. Aside from medical and nursing staff personally assisting guests, it was generally expected that all staff working on site would maintain physical distancing from guests during their stay in hotel quarantine. All staff were expected to comply with the same physical distancing and hygiene (in particular, hand hygiene) requirements that applied in the community.[469] Security staff were instructed not to attempt to physically restrain guests if they attempted to leave their rooms without authorisation (which happened rarely).[470]

210. Procedures in place for movement of guests out of and back to their rooms if authorised by an AO (including for fresh air breaks) were implemented to manage the transmission risks of which the command were conscious.[471] It was Pam Williams' evidence that fresh air breaks were difficult to implement without transmission risk due to the limitations of many of the hotels (for instance, they did not have open areas that could be sectioned off from the public to reduce flight and transmission

[465] Williams statement at [41(b)].
[466] Williams statement at [41(d)].
[467] T1281.35-39; T1281.40-42.
[468] Williams statement at [41(c)]; PPE requirements for nursing staff were set out in the document ti led "PPE Advice for Hotel-based Healthcare Workers Contact with COVID-19 Quaran ined Clients", at [DHS.0001.0001.1358], Exhibit 131.
[469] Williams statement at [42].
[470] Williams statement at [71].
[471] T1270:44-46, T1271:3-4, T1281:39-40 (Pam Williams).

risk). The DJPR and DHHS safety officers worked with the hotels, AOs and security in April and May to develop specific fresh air procedures for each hotel (see par 343 below).[472]

211. The process of placing 'plane-loads' of travellers into a single hotel until it was full and moving COVID positive guests to a specific hotel (discussed further at 259) meant that after about 14 – 16 days a hotel would be completely empty and able to be fully cleaned, re-stocked and made ready for a new set of guests after a few days.[473]

Training

212. The hotel managers and security companies gave evidence about the detailed training given to their staff, as required pursuant to the terms and conditions of their respective contracts.

213. **Rydges:** The contractually required training at the Rydges was initially developed by the employer prior to the first quarantine guest arriving on 12 April 2020[474] and included a 'toolkit' for its general managers providing information relating to COVID-19 transmission, links to information regarding COVID-19 (both government and non-government), cleaning and disinfection practices, hand hygiene/hand washing technique, PPE and environmental hygiene.[475] Rydges had a number of standard Operating Procedures[476] which included guidance on cleaning and disinfecting.[477]

214. Rydges had been given information by DHHS on 10 April that "asked staff to assume that all quarantine guests were COVID-19 positive", and that service procedure required staff to:

(a) put on required PPE based on each task to be performed (including overalls, masks, googles and gloves) prior to entering the service lift, and

(b) Attend a doffing station after delivering the food and other items to properly dispose of gloves and masks and clean their hands with sanitiser before entering the service lift.[478]

215. Mr Menezes, General Manager of the Rydges explained that the hotel "had responsibility for training its staff"[479] and that they received on the job training included with respect to PPE practices.[480] that "Rydges head office [provided]… learnings of Covid-19… best practice [and] instructions which [were shared] with the team[481]" and that the hotel would ensure "guidance on the correct use of PPE" and updates to staff if "they returned to work following a period of time off."[482]

216. Mr Menezes accepted relation to further staff training by DHHS or YNA that "when you made requests, if you ever had them, you found people, particularly DHHS staff, were always happy to oblige you with those requests that you had."[483] Consistent with this, security guard 2 gave evidence to his PPE training at the Pullman.[484]

217. Further, "on about 11 and 12 April 2020, "specialist infection control experts engaged by the DHHS inspected the [Rydges] Hotel and arranged for PPE stations to be strategically placed around the hotel, along with posters and instructions about how to correctly don and doff PPE. … During that visit, the infection control experts showed me and a limited number of my staff … how to correctly don and doff PPE. We were advised to show other Hotel staff how to correctly don and doff PPE. …. During the following weeks there were ad hoc occasions where the onsite nurses would provide refreshers as to how to don and doff PPE."[485]

218. **Stamford:** Mr Unterfrauner, General Manager of Stamford Hotel, explained that: "Stamford provided training to staff regarding infection control, personal hygiene, social distancing and the use of PPE. Staff were trained by their department head using Stamford's own "COVID-19 Operational Health and Safety On-boarding."[486] Stamford staff also completed the Australian Government Department of

[472] Williams statement at [41(e)]; T1270:39-42, T1272.40-41 (Pam Williams).
[473] This 'res ing' of a hotel possibly reduced risks, although the IPC Cell advised that there was no scientifically proven length of time after which any COVID virus would no longer be active: Williams statement at [41(g)].
[474] Ex 45, statement of Roswyn Menezes, RYD.0001.0023.0001 [18], [22].
[475] Mr Rosswyn Menzies statement 17 August 2020 at [47]-[48].
[476] Ex 45, statement of Roswyn Menezes, RYD.0001.0023.0001 [51].
[477] Ex 45, statement of Roswyn Menezes, RYD.0001.0023.0001 [45].
[478] Ex 45, statement of Roswyn Menezes, RYD.0001.0023.0001 [22]; see detailed document referred to in par 22: RYD.0001.0012.0090 and photograph of PPE doffing station RYD.0001.0012.0102.
[479] T597.43-44.
[480] Ibid at [50].
[481] T563.40-47.
[482] Ex 45, Statement of Roswyn Menezes, RYD.0001.0023.0001 [61].
[483] T595.27-29.
[484] See, for example, T334-335, 337, 3552-353 (PPE training at the Pullman); T338-340, T344, 366 and Exh HQ 0029, Statement of Security 2, [38], [56] (PPE training at COVID-19 hotel, from 23 June to 13 July 2020).
[485] Ex 45, statement of Roswyn Menezes, RYD.0001.0023.0001 [44].
[486] Ex 47, statement of Karl Unterfrauner, STAM.0001.0004.0009, [35]. : See also he acknowledgement of the contractual training requirements by Mr Unterfrauner at T606.

Health on-line infection control training.[487] Stamford reinforced the training with daily toolbox briefings and PPE and operational procedures on display.[488]

219. Mr Unterfrauner, with respect to the contractual requirement that cleaning would be conducted "to a standard consistent with the most recent recommended public health standards in respect of Covid-19"[489], acknowledged the work done with the contracted housekeeping provider on creating a specific standard operating procedure,[490] based on the government information made available, highlighting the sophisticated understanding of that clause which would be expected by a business being contracted for significant sums to provide services of the kind with which the hotel was experienced.[491]

220. **Other hotels:** Each other Hotel also had contractual requirements to provide training and did do so.[492] Crown hotels, for instance, provided extensive training and instructions to its staff consistent with its obligations as an employer and under its contract with DJPR. These included directions communicated to staff as to:

(a) "COVID-19 Standards", a set of 10 guiding principles to which Crown staff were required to adhere in the conduct of their duties at Crown; [493]

(b) Standard operating procedures first prepared on or around 31 March, including "CHQ5 – PPE Usage" and "CHQ10- Cleaning of COVID-19 positive rooms" which could be accessed by all staff through Crown's intranet;[494]

(c) managers and supervisors briefed their teams daily on the expectations to comply with the work instructions on an ongoing basis, [495] and

(d) COVID-19 information sheets with directions regarding PPE were placed prominently throughout Crown's premises and distributed electronically to staff by email, through Crown's "Workplace@" page, and available on Crown's staff intranet page.[496]

221. Further, Crown developed a COVID Response Team which functioned to assist managers and supervisors for monitoring compliance by Crown Staff and contractors.[497]

Information provided to hotels by Government

222. Detailed information with respect to cleaning and use of PPE was made available to DJPR and the hotels. The Executive General Manager of Crown Melbourne Hotels gave evidence of his understanding that Crown was expected to monitor the ongoing guidance that the Government departments provided either by way of direct communication to Crown or by way of public announcement and reflect this in its ongoing management of the hotel quarantine program, and Crown did so;[498] and DHHS provided guidance directly to Crown from time to time and PPE use and cleaning.[499] DHS staff also provided guidance in a walkthrough of Crown practices, including PPE use and cleaning procedures.[500]

223. Only two of those many hotels involved in the program had outbreaks., The extent to which those outbreaks are the result of person to person transmission or environmental exposure is not – as discussed below at 282– the subject of adequate evidence in this Inquiry to make any conclusions. What the Board can determine, however, is that there was transmission of the virus only at the Rydges and Stamford hotels. That there were not transmission events at any of the other hotels suggests that the cleaning and PPE advice was sufficient for those hotels and that there were not failings of a systemic nature in relation to Hotel cleaning.

---

[487] Ex 47, statement of Karl Unterfrauner, STAM.0001.0004.0009, [35].
[488] Ex 47, statement of Karl Unterfrauner, STAM.0001.0004.0009, [35].
[489] T604.36-38.
[490] The Standard Operating Procedure were created and implemented in or around 12 April 2020, prior to Stamford accepting any quarantine guests *Isolation Guests (Housekeeping Cleaning* STAM.0001.0001.0158, which was reviewed by DJPR: Exhibit 47, Witness Statement of Karl Unterfrauner, STAM.0001.0004.0009, paragraph 35, page 14.
[491] T604.40-45: Mr Unterfrauner explained that in crea ing the standard opera ing procedure "as a resource, we used Government guidelines which were available online and also guidelines from the Australian Hotel Association to compile that, which was a --- it detailed the sanitisation of high-touch points, it detailed on the cleaning and the cleaning products which should be used."
[492] See, eg , evidence as to training included in Mead statement at [34]-[35], [40] and [45]; Unterfrauner, statement at [35]; Henderson statement at [35] and [40]; Mandyam statement at [93]-[95]; Menezes at [47]-[52], [61]; D'Cruz, statement at [92] – [93] and [104].
[493] Witness Statement of Shaun D'Cruz, Exh 4 CML.0001.0014 0001 at [92].
[494] Witness statement of Shaun D'Cruz, Exh 41, CML.0001.0014.0001 [110], [119]-[120].
[495] Witness statement of Shaun D'Cruz, Exh 41, CML.0001.0014.0001 [110].
[496] Witness statement of Shaun D'Cruz, Exh 41, CML.0001.0014.0001 [110].
[497] Ibid [104]. Mr D'Cruz states further that the CRT would regularly observe the day to day practices by various business units and, where necessary, remind staff of the need to comply with Crown's COVID-19 protocols.
[498] Statement of Shaun D'Cruz, (Exhibit 41 CML.0001.0014.0001), at [89], page 18.
[499] Including cleaning information on 2 April and 17 June: Statement of Shaun D'Cruz (Exhibit 41, CML.0001.0014.0001) at [57]; fn 11 CML.0001.0007.0058, and [60], footnote 14: CML.0001.0001.0209; [61] fn 15 CML.0001.0001.0267.
[500] Statement of Shaun D'Cruz, (Exhibit 41 CML.0001.0014.0001), at [61].

Security

224. The evidence showed a range of training and guidance measures put in place by the firms.

225. **MSS** conducted a risk assessment prior to commencing work.[501] It also had a bespoke online Infection Control Training Module that it required its security staff and subcontractors to undertake.[502] MSS Security provided its security guards ongoing on the job training which included shift briefings detailing changes in practices or reminders regarding appropriate PPE usage and social distancing.[503] Wilson provided all security guards with the Wilson COVID-19 Pack which was created by Wilson's Health, Safety and Environmental Specialist and Risk and Operations specialist with input from Wilson's Chief Medical Advisor.[504] Unified Security required all of its security guards to complete the Australian Government Department of Health COVID-19 online training course,[505] and all staff were fully briefed on their first day including with respect to "the requirements and use of PPE and … the risk of COVID-19".[506]

226. **Wilson Security:** Established infection control, PPE and staff training protocols. Wilson had an internal team who was responsible for procuring PPE supplies for its staff.[507] Wilson Security implemented a comprehensive training and induction program for its security guards (including subcontract guards) which included, inter alia, a three week training course[508] an induction program[509] and specific training in relation to the HQ Program, which included explaining the core remit and objective of security staff[510,] provision of the Wilson COVID-19 Pack[511] and onsite training and supervision by way of toolbox talks, daily briefings and dissemination of updated information.[512]

227. What is clearly demonstrated by the evidence of both the hotel and security companies is that they understood their individual obligations to provide training and guidance to their staff, and indeed an ability to do so comprehensively and in an ongoing manner. In these circumstances was entirely appropriate to require by contract that organisation ensure the proper training and protection of their employees, and to expect that this training was conducted. That was done with the availability of government resources – both DHHS and Commonwealth[513] – and the independent resources engaged by the companies themselves.

228. It is put that absent clear oversight, it was not appropriate to use security guards for the roles that they performed.[514] Dr McGuiness gave evidence that as scientific understanding on COVID-19 has continued to develop, PPE and IPC practices that would have been regarded as appropriate in May, such as, it is submitted, guards escorting travellers on fresh air breaks, may not necessarily be the same as recommended now.[515] At the time, and as set out above, the security companies gave evidence as to the IPC and PPE training they provided and of receiving public health advice as to how to safely conduct the breaks.[516] The Infection Control Consultant's evidence, which was not challenged, was that the PPE advice she developed and which was provided to Operation Soteria to provide to DJPR, was appropriate, including for guards conducting fresh air breaks.[517]

229. It is evident that employers in the program did undertake significant work to ensure that proper training and protections were in place. To the extent that there were failures to do so, this was likely to have been in breach of contract. It would undermine all government contracting and service provision to the public to suggest that large companies contracted to government for high value contracts for service provision of a specialised standard would not be able to accept contractual liability for protecting their employees, or that government could not rely on such compliance. Any suggestion to the contrary risks jeopardising the ability for the government to engage a number of private sector resources in an emergency including for example use of private sector aerial firefighting services in a bushfire.

---

[501] Statement of Jamie Adams, Exh 65, at [73] and Risk assessment form therein (in bundle of annexures :exhibit 66).
[502] Statement of Jamie Adams [98], [120]-[121] and documents referred to therein. See also T820.36-46.
[503] Jamie Adams statement MSS dated [125]; Krikelis, MSS, dated 17 August 2020 at [70].
[504] Statement of Gregory Robert Watson, [128] (exhibit 61) WILS.0001.0010.0037 .and see attachments: WILS.0001.0002.2137 and WILS.0001.0005.6913.
[505] Statement of Mo Nagi at [69] (Exh 75 WIT.0001.0036.0001). Statement of David Millward at [65]-[66] (Exhibit 69, USG.9999.0001.0001. See also completion certificates referred to in par [66] in the documents in exhibit 70.
[506] Statement of Mo Nagi at [69] (Exh 75 WIT.0001.0036.0001) at [70].
[507] Greg Watson, MSS Security, dated 2 September 2020 (Watson statement) at [98].
[508] Ibid at [120].
[509] Ibid at [12].
[510] Ibid at [125] – [126].
[511] Ibid at [128]; Ex 63, Shaun Hogan [88].
[512] Ibid at [130]; Ex 63, Shaun Hogan [86].
[513] See eg par 317 below referring to the obligation to complete the Commonwealth Department of Health online COVID-19 training course.
[514] T2265: 27-30 (Neal).
[515] McGuinness statement, [101].
[516] Exhibit 114, Email from Dr Romanes, 4 April 2020, DHS.5000.0095.9277.
[517] Ex 203, Statement of Infec ion Control Consultant, DHHS at [54]-[55].

AO training

230. The Board also heard evidence of the training of AOs. Prospective AOs were required to attend training before being rostered on to commence work at a hotel site.[518] Contrary to the assertions in the evidence of Mr Ashford that AOs received no training on IPC or PPE,[519] evidence from the Department's witnesses establishes that around early April, AOs received training[520] by a 1 hour teleconference before starting work on the ground at hotels, occupational health and safety, safety and wellbeing, the role of AOs on the ground and training on the advice on use of PPE, the importance of personal hygiene, making sure PPE was donned and doffed appropriately (and if unsure, to seek advice on shift from the nursing staff), the risks of becoming complacent about hand hygiene and touching surfaces if wearing gloves, and the importance of following the CHO's recommendations at the time regarding hand washing, using hand sanitiser, coughing or sneezing into elbows, and not touching faces.[521]

231. In around June, the Department developed a more intense 5 day classroom training program followed by onsite training. This training program was developed to cater for recruits from the private sector.[522] AOs were also provided with general information and FAQ documents about their role as part of the onboarding process.[523] AOs also undertook the Australian Government Department of Health Online Infection Control Training which provided information in relation to the use of PPE.[524]

Training for other on-site staff

232. In the first week of the program, Merrin Bamert, (who in addition to her emergency management experience is highly trained and experienced as an Emergency Department nurse)[525] visited hotel sites (the Crown Promenade and Metropol) and to make contact with Department Team Leaders and nursing staff to give Department staff instructions about the use of PPE (donning and doffing) and provide information about how to don and doff PPE printed from the Department's COVID19 website.[526]

233. From the commencement of the program, the Department required its Team Leaders to lead by example with physical distancing and other infection control and OHS activities[527] and to conduct a shift handover briefing for Department staff (including AOs and nursing staff) and the Dnata team leader if possible, covering PPE instructions, OHS considerations and physical distancing.[528] This requirement was reflected in the guide to "Operation Soteria Standard Operating Procedures (a guide for team leaders)" which provided that at the beginning of each shift, the Team Leader should provide a briefing to all personnel on the floor, which should involve everyone present including the Department, DJPR, nurses, concierge staff, AOs, security representative, hotel representative and any other relevant parties.[529], A DJPR site manager, and a range of hotel managers and security staff, gave evidence confirming that daily briefings took place.[530] Witness "Senior Project Officer", a DHHS Team Leader, gave evidence that Team Leaders — including at the Rydges — provided reminders about infection prevention and PPE at twice daily on-site team meetings, which were attended by the Department Team Leader, the onsite security supervisor, AOs and nurses.[531]

234. Training and induction for Team Leaders included working as a 'Team Leader Support' and shadowing a more experienced Team Leader, including an informal induction; the induction included an overview of the Team Leader role, policies and procedures (which were available via the Teams site and on site at hotels, and updated emailed to staff).[532] 'On the job' training for Hotel Team Leaders included:

    (a) twice daily teleconferences conducted with the EOC for all Team Leaders and Team Leader Supports where advice and training was provided, including advice on the methods for

[518] Ex 109. Statement of Authorised Officer, Operations Support at [16(f)].
[519] Exhibit 23, Witness Statement of Luke Ashford, WIT.0001.0006.0002 at [10] and [17].
[520] Ex 109. Statement of Authorised Officer, Operations Support at [22]; Ex 77, Statement of Unnamed Senior Authorised Officer Statement at [15]-[16], [23].
[521] Ex 109. Statement of Authorised Officer, Operations Support at [23].
[522] Ex 109. Statement of Authorised Officer, Operations Support statement at [27].
[523] Ex 109. Statement of Authorised Officer, Operations Support at [36] and [37]; Ex 77, Statement of Unnamed Senior Authorised Officer at [17] and [20].
[524] Ex 77, Statement of Unnamed Senior Authorised Officerat [18].
[525] Ex 135, statement of Merrin Bamert [3] to [6].
[526] Bamert statement at [15(b)] and [25]; see also Williams Statement at [58(a)] and Exhibit 131, DHS.5000.0003.2294.
[527] Bamert statement at [26]; Exhibit 136, Email from Merrin Bamert dated 4 April [DHS.0001.0008.0170].
[528] Bamert statement at [26]; Exhibit 136, Email from Merrin Bamert dated 4 April, [DHS.5000.0054.0804], and email from Merrin Bamert to SEMC dated 4 April DHS.5000.0054.0804.
[529] Bamert statement at [26]; Exhibit 136, Standard Operating Procedures (a guide to Team Leaders), 30 May 2020 [DHS.5000.0003.1053].
[530] Exhibit 84, Witness Statement of CCOC, DJP.050 007.0001 at [15]; Mead statement at [19]; Exhibit 47, Statement of Karl Unterfrauner, STAM.0001.0004.0009, para 19, page; Exhibit 43, Statement of Nick Henderson dated 17 August 2020, para 19, page 5; Menezes at [27]-[28] and [35]; Exhibit 29, Statement of Security 2, WIT.0001.0026.0001, para 34, page 6]. See also the evidence of Ms Spiteri to this effect: T1606: 19-T1607:5 (Spiteri).
[531] Ex 205, statement of Senior Project Officer statement at [42], [68].
[532] See Ex 205, statement of Senior Project Officer at [26]; [28]-[31].

collection of clinical waste or for any changes or refinement to policies and reinforcing the use of PPE in accordance with policies and practicing of hand hygiene;[533]

(b) regular site visits from the Deputy Commander Hotels, Department Operation Leads, Senior AOs and senior staff from DJPR where Hotel Team Leaders could ask questions and receive advice and informal training, as well as site visits by the Accommodation Commanders where PPE and IPC policies would be reiterated;[534]

(c) advice and training from the Department's Operation Soteria Safety Officer based at the EOC;[535]

(d) the Department's specialist infection control staff provided advice and training to onsite staff on occasion.[536]

235. The DHHS Workplace Health and Safety Officer for the program also undertook onsite visits to check availability of hand sanitiser and signage, including on 20 May, placing signage on walls and doors relating to social distancing and the maximum number of staff allowed in an area at one time.[537]

236. The evidence is that in practice, Department staff on site were alert to PPE and social distancing concerns and issues were called out and/or escalated up the Department's chain of command.[538] It was the practice of the DHHS Team Leader at the Rydges to remind staff (including security staff or nurses) of PPE and IPC protocols if they observed hand hygiene or social distancing practices not being followed consistently.[539] For instance, a Department Team Leader gave evidence of steps following observations of security guards not complying with PPE, social distancing and hand hygiene requirements, including contacting Stamford Plaza Hotel and the security manager enclosing the Department's current PPE policy and also a link to a YouTube video demonstrating cross contamination and requesting that the hotel print copies of the policy and place it in convenient locations for staff, including security staff, to access,[540] and discussing with individual security guards and also the security manager,[541] and arranging for one of the nurses on duty (who had training experience) to provide instruction and training to the security staff on appropriate PPE usage.[542]

237. Contracted nursing companies gave evidence of training requirements, and training provided, for their own staff[543] as well as further training provided by the Department on site.[544] Dr Garrow (of onsite doctor) similarly gave evidence that medical staff on site received PPE guidance from the Department and conducted their own training in PPE.[545] On around 11 April, the Department arranged for a PPE briefing to be provided by the IPC consultant from IPA for GPs and nurses working at the Rydges hotel.[546]

238. A Department team leader gave evidence that when issues arose about the use of PPE or there was a change in procedure necessitating the use of PPE by staff unfamiliar with its use, there would be training from the onsite nursing staff, who were rostered on 24/7, on infection control and PPE use.[547] That evidence was consistent with a range of evidence from hotel and security staff, that nurses would themselves provide PPE training for hotel staff prior to the arrival of quarantine guests and for security staff in orientation sessions, and provided impromptu refresher sessions on how to use PPE and appropriate hand hygiene for other staff on site.[548] The Board has heard that it was entirely appropriate for them to do so.[549]

---

[533] Bamert statement at [27]; William Statement at [49] and [58(b)]; Ex 205, statement of Senior Project Officer at [32].
[534] Bamert Statement at [27]; William Statement at [49] and [58(b)]; Ex 205, statement of Senior Project Officer at [32].
[535] Ex 205, statement of Senior Project Officer at [32].
[536] Ex 205, statement of Senior Project Officer at [32]; Bamert statement at [28].
[537] Bamert statement at [29]; Exhibit 136, examples of PPE signage, DHS.5000.0081.9224 and DHS.5000.0081.9225.
[538] Bamert statement at [27]; Williams Statement at [58(c).
[539] Ex 205, statement of Senior Project Officer at [67]. This was confirmed by at least one security staff witness: Exhibit 65, Witness statement of Jamie Adams, No Doc ID, para 125, page 17].
[540] Statement of learning consultant at [23(c)]; Exhibit 201 [Learning consultant exhibits], DHS.5000.0151.2702 (Email from witness with Youtube link and PPE advice for hotel security staff and AOs).
[541] Ex 201,Learning consultant statement at [23(f)]; [25].
[542] Ex 201,Learning consultant statement at [50].
[543] [Exhibit 90, Witness Statement of Eric Smith, SWI-0001-0001-0013_0001, para 8.1-8.4, page 2; Exhibit 100, Statement of Simone Alexander, ALFH.0001.0001.0001_R, para 27 and [79]-[80]; exhibit 64, Statement of Jan Curtain,YNA.0001.0001.0001, para 77, page 12].
[544] Exhibit 90, Witness Statement of Eric Smith, SWI-0001-0001-0013_0001, para 22.2, page 8.
[545] Garrow statement at [19] and [21], [26].
[546] Bamert statement at [28].
[547] Ex 205, statement of Senior Project Officer at [32]; , Exhibit 201 Statement of Learning Consultant DHHS, [23].
[548] Menezes at [44]-[46]; Mead statement at [8(c)], [34] and [40]; Exhibit 58, Statement of Eddie Chakik, WIT.001.0011.0001, para 23 and [42]; Exhibit 57, Statement of Dan Banks, No Doc Id, para 24, page 12; Exhibit 69, Witness statement of David Millward USG.9999.0001.0001, paras 126 - 127, page 21]; Exhibit 52, Statement of Mina Attalah, URM.0001.0001 0204_001, para 23, page 5]; Exhibit 67, Witness statement of Sam Krikelis, MSSS.0001.0014.0001_0001, paras 63 – 66; Exhibit 63, Statement of Shaun Hogan, WILS.0001.0010.0001, para 82, page 24]. Evidence of Cleaves, T922: 5-9.
[549] Evidence of Bamert: T1337: 13-33.

239. Reinforcing consistent uptake of IPC messaging by security and other staff was a challenge and there were gaps in the knowledge and uptake of PPE.[550] In particular, it became apparent following the Rydges and Stamford outbreaks that there had been challenges in embedding understanding of social distancing, hand hygiene and appropriate PPE usage amongst some security and hotel staff.[551] This is consistent with evidence from at least one security company that it advised its guards against following DHHS guidelines.[552] It also became apparent later, when the Department audited PPE usage and training in late May, that not all staff were receiving PPE training, in large part due to different shift times when training was conducted.[553]

240. As part of the Department's outbreak management response following the Rydges outbreak, and later the Stamford outbreak, the Public Health Outbreak Management team observed and provided instruction to staff on site (including security and nursing staff) on a number of occasions in late May and June, including through formal training sessions.[554] The Department provided detailed IPC and PPE training for hotel and security staff between mid-June and early July.[555]] This included training and meetings by the OMT.[556] Merrin Bamert made recommendations to increase uptake of training including conducting sessions across multiple shifts and providing translated materials for security guards for whom English was not a first language.[557] The Department also engaged the Behavioural Insights Team of the DPC to improve understanding and uptake of IPC and PPE advice, particularly amongst security guards.[558]

Testing in Hotel Quarantine

241. The Board should find that the testing policies deployed and applied in Hotel Quarantine were appropriate and adequate for the following reasons:

    (a) throughout the program, testing was always offered to symptomatic guests as soon as they exhibit COVID-19 symptoms;[559]

    (b) there is no evidence of any break down in testing policies and procedures leading to unidentified community transmission. The limited circumstances of transmission because of untested positive guests leaving quarantine were isolated and, subsequently addressed by the 10 day extension to quarantine for people refusing testing;[560]

    (c) the Victorian position on testing was the most robust in Australia; [561]

    (d) the family of returned at Rydges was tested and known to be positive at the time of the transmission event;

    (e) there is no evidence to support a finding that the testing policies and procedures were not adequate or appropriate.

242. Dr van Diemen gave evidence that in the first few weeks of the program no jurisdictions in Australia were doing asymptomatic testing.[562]

---

[550] Williams Statement at [49]; Evidence of Ms Williams, T1289: 14.
[551] Bamert statement at [36]. The evidence also shows, for example, one occasion where a DHHS Team leaders's reminders to to a security supervisor about social distancing were rejected so that she was required to escalate it; also she experienced resistance in compliance by security with PPE policy, but ultimately insisted: Ex 201, Statement of Learning Consultant, [23].
[552] Exhibit 69, Witness statement of David Millward USG.9999.0001.0001, paras 108 - 110, pages 17 - 18.
[553] Williams Statement at [60(b)].
[554] Ex 135, Statement of Merrin Bamert, [30].
[555] Exhibit 65, Witness statement of Jamie Adams, No Doc ID, para 102, page 13]; Exhibit 65, Witness statement of Jamie Adams, No Doc ID, paras 137 - 138, [146]; Exhibit 67, Witness statement of Sam Krikelis, MSSS.0001.0014.0001_0001, paras 106 - 107, page 13; Exhibit 51, Statement of Sorav Aggarwal, SSG.0006.0001.0001, para 33-35 , page 8]; Exhibit 47, Statement of Karl Unterfrauner, STAM.0001.0004.0009, para 34, page 13, Ex 135, Statement of Merrin Bamert, [44]; Ex 103, Statement of Simon Crouch, [32] and [35]; Ex 151, Statement of Jacinda De Witts, [32], [42] and [44]; Ex 97, Statement of Claire Looker, [74]; Ex 106, Statement of Sarah McGuinness, [93]; Ex 186, Statement of Khym Peake, [214] and [237]; Ex 153, Statement of Professor Brett Andrew Sutton, [225] and [227]-[228]. Ex 103, Statement of Simon Crouch, [31], [33] and [35]; Ex 97, Statement of Claire Looker, [62] and [93]; Ex 160, Statement of Dr Annaliese van Diemen, [106]; Ex 153, Statement of Professor Brett Andrew Sutton, [226]; Ex 186, Statement of Khym Peake, [237]. Ex 97, Statement of Claire Looker, [36], [39], [62] and [72]. Ex 186, Statement of Khym Peake, [249] and [252]; Ex 160, Statement of Dr Annaliese van Diemen, [105]. Ex 130, Statement of Pam Williams, [50].
[556] OMT training post outbreak: Ex 135, Statement of Merrin Bamert, [44]; Ex 103, Statement of Simon Crouch, [32] and [35]; Ex 151, Statement of Jacinda De Witts, [32], [42] and [44]; Ex 97, Statement of Claire Looker, [74]; Ex 106, Statement of Sarah McGuinness, [93]; Ex 186, Statement of Khym Peake, [214] and [237]; Ex 153, Statement of Professor Brett Andrew Sutton, [225] and [227]-[228]; OMT team/nurses inspecting Rydges/Stamford post outbreak and monitoring compliance: Ex 103, Statement of Simon Crouch, [31], [33] and [35]; Ex 97, Statement of Claire Looker, [62] and [93]; Ex 160, Statement of Dr Annaliese van Diemen, [106]; Ex 153, Statement of Professor Brett Andrew Sutton, [226]; Ex 186, Statement of Khym Peake, [237]; OMT meetings discussing training to be provided by OMT: Ex 97, Statement of Claire Looker, [36], [39], [62] and [72]; Training from department: Ex 186, Statement of Khym Peake, [249] and [252]; Ex 160, Statement of Dr Annaliese van Diemen, [105]; Cleaning training post outbreak: Ex 130, Statement of Pam Williams, [50].
[557] Bamert statement at [23], [30] and [36]; Exhibit 136, Email from Merrin Bamert to Department staff, "IPC advice for security staff at hotels", dated 30 May, DHS.5000.0019.3535; Exhibit 136, Email from Merrin Bamert to Nicole Cummins, Clare Looker and Katherine Ong, "Re Rydges hotel – two new COVID cases" dated 30 May 2020, DHS.5000.0088.5778.
[558] Williams Statement at [49(d)]; Exhibit 131, DHS.0001.0001.0711.
[559] Sutton at [191].
[560] Sutton at [199]; T1465.21-22.
[561] Sutton at [193]; T1550.37-47 (van Diemen).
[562] T1550.37-47 (van Diemen).

243. The approach to testing those in quarantine changed over time but throughout the program testing was always offered to symptomatic guests as soon as they exhibit COVID-19 symptoms.[563] The ongoing development of the testing arrangements is a good example of the extent of public health leadership and engagement in the program.

244. When the program commenced on 28 March 2020, consistent with the public health advice at that time, COVID-19 testing was not carried out on returning travellers on a routine but, rather, offered to symptomatic people. Prof Sutton gave evidence that "[t]his position not only reflected the position in the wider community, but also reflected the reasoning behind travellers returning from overseas being required to quarantine – the quarantine period of 14 days was identified because it would be enough time for symptoms of the virus to become apparent, on the basis of what was known about the incubation period for the virus."[564]

245. In April 2020, testing criteria in the community expanded first to persons at higher risk of exposure and then to anyone displaying clinical symptoms of COVID-19. At this time, this testing criteria for Victoria was the broadest in Australia.[565] From 27 April 2020 – 11 May 2020, Victoria commenced a 'testing blitz' to understand the spread of COVID-19 in the community. As part of the blitz, asymptomatic persons in hotel quarantine were offered COVID-19 tests on day 3 and 11 of their quarantine (and day 10 in the case of certain religious exemptions).[566]

246. Prof Sutton gave evidence about the increasing resourcing and capability of testing, including referring to the AHPPC advice released on 16 May 2020[567], which stated that testing in quarantine cannot be relied upon to reduce the duration of quarantine, and that asymptomatic testing should only be carried out in limited circumstances to ensure that resources are being used appropriately.[568] The 16 May AHPPC Statement references the Public Health Laboratory Network's complete evidence review and technical explanation dated 25 May 2020 titled "*Public Health Laboratory Network evidence review on the utility of COVID-19 testing to reduce the 14-day quarantine period*". That paper, which is publicly available[569], states (footnotes omitted):

> PHLN confirms the requirement for any quarantine period to remain at 14 days duration.
>
> There is no new evidence to indicate the quarantine period should be reduced. Testing early in the incubation period before symptoms develop may not detect infection, and a negative test result cannot be used to release individuals from quarantine prior to the outer range of the incubation period. An asymptomatic person who returns a negative test prior to the outer limit of the incubation period may still become infectious in that period. The median incubation period for COVID-19 is 4.9 to 7 days, with a range of 1 to 14 days. The duration of any required quarantine is 14 days, because it is possible for an individual to be infected just prior to quarantine and not become infectious until late in that period. Early testing may not detect infection, and release from quarantine based on a negative test could allow an infectious person to infect others in the community. Most people who are infected and develop symptoms will develop symptoms within 14 days of infection.

247. In early May 2020, Victoria was the first state to introduce this routine asymptotic testing in hotel quarantine.[570] Prof Sutton explained that it became known over time that some people may have extremely mild symptoms or develop asymptomatic illness. Testing on day 3 and day 11 was intended to pick up those people with very mild illness who may not be aware they were unwell, or because the pending release from quarantine on day 11, 12 or 13 may be encouraged not to disclose their illness.[571]

248. Dr Romanes gave evidence that on behalf of the DCHO/PHC, he endorsed the policy to introduce day 11 testing of people.[572] His evidence was that the policy took into account a concern that people due to leave quarantine may downplay symptoms to prevent them from travelling interstate on their

[563] Sutton at [190]-[191].
[564] Sutton at [192]. Also see T1463.12-22.
[565] Sutton at [193].
[566] Sutton at [194]; T1551.1-7 (van Diemen).
[567] Sutton at [197] referencing AHPPC Statement dated 16 May 2020 published at https://www.health.gov.au/news/australian-health-protection-principal-committee-ahppc-coronavirus-covid-19-statements-on-14-may-2020.
[568] Sutton at [197].
[569] Published at https://www.health.gov.au/resources/publications/phln-evidence-review-on-the-utility-of-covid-19-tes ing-to-reduce-the-14-day-quarantine-period.
[570] Sutton at [195]; T1551.5-7 (van Diemen).
[571] T1463.24-31 (Sutton).
[572] Romanes at [80]; Exhibit 114, Email from Dr Romanes, 9 May 2020, DHS.5000.0119.6251 attaching DRAFT - Enhanced testing programme for COVID-19 in mandatory quarantine, DHS.5000.0119.6252.

release.[573] The purpose of day 3 testing was to detect cases early in quarantine and that testing on day 11 would allow sufficient time for results to be returned so that travellers could be released with a direction to isolate at home if positive.[574] The Victorian policy of day 3 and day 11 testing for quarantined travellers later was adopted by the AHPPC and part of its advice issued on 26 June 2020.[575]

249. On 1 July 2020, Victoria implemented the Detention and Direction Order (No. 6).[576] Although the Direction did not require mandatory COVID-19 tests in Hotel Quarantine, it contains the requirement that if a person refused to receive a COVID-19 test, they were required to undergo an additional 10 days of quarantine. While testing was still not mandatory, a refusal to undergo a test resulted in an extension of the quarantine period.[577]

250. Prof Sutton explained that the additional 10 day quarantine period was:

(a) a preferred mechanism to coercive testing, [578] a review also expressed by Dr van Diemen;[579]

(b) the extra 10 days was a conservative measure of the infectious period if someone were to become unwell on the very last day of quarantine and that the great majority of people will be not infectious at the end of 10 days;[580]

(c) as an action to address learnings of outbreak events, including at the Stamford where a COVID-19 positive guest infected the person who drove them away from hotel quarantine.[581]

251. This evidence also demonstrates the ongoing regard by Dr van Diemen and Prof Sutton to the important ongoing balancing of individual rights against public health risks.

COVID-19 positive guests leaving hotel quarantine on day 14

252. Consistent with the requirements in place for members of the Victorian public generally, people in hotel quarantine who, by the end of the 14 day period, had tested positive were released and required to self-isolate at home.[582] This self-isolation was effected by an end of quarantine notice pursuant to s 200 of the PHWA on the requirements that applied in relation to isolating when positive[583] and because of the isolation direction which required them to proceed directly to a place in which they could safely isolate.[584] Dr Romanes explains that different notices were prepared as formal directions under the PHWA requiring COVID-19 positive people leaving detention to self-isolate in the same manner as in the community.[585]

253. The justification for releasing positive returned travellers to self-isolation at home was explained by Dr Romanes:

> Our assessment was that it was appropriate for someone to leave mandatory detention if they were a confirmed case of COVID-19 so long as we transitioned the person to a safe place to self-isolate for the remainder of their infectious period, as was required under the Diagnosed Persons and Close Contact Directions in force at the time, in keeping with other diagnosed persons already self-isolating in the community. This was because the key public health imperative was knowing whether or not someone was infected with COVID-19, and being clear with the person what actions were needed to prevent transmission. That way, we could agree and implement clear isolation arrangements, with a recognition between the person and the department that the person was potentially infectious and must carefully isolate.[586]

254. Dr Romanes advised transport occur by non-emergency patient transport (NEPT) while wearing PPE or via Ambulance Victoria transport if needed, as opposed to using commercial passenger vehicles.[587] Prof Sutton also explained that persons who tested positive after a day 11 test who did not have a situation in which they could adequately self-isolate were supported with alternative

[573] He explained it in this way (Statement at [70]: "…some people may have been motivated to decline testing and to decline to disclose symptoms, because they wanted to leave quarantine and might believe this would not occur if they got tested. If they were to hide any symptoms, they might exit quarantine whilst infectious and may not appropriately isolate. Put another way, given that people wanted to leave hotel quarantine, he concern was that some people would hide their symptoms or refuse to get tested, and then exit hotel quarantine in an uncontrolled and potentially unsafe manner.
[574] Romanes [77]-[80].
[575] Sutton at [186].
[576] Sutton at [205]; Exhibit 155, Detention and Direction Notice (No. 6), 1 July 2020, DHS.2000.0003.0001.
[577] Sutton at [199].
[578] T1464.18-22 (Sutton).
[579] T1548.37 – T1549.1 (van Diemen).
[580] T1464.18-22 (Sutton); Sutton at [206].
[581] T1465.21-22 (Sutton).
[582] Sutton at [200].
[583] Sutton at [200].
[584] T1550.20-24 (van Diemen).
[585] Romanes at [79].
[586] Romanes at [77].
[587] Romanes at [79].

emergency accommodation.[588] Dr van Diemen explained that in some instances people remained in hotel quarantine because they were either from interstate or did not have a home to return to.[589]

255. Prof Sutton's understanding was that people who were symptomatic leaving hotel quarantine were tested, and he was not aware of any circumstance were a symptomatic guest was not tested before release and that, hypothetically if there were such a case, it could have been escalated to him for use of individual public health orders.[590] Similarly, Dr van Diemen gave evidence that the vast majority of people released into the community had been tested and knew the results of those tests.[591]

256. Dr van Diemen explained that allowing people to self-isolate at home provided a testing incentive and the risk of those individuals breaching isolation requirements was balanced by their general cooperation (because they were at home), the checks made on them by daily phone calls and because "people's behaviour shifts significantly when they know that they have an infectious disease that is causing a worldwide pandemic, compared to when they have not been diagnosed with that condition".[592] That evidence is consistent with the evidence given by Dr Alpren.[593]

E. COVID positive hotel

The decision to make a "hot hotel"

257. Counsel assisting accept that the idea of cohorting positive cases together in a single location or hot hotel "appears to have made sense as a sound public health measure".[594] However, it is put that those involved in decided to implement the concept needed to have particular regard to IPC measure deployed at Rydges[595] and the workforce to be used and did not do so, and that it was not a wrong decision in principle but that it was poor in delivery.[596] It is also put that insufficient regard was paid to the increased risk patent upon concentrating those cases in one location.[597]

258. Counsel assisting also put that the Board should find that the consequences of a transmission event was foreseeable.[598] This should be rejected for a number of reasons, including the fact that the Board has not heard all relevant evidence about the circumstances of transmission to make it open to make any findings that the transmission event was causative of those consequences. Rather, as set out in paragraph 282, there are considerable matters on which the Board has no evidence and which are relevant to the consequences of the transmission and its subsequent trajectory.

259. The decision to have a hot hotel came about from an early need to consider how to respond to COVID-19 positive returned travellers.

260. On 30 March 2020, the DPHC, Dr Romanes raised with SEMC whether a policy intention could be set to move COVID-19 positive travellers within the hotel quarantine program to a dedicated hotel.[599] Prof Sutton gave evidence that combining positive cases into one location is a sound approach from an IPC perspective as it minimises the risk of transmission created by positive cases being accommodated with people who have not been exposed.[600]

261. On 31 March 2020, in the context of a single arriving passenger with COVID-19, the DPHC passed on the CHO's view that cohorting of positive COVID-19 cases in hotels should ideally be in one hotel only, or if necessary, on one floor of a hotel".[601] That advice was initially implemented by Operation Soteria with COVID positive guests (and in some cases their close contacts) being moved to a separate floor in their hotel.[602]

262. DJPR identified Rydges as a hotel which would accept COVID-positive cases on or before 2 April 2020.[603] Mr Menon,[604] who explained he identified Rydges following a request made to him by Ms Febey[605], but was not able to explain the matters DJPR took into account in making the decision.[606]

---

[588] Sutton at [198].
[589] T1550.12-15, 20-24. (van Diemen).
[590] 1465.47-T1466.13 (Sutton).
[591] T1550.37-47 (van Diemen).
[592] T1551.17-36 (van Diemen).
[593] T97.24-5 (Alpren), "In my experience, I should really stress that I feel that people are very, very happy to try to engage in behaviours that limit the transmission of disease."
[594] T2239.11.
[595] T2239.15.
[596] T2238.8.
[597] T2266: 37-T2267: 3 (Neal); T2239: 22-31.
[598] T2239.19.
[599] Exhibit 114, Email from Dr Romanes, 30 March 2020, DHS 5000.0054.6660.
[600] Sutton statement at [151]. T1516.10-14.
[601] Exhibit 114, Email to Dr Romanes, 31 March 2020, DHS.5000.0054.9039. Romanes statement at [58]. van Diemen statement at [135].
[602] Williams statement at [41(f)].
[603] See email from Rydges Hotel to DJPR, copied to Andrea Spiteri, DHS DHS.5000.0001.1240, Spiteri statement, Exhibit [162].
[604] T6757.42 to T658.
[605] T674.26.
[606] T674.25.

These are matters for that department as the entity with responsibility and knowledge of the relevant hotels and their suitability.

263. Ms Williams gave evidence that she was made aware of only two hotels that agreed to have a concentration of COVID-19 positive travellers.[607] Ms Peake also gave evidence that when the Premier contemplated using a hotel near the airport, the Secretary for DJPR, Mr Phemister agreed to raise the matter with the Premier's Private Office such that Rydges would continue to be used, as planned.[608] Ms Peake also gave evidence that the use of Rydges as a COVID-19 positive hotel was presented to her by the DJPR.[609]

264. The DHHS also makes the following three observations.

(a) First, prior to operating as a COVID-19 positive hotel, Rydges, as part of the hotel quarantine program, already had IPC and PPE measures in place. On 29 March 2020 (the first day of operation of the hotel quarantine program), a medical expert engaged by the DHHS developed initial guidance for operations within a hotel quarantine context, including IPC advice. This set out that each hotel site would be separated into three zones, a red zone for any locations where confirmed COVID-19 positive returned travellers were located, an orange zone where other returned travellers were located for the period of their quarantine for monitoring for the development of symptoms, with all residents in that zone required to maintain social distance, and a green zone for staff engagement only. Initial PPE advice was set out for each of these three zones. Signage was erected at each hotel site to provide clarity to all on-site staff as to the specific zones that applied.[610]

(b) Second, as with all hotels, the Rydges had contractual obligations with DJPR to provide PPE and provide training in the appropriate and proper use of PPE. Further, Rydges had legal obligations under occupational health and safety laws to provide a safe workplace to its staff.

(c) Third, the practice of cohorting positive COVID-19 cases was implemented in at least one other jurisdiction (New South Wales) prior to Victoria implementing it.[611] The Board has heard no evidence on the measures adopted in COVID-19 positive hotels in other jurisdiction, including where, as a matter of public record, there have also been COVID-19 outbreaks.

265. In early April, the specific question of whether a "hot hotel" should be used became particularly urgent in the context of a flight arriving from Uruguay with 70 passengers on board that were COVID-19 positive,[612] being passengers from the Greg Mortimer cruise ship.[613] There is no evidence of any transmission occurring from any of these passengers during their accommodation at Rydges.

266. Given the numbers of COVID positive guests in any hotel were quite small and holding a whole floor for those guests limited access to all the rooms in the hotel (at a time when there were between 3,000 and 4,000 guests to be accommodated at any one time), the DCHO agreed on 22 April that all COVID positive guests should be moved and held in a specific COVID hotel (Rydges) to improve operational efficiencies and focus support for those with COVID. From late April, all guests who became COVID positive and in some cases their close contacts were moved by NEPT to the COVID hotel.[614]

IPC and PPE at the COVID-positive hotel

267. The evidence was that it was expected that IPC and PPE practices and procedures would not be different at the "hot hotel" because at all quarantine hotels there was a possibility that a returned traveller may be COVID-19 positive and at risk of transmitting it unknowingly to others.[615]

268. First, the Infection Control Consultant prepared advice in relation to IPC and PPE that applied to COVID-19 and was available for the hotel program. The advice was prepared having regard to national and international guidance and was available for both healthcare and non-healthcare settings on the departmental website at the time that Operation Soteria commenced.[616] For example, advice about the sequence for doffing PPE was prepared based on NHMRC Australian Guidelines

[607] T1282.35. Ms Skillbeck similarly gave evidence that she was not involved in the decision: T1320.38-41.
[608] T1987.15.
[609] T2067.
[610] Witness Statement of Kym Peake [81].
[611] van Diemen statement at [136].
[612] Sutton statement at [150].
[613] van Diemen statement at [134].
[614] Williams statement at [41(f)].
[615] Crouch statement at [43]. Ex 203, Statement of Infection Control Consultant, DHHS at [94].
[616] Ex 203, Statement of Infec ion Control Consultant, DHHS and annexures Exhibit 204.

for the Prevention and Control of Infection in Healthcare (2019).[617] It was provided to Operation Soteria, for implementation in the hotels.[618]

269. Second, specialised IPC advice was provided to Rydges. On 10 April 2020, the Deputy Manager, Emergency Operations, Emergency Management Branch[619] emailed the IPC Cell the context of Rydges being designated as a COVID-positive site and sought assistance with arranging an IPC briefing and training GPs and nurses. The Infection Control Consultant and the IPC team did not have capacity at the time to deal with this request.[620] Accordingly, the Infection Control Consultant provided contact information for the independent consultancy IPA to assist.[621] A site walk through had been arranged to flag any issues that required attention and that the topic of training was raised with the consultant.[622]

270. On 11 April 2020, the Infection Control Consultant received a copy of the IPA assessment and recommendation following her site visit to the Rydges. It contained recommendations about the manner in which guests should be triaged and some observations about PPE availability and other matters. This email was circulated to the IPC Cell.[623] The Infection Control Consultant gave evidence that on the assumption that those IPC procedures and practices reflected the recommended standards contained in the information provided by the IPC Cell, they would have been based on the prevailing international and national guidelines in place at the time and that this was both appropriate and adequate.[624]

271. Subsequently, the Infection Control Consultant was informed by email the Manager, Emergency Operations that the consultant had been of "great assistance in supporting the operationalising of a COVID+ve hotel" and that emergency operations would like to engage her for further support at hotels,[625] and IPA was again engaged.[626]

272. IPA later developed bespoke PPE guidance for the Hotel Quarantine program, which was reviewed and endorsed by the IPC cell within the PHIMT. In so doing, the IPC cell had regard to relevant standards from the AHPPC advisory group and the WHO, available at the time.[627]

273. The Board did not call evidence from the lead consultant or any representative of IPA, as to the advice she provided to Rydges or her views on its suitability to protect against a transmission risk at the Rydges.

274. Further, the Board received evidence of specific practices at Rydges to manage infection risk. For example, guests would arrive in the basement and travel directly to their rooms (rather than moving those a reception or foyer area), escorted by nurses with the assistance of security.[628] This meant that they did not need to go through the common area of the lobby.[629] A specific fresh air policy was developed under which fresh air breaks were not routinely provided,[630] other than if a nurse identified that they were required for mental health reasons.[631]

Cleaning advice provided to DJPR and Rydges

275. As noted above, the DHHS provided advice to DJPR about the cleaning practices, procedures and standards to be expected of cleaning in quarantine hotels, based on public health advice,[632] expected that the advice would inform contracted cleaners and hotel operators,[633] as Ms May of DJPR gave evidence was the case.[634]

[617] van Diemen statement at [98].
[618] van Diemen statement at [99].
[619] Exhibit 161, Email, 10 April 2020, DHS.5000.0087.4479.
[620] van Diemen statement at [100].
[621] Exhibit 204, Email from Infection Control Consultant, 10 April 2020, DHS.5000.0102.1214.
[622] Exhibit 204, Email to Infection Control Consultant, 11 April 2020, DHS.5000 0087.8605. Ex 203, Statement of Infection Control Consultant, DHHS at [89].
[623] Exhibit 204, Email, 11 April 2020, DHS.5000.0128.7672. Ex 203, Statement of Infection Control Consultant, DHHS at [90].
[624] Ex 203, Statement of Infec ion Control Consultant, DHHS at [91].
[625] Exhibit 204, Email chain, 15 April 2020, DHS.5000.0088.8925.
[626] Exhibit 204, Email copied to Infec ion Control Consultant, 18 April 2020, DHS.5000.0052.5490. Ex 203, Statement of Infec ion Control Consultant, DHHS at [91].
[627] van Diemen statement at [101].
[628] Ex 77, Statement of Unnamed Senior Authorised Officer at [97].
[629] T1285:11-21 (Pam Williams).
[630] Ex 77, Statement of Unnamed Senior Authorised Officer at [98].
[631] Ex 205, statement of Senior Project Officer
[632] Williams Statement at [27]; Evidence of Ms Williams, T1298: 1-10 and T1299: 5-12.
[633] Evidence of Ms Williams, T1298: 30-T1299: 3; Evidence of Ms Bamert, T1319: 11-14, T1320: 4-7.
[634] Second Statement of Rachaele May 28 August 2020, [29].

Evidence from Rydges as to IPC measures

276. The Rydges manager Mr Menezes gave evidence that prior to receiving quarantine guests, on 10 April 2020, he was aware the hotel would be receiving COVID-19 positive travellers[635] and he received directions from the DHHS in relation to procedures for their arrival, check-in, meals, and supervision for the hotel in advance of the first quarantine guests arriving.[636] Mr Menezes understood from this information that hotel staff should assume that all quarantine guests were COVID-19 positive. In addition, the service procedure for delivery food and other items to quarantine guests at their rooms required all staff to:

    (a) put on required PPE based on each task to be performed (including overalls, masks, googles and gloves) prior to entering the service lift;

    (b) place items outside rooms, knock on the door and move away; and

    (c) attend a doffing station after delivering food and other items to properly dispose of gloves and masks and clean their hands with sanitiser before entering the service lift.[637]

277. Mr Menezes gave evidence that room changeover after sanitisation and a deep clean with fresh linen was a task for which the hotel was responsible.[638]

278. Mr Menezes gave evidence, that on 11 or 12 April, consistent with the evidence from the Infection Control Consultant (above at par 269, specialist infection control experts engaged by DHHS inspected the hotel and arranged for PPE stations to be strategically placed around the hotel, along with posters and instructions about how to correctly don and doff PPE.[639] During that visit, the experts showed Mr Menezes and a limited number of his staff how to correctly don and doff PPE. They were advised to show other hotel staff how to correctly don and doff PPE. To Mr Menezes knowledge, the only training the hotel staff received from DHHS was in relation to how to don and doff PPE.[640] However, part of the training included showing Mr Menezes to use the materials to then train other hotel staff in donning and doffing and that he or his senior management did so prior to every shift.[641] Mr Menezes accepted that he had responsibility for training his staff according to the contracts entered into with DJPR.[642]

279. On 12 April 2020, Mr Menezes received an email from DHHS nurses regarding PPE protocol, sanitisation, and cleaning practices.[643] The same day, Mr Menezes gave suggestions to DHHS staff regarding the procedure for quarantine guest arrival, which involved having quarantine guests entering the hotel through the basement.[644] Mr Menezes also gave evidence that DJPR provided information regarding the setup of the hotel.[645]

280. On or around 27 April 2020, following the departure of the initial quarantine guests from the Greg Mortimer cruise ship, it was decided by DHHS that the Hotel would be declared as a "positive hotel" for confirmed COVID-19 cases only. Mr Menezes understood that the Hotel's intake of quarantine guests from that date onwards did not include any individuals who had not yet tested positive for COVID-19.[646] Mr Menezes introduced temperature checking for hotel staff from 21 May 2020.[647]

281. As discussed in relation to the challenges experienced in the Rydges outbreak, from paragraphs 320 to 327, there is no evidence that in early April, the risks of using security staff at Rydges and in other hotels (and the degree to which this may have involved a highly casualised workforce, which was not in fact the case across all security firms[648]) were known or understood by those with responsibility for Operation Soteria).

[635] T567.4.
[636] Exhibit 45, Menezes Statement at [36]; Exhibit 46, RYD.0001.0001.1140 and RYD.0001.0001.1141.
[637] Exhibit 45, Menezes Statement at [22]; Exhibit 46, RYD.0001.0012.0090.
[638] Transcript - Page 556 at [5] to [10].
[639] Exhibit 45, Menezes Statement at [44]; Exhibit 46, RYD.0001.0012.0102 and RYD.0001.0012.0105.
[640] Exhibit 45, Menezes Statement at [44].
[641] T577.29--578.14.
[642] T597.43.
[643] Exhibit 45, Menezes Statement at [36]; Exhibit 46, RYD.0001.0001.0641.
[644] Exhibit 45, Menezes Statement at [36]; Exhibit 46, RYD.0001.0001.0320.
[645] T569.
[646] Exhibit 45, Menezes Statement at [23].
[647] T578.41.
[648] T449.10-T451.14 (Katrina Currie); Ex 36, Statement of Katrina Currie, [39]; Ex 52, Statement of Mina Attalah, [18]

F. Outbreaks

Rydges outbreak

282. Counsel assisting submit that it is open to find that the failure of the program to contain the virus is responsible for the death of 768 people and the infection of 18,418 others.[649] The reasons why such a finding is not open on the evidence are referred to at paragraphs 91 to 96 above and discussed further below. The Board is also urged to find that it is more likely than not that the outbreak occurred from environmental transmission rather than from person to person contact,[650] and that delays in hotel cleaning and decisions to cohort staff contributed to a proliferation of the virus into the community.[651] These findings are not open. Even if it were possible in retrospect, and having regard to every possible evidentiary source, the evidence before Board does not include the following categories of evidence which would be relevant to the question:

(a) whether the transmission event came about from environmental contamination or from the family to case 1, an intermediary person[652] or to one or any of cases 2-5;

(b) the consequences of deciding on 30 May 2020 to cohort staff that had worked at the Rydges, as opposed to making that decision earlier;

(c) whether the 8 hotel workers, and the other staff members that were so asked to isolate did, or did not, and whether they thus caused onward;

(d) how COVID-19 spread from the 8 personnel that worked at Rydges and tested positive to the wider Victorian community, including to those household contact;

(e) the consequences of the delay in cleaning the hotel, from the evening of 26 May to the evening of 28 May;

(f) the consequences of the timing of the outbreak and the general easing of restrictions in the Victorian community at that time; and

(g) whether the index family quarantined appropriately on their release or caused onward transmission in the community.

The transmission event

283. Dr Crouch, leader of the Outbreak Management Team for the Rydges Outbreak, have evidence, consistent with the contemporary Outbreak Management Report, that:

> Transmission of SARS-CoV-2 has occurred at the workplace from a COVID case in quarantine (either directly, via fomites or through contact with an unidentified intermediary staff case).

284. Dr Crouch gave evidence that when two people from an epidemiological or contact tracing perspective have shared a common space, it is impossible to determine whether the transmission event has been direct or via a third, inanimate object.[653] Dr Crouch was clear in rejecting the preference for environmental contamination being the more likely source of transmission:

> …I just would like to be clear that that was not our conclusion, that there certainly was environmental transmission, the hypothesis was that it was a possibility, among other forms of transmission, that person-to-person spread, as I mentioned previously.[654]

285. Dr Crouch reiterated this view in extended cross-examination, culminating with the observation::

> …. Would you say now, and appreciating we can never be certain about these things, certainly not scientifically certain, but even at that early stage, it presented as the most likely form of transmission, did it not?
>
> A. Look, in my statement, I said at that early stage it was a likely consideration. I don't think I am able at this point to look back and say definitively either way, and we have to be open to the possibility that it could have been through environmental contamination, or, as I mentioned, it could have been through an intermediary, unidentified person-to-person mechanism.[655]

[649] T2234.36.
[650] T2267: 5-8; T2236.17.
[651] T2267: 9-11.
[652] As contemplated by Dr Crouch, see transmission hypothesis in the Ou break Management Report and extracted in Dr Crouch's statement at [67].
[653] T1068.26.
[654] T1069.29.
[655] T1075.14-.38.

286. Dr McGuinness' evidence was that while case 1 – 4 denied working close contact with each other or with a guest, Dr McGuinness disagreed this discounted face to face transmission as a possibility, as people often do not recall person to person contact.[656] Dr Crouch's evidence is also to the effect that understanding as to fomite transmission was still evolving in May 2020, and that in fact in his view, we may not yet fully understand how COVID-19 is transmitted.[657]

287. On this evidence, the Board cannot find that environmental transmission was more likely than not. This is particularly the case where, in circumstances allowing for more time and a more comprehensive range of witnesses and evidence could be called which would directly bear on the issue. Specifically, the Board has called no evidence from the family to determine or consider their interactions with case number 1, 2, 3, 4 or 5 or any other person who could have been an intermediary (including an asymptomatic intermediary).

288. The Outbreak Management Report notes that the family had interactions with staff members, who were not called and their movements were not examined. The family was taken for a walk on 18 May accompanied by 4 guards (wearing masks and gloves) and two nurses (wearing full PPE). The Board is unable to determine if these interactions resulted in face-to-face transmission, including to an intermediary person as contemplated by Dr Crouch.

289. This is pertinent where the Board can compel evidence where the Case and Contact Management (**CCOM**) Team only sought information voluntarily. If the Board sought to identify the transmission event with certainty, it has not exhausted all sources for doing so. This is not expressed as a criticism, where the Board had limited time and needed to seek evidence in a rapid time frame in order to report. But it remains that evidence available to determine the transmission has not been called and this has implications for the findings reasonably open to the Board to make. Given these uncertainties, the Board should resist the findings counsel assisting urge the Board to make.

290. The caution that the Board must exercise in making any finding on such limited evidence, which as a whole does not disclose any more likely transmission mode - is particularly necessary when counsel assisting also seek a finding that there is a causal relationship with Victorians dying or being infected from COVID-19. When Victoria, Australia and countries around the world have had outbreaks with varying consequences, it is evident that the consequences of a transmission event cannot be determined with any certainty, and certainly not on the basis of a such limited evidence as to the cause of the transmission event or what happened subsequently.

291. Further, as the Board called no evidence from the 8 Rydges contacts, it cannot make findings as to how COVID-19 spread in the community and what factors – such as cooperation or lack thereof with contact tracers, or compliance with isolation requirements – resulted in a spread with different outcomes than other outbreaks, such as the Ruby Princess, Cedar Meats or the outbreaks in the Victorian community at that time (noted in the outbreak summaries circulated throughout late May).[658]

292. The Board heard some evidence, which was not elaborated on in any detail but was uncontested, as to the difficulties both of lack of candour in responses to contact tracing, and the competing priorities people have in complying with stay at home or isolation directions. Each of Dr Looker, Dr Crouch, Dr van Diemen, Prof Sutton and Dr McGuinness gave evidence of these issues in their statements, yet counsel assisting did not explore these matters with the witnesses. Dr van Diemen's lack of confidence that people would comply with stay at home directions in March was one of the reasons for her making the Direction and Detention Notice, that:

> "…on balance, at that particular time, the most appropriate thing was to require people to undertake their quarantine in a hotel scenario so that we could be absolutely certain that incoming importations were being contained in the hotel environment rather than having an opportunity to spread into the community with less control."[659]

293. There is no evidence of whether and how the close contact staff directed to quarantine (described below from paragraph 307) did in fact do so. It is relevant to call the evidence of:

(a) security guard 16, who did food deliveries on the night that he was tested (because he was bored at home and wanted a change of weather or change of mind);[660]

---

[656] T1113.15.
[657] Exhibit 103, statement of Dr Crouch, [37] and [39].
[658] Ex 98A, Outbreak Summaries – 27 May, DHS.5000.0008.4829, page 3; See also Ex 98A Outbreak Summaries – 28 May, DHS.5000 0106.2903, page 3: this is an outbreak summary sent by Dr Sarah McGuinness.
[659] T1541.37-41.
[660] T379.24-.33.

(b) a security guard told to isolate who dishonestly denied sharing his sleeping area without anyone else, when his roommate then travelled to Queensland unaware that he had contracted COVID-19 for the security guard;[661] and

(c) another security guard who denied working, and who was later discovered, as a close contact, to be working at the Stamford.[662]

294. The Board has also called no evidence to make any conclusion as to whether a single transmission event is likely to have greater or less onward transmission. Rather, where two transmission events at the Stamford did not go on to have the onward transmission numbers that Rydges had, the Board should resist that finding. There is no evidence that a transmission will have particular onward transmission. Rather, that evidence is to be found in considering the cohort and conduct and activities of that cohort of infected persons, in respect of which the Board called no evidence. Prof Grayson's evidence shows the complexity of the transmission process to be considered and which would have to be explored in any context where a finding was to be made as to the foreseeability and consequences of the transmission event:

> the term "super spreaders" refers to the concept that certain people may be more likely to transmit the virus to others (for example, because they have a higher viral load and may therefore be likely to be more infectious, or because they are asymptomatic and are therefore less likely to suspect they have COVID-19 and need to self-isolate). Thus, super-spreading occurs when a single patient infects a disproportionate number of contacts. For instance, in the SARS-CoV outbreak in 2003, the index patient of the Hong Kong epidemic was associated with at least 125 secondary cases (Riley *et al.* Transmission dynamics of the etiological agent of SARS in Hong Kong: impact of public health interventions. Science. 2003 Jun 20; 300(5627):1961-6.). For COVID-19, some recent overseas studies have suggested that possibly 10-20 percent of COVID-infected patients may be responsible for 80 percent of all cases.[663]

The outbreak management response was appropriate

295. The evidence from Dr Crouch, Dr McGuiness and Dr Looker (who was not called) shows that quick and decisive action was immediately taken by the CCOM, consistently with the Outbreak Management Plan (**OMP**)[664] and, in some cases, in a way that was more conservative with that plan.

296. The OMP outlines the key components of the DHHS's management of COVID-19 outbreaks in Victoria and articulates when a response to an outbreak should be escalated and how decisions in relation to outbreak management are to be made. The OMP includes lists of actions to be taken, descriptions of how key decisions will be made and by whom. It defines public health and emergency management roles and responsibilities and articulates concise and clear actions to ensure rapid and effective COVID-19 outbreak management in Victoria.[665]

297. The Operation Soteria EOC was informed that on 25 May 2020, a hotel staff member (what would come to be described as case 1) started feeling unwell and had been tested for COVID-19 by their general practitioner. During the course of 26 May 2020, case 1's test was confirmed as positive.[666] Following notification to the DHHS of the Rydges Hotel outbreak, immediate action was taken by the CCOM team, which provided recommendations for managing the outbreak and also commenced its own investigations of the circumstances of the transmission.[667]

298. The details of the decisions are particularly found in the evidence of Dr Looker, who gave a statement but was not called to give evidence. Dr Looker was asked address what steps the DHHS took to contain the outbreak between 26 May and 30 May 2020 and whether, in her view those steps were adequate and appropriate. Dr Looker explained the actions taken[668] and that, in her view, judging them either at the time or with the benefit of hindsight, those actions were adequate and appropriate.[669] Given that evidence was not challenged, her evidence should be accepted.

299. Dr McGuiness gave evidence of the decisions made to quarantine staff and the escalation of control measures that were put in place between 26 and 29 May 2020, including the requirement on 26 May

[661] Exhibit 106, McGuinness, [97].
[662] Exhibit 106, McGuinness, [98].
[663] Grayson statement, [19].
[664] Drafted by Dr van Diemen and Dr Crouch, and approved by the CHO, Crouch, [23]. See Crouch at [49] as to compliance with the Plan.
[665] Crouch, [24].
[666] Crouch Statement at [71]; Exhibit 105, Email from Sandy Austin to Dr Crouch dated 26 May 2020; Exhibit 105 DHS.5000.0016.5475; Exhibit 105, Email from Dr McGuinness to Dr Crouch, 27 May 2020, DHS.5000.0105.8087.
[667] de Witts Statement at [30]; Exhibit 152, DHS.5000.0125.0355.
[668] See Statement of Dr Clare Looker, DPHC CCOM, from [29]-[48].
[669] Looker, [49]-[50].

that cleaning be instituted, and the decision on 29 May to require any staff member that had been present at Rydges from 11 May 2020 to isolate for 14 days and not work elsewhere, discussed below from paragraph 302.

300. Dr Looker was asked to identify if there were material differences between the management of two outbreaks,[670] and gave evidence that the only material difference was, following the experience of the Rydges outbreak, a very conservative approach was immediately taken in relation to Stamford to the determination of close contacts amongst other staff who worked at the hotel.[671] Her unchallenged evidence was that both outbreaks "were managed in accordance with the OMP and I do not consider I would have done anything differently. The decisions made by me (including in consultation with my colleagues) were made on the evidence and information we had available to us at the time."[672]

Decision to quarantine staff

301. It is put that CCOM did not make a timely decision to cohort staff and this meant that staff that worked at Rydges between 26 May and 30 May contributed to a proliferation of virus into the community.[673] This should be rejected.

302. Dr Looker gave evidence that on 29 May 2020:

(a) testing was recommended for all staff who had worked at Rydges since 11 May 2020 (14 days before symptom onset in the first case); and

(b) all staff were cohorted (required not to work elsewhere), unless they had not been on site in the preceding 14 days (i.e. since 15 May 2020) and had a negative swab.

(c) A subgroup of staff who had worked an overlapping shift with one of the positive cases during the case's infectious period were also designated as close contacts. These staff were required to quarantine for a full 14 days from their last date of exposure to a case.[674]

303. The Board did not call Dr Looker and did not put to her that this decision was inappropriate or should have been taken earlier, so it would be not open without some further opportunity for response to find to the contrary.In any event, there is no evidence that an earlier decision would have had different consequences.

304. Dr McGuinness and Dr Looker had met with the Public Health Commander on 29 May 2020 to discuss the hypothesis that there was potential environmental transmission at the Rydges. The decision was also communicated through to the CHO and the Secretary.[675] Dr McGuinness proposed four alternative approaches to the management of other staff at the hotel:

> Stage 1 – active monitoring only
>
> Stage 2 – test everyone but do not enforce restrictions
>
> Stage 3 – testing PLUS cohorting of staff (i.e. say they can't work elsewhere for now) +/- designate certain people (e.g. overlapping shifts with a case during their infectious period) as close contacts
>
> Stage 4 – designate everyone as close contacts and get in an entirely new workforce.[676]

305. Dr Looker considered the risks associated with the consequences of this decision, being the relocation of a hotel of COVID-19 positive persons. In ultimately making this decision on 29 May, Dr Looker weighed up this risk, when they learnt that three cases all worked at the hotel on 23 May,[677] as follows:

> This decision was made to balance the need to manage the public health risk with the impact of the measures, which in this case, would have resulted in the hotel no longer being able to operate and the need to rapidly relocate a large number of hotel guests with confirmed COVID-19. The sudden movement of a large number of positive cases through a hotel also poses a transmission risk. We formed the view that the 'stage 3' approach was appropriately cautious

[670] Question 8, NTP-123.
[671] Looker, [53].
[672] Looker, [94].
[673] T2267.10.
[674] Exhibit 97, Looker statement [45].
[675] Ex 98A, Email from Case and Contact Management Lead, 29 May 2020, DHS.5000.0105.5928
[676] Looker Statement at [42], Exhibit 98A, Email from Dr McGuinness, 29 May 2020, DHS.5000.0105.5936.
[677] Looker Statement at [43], Exhibit 98A, Email from Case and Contact Management Lead, 29 May 2020, DHS.5000.0105.5928.

and proportionate to the evidence available at the time.[678]

306. This decision was made to balance the need to manage the public health risk with the impact of the measures, which in this case, would have resulted in the hotel no longer being able to operate and the need to rapidly relocate a large number of hotel guests with confirmed COVID-19, which would involve managing a significant transmission risk. Dr Looker's evidence is that CCOM formed the view that the 'stage 3' approach was appropriately cautious and proportionate to the evidence available at the time.[679]

307. Later on the evening of the 29th, CCOM learnt that there were two further cases that had tested positive to COVID-19 (bringing the total to six cases). Dr Looker advised Operation Soteria of the two new cases and directed that the following immediate actions take place:

(a) no staff who worked at the hotel since 11 May 2020 should work elsewhere unless they had not been on site for 14 days and tested negative;

(b) daily commercial cleaning should be implemented;

(c) there should be no further admissions to the hotel;

(d) movement of returned travellers outside their rooms should be minimised; and

(e) there was to be no movement of staff between hotel sites (including health staff, AOs, team leaders, support staff, DJPR team leaders, security and hotel staff).[680]

308. These measures were implemented.

309. Dr Looker gave evidence that, given the concerns about environmental transmission and inadequacy of current cleaning practices, CCOM advised Operation Soteria of the need for Rydges to undertake at least once daily cleaning and disinfection of all common areas and high touch surfaces. DHHS guidelines for cleaning and disinfection were provided.[681]

310. As part of the decided approach, testing was recommended for all staff who had worked at Rydges since 11 May 2020 (14 days before symptom onset in the first case) and all staff were cohorted (required not to work elsewhere), unless they had not been on site in the preceding 14 days (i.e. since 15 May 2020) and had a negative swab. A subgroup of staff who had worked an overlapping shift with one of the positive cases during the case's infectious period were also designated as close contacts. These staff were required to quarantine for a full 14 days from their last date of exposure to a case.[682] There is no evidence of transmission from these staff members to households. The Board cannot therefore find, as submitted by counsel assisting that a delay in quarantining staff, which the DHHS rejects was in fact a delay, contributed to further proliferation of the virus into the community.

311. There is no other evidence that of the impact of the decisions taken on 29 May, discussed in paragraph 302 above, being taken on any of 26, 27 or 28 May; that is, if the decision had been taken earlier, a different result would have ensued.

312. The evidence in the Outbreak Management Report shows that cases 1, 2 and 5 developed symptoms on 25 May; case 4 developed symptoms on 27 May, case 6 (a nurse) on 29 May and case 8 on 4 June. Cases 3 and 7 were asymptomatic.[683] Dr Alpren's evidence is that the average incubation period is 5.5 days.[684] Only case 8 developed symptoms more than 5 days after 26 May, and while there is a theoretical possibility that case 8 could possibly have contracted COVID-19 26-28 May, that conclusion is not open as there is no evidence that case was on site in that time, and in any event the incubation period has a range of 2-14 days.[685] This similarly means that those with later symptom onset dates could still have acquired the virus prior to 26 May, and not after.

313. The Outbreak Management reports that as of 12 June, CCOM had identified 120 close contacts and all were tested and all results were, at that stage negative. There were 3 day 11 tests outstanding and one person yet to be tested.[686] This suggests that the delay in cohorting did not contribute to further proliferation, where it appears that of those staff members for whom test results were

[678] Exhibit 97, Looker statement, [44].
[679] Looker Statement at [44].
[680] Looker Statement at [47] Exhibit 98A, Email to Commander, Operation Soteria and others, 29 May 2020, DHS 5000.0016 5676.
[681] Looker Statement at [46].
[682] Looker Statement at [45]; Exhibit 98A. Dr Looker sent an email to the Secretary, CHO and o hers that evening recording the decision: email sent by Dr Looker, 29 May 2020, DHS.5000 0114.7238.
[683] Exhibit 105, attachments to Dr Crouch's statement, Outbreak Management Report, DHS.0001.0036.0145, p 24.
[684] Exhibit 8, statement of Dr Alpren [57(b)].
[685] Exhibit 8, statement of Dr Alpren [57(b)].
[686] Exhibit 105, attachments to Dr Crouch's statement, Outbreak Management Report, DHS.0001.0036.0145, p 2.

available at 12 June, those who may have worked at the Rydges during that period, did not acquire COVID-19.

314. When asked whether action was quicker in response to the Stamford outbreak, Dr McGuiness agreed but stated[687] that

> … every outbreak offers opportunity for 10 learning and improvement, and the Rydges outbreak was the first hotel quarantine outbreak that we had dealt with in Victoria, and indeed it was one of the first hotel quarantine outbreaks in a global sense, and there was not a great deal of knowledge or evidence to support the public health management actions to be taken in that setting. I think what we did for the Rydges outbreak, you know, really responded to the evidence that we had at the time and our knowledge of transmission of COVID at the time. And because of our learnings from the Rydges outbreak, we took faster and more decisive measures in the Stamford outbreak.

Cleaning

315. Counsel assisting put that the delay in cleaning contributed to the further proliferation of virus into the community or resulted in transmission in household contacts.[688] Including for the reasons set out above and below, there is no evidence to support this finding.

316. The DHHS requested DJPR conduct a clean immediately, on the evening of 26 May 2020[689] and repeated this request on 27 May. Dr McGuinness gave evidence that direction was provided by the department to clean the hotel on 26 May 2020,[690] explained on 27 May 2020[691] to mean a full commercial bioclean involving cleaning and disinfection. A full clean was not undertaken until the afternoon of 28 May 2020.[692] Dr McGuiness stated that this rendered the site an uncontrolled site for longer than it may have otherwise been and required a greater number of people to self-isolate. Ms Williams confirmed that Ms May, for DJPR received an email from Ms Williams with respect to a COVID-positive case in the Rydges on 26 May 2020. Ms Williams confirmed that she received from the DHHS advice that a cleaning of all common areas was required and Ms Williams forward a copy to Ms May.[693] Ms May confirmed that she had all the information required to instruct cleaners by 28 April.[694] Thus the DHHS provided DJPR advice that the cleaning and disinfection advice document previously provided to DJPR was equally applicable to the hotel setting for cleaning COVID-positive hotel rooms.[695] Mr Girgis, for IKON, who performed the clean also gave evidence that DJPR asked IKON to conduct the bio-clean on the afternoon of 27 May 2020.[696]

Suggested loss of trained security guards

317. Counsel assisting put that due to security guard misconduct, those guards at Rydges that had received an IPC tutorial and nursing briefings were stood down and the beneficial effect of this training in so far as security was concerned at Rydges was lost.[697] This submission does not take account of the evidence of Mr Aggarwal, from Stirling Pixel (a subcontractor of SSG Security), that took over the security work at Rydges from 11 May 2020.[698] Mr Aggarwal's evidence was that guidelines for the use of PPE were provided by DJPR to Unified and were used by Unified to train SSG security staff,[699] along with OH&S training.[700] Further that all staff engaged by Sterling Pixxell were required to complete online IPC training providing by the Commonwealth Government[701] and that staff completed this training from March to July.[702] Records of this training were produced to the Inquiry and may establish whether the guards that worked at Rydges had received the training prior to the outbreak. Mr Aggarwal's evidence was that at the hotels, there was PPE available and proper

[687] T1120.
[688] T2223.20.
[689] Looker Statement at [31].
[690] McGuinness Statement at [49], Exhibit 98A, Email from Case Contact and Outbreak Lead to the Operation Soteria EOC dated 26 May 2020 seeking information (including case 1's duties, roster information for others and information on the cleaning regime at the hotel and requesting that a full clean of all common areas and the cases' direct work areas, DHS.5000.0015.3873.
[691] McGuinness Statement at [49], Exhibit 98A, Email from Outbreak Squad Coordinator to me and Operation Soteria EOC, dated 27 May 2020, DHS.5000.0016.5753 detailing the requirements of the bioclean.
[692] Looker Statement at [37], Exhibit 98A, Email from Dr McGuinness – draft Outbreak Summaries, 28 May 2020, DHS.5000.0106 2903.
[693] Transcript, cross examination of Williams, Page 1299 at [5]; DHS.5000.0001.95.
[694] T983.32-T985.21. See in par icular T985.10-21
[695] Transcript, evidence of Pam Williams, page 1298, at 40-45.
[696] Transcript, Girgis, page 1257 at [15].
[697] T2238.11-.33.
[698] Exhibit 51, statement of Mr Aggarwal, [80].
[699] Exhibit 51, statement of Mr Aggarwal, [34].
[700] It is not clear from the evidence whether this occurred before 25 May 2020.
[701] Exhibit 51, statement of Mr Aggarwal, [37].
[702] Exhibit 51, statement of Mr Aggarwal, [38].

training;[703] that his guards did the Commonwealth COVID-19 induction and that at the start of each shift, the supervisor would provide a brief and that Unified would provide PPE training.[704]

Stamford Outbreak

318. It is not open to the Board to make findings at the Stamford as to the cause of the transmission events that took place.[705]

319. It is submitted that the different trajectory of cases from Rydges and Stamford, together with, at Stamford, either "prompt and appropriate cleaning or because of the immediate and swift quarantining of all staff or both were more effective in preventing the spread of the virus into the community".[706] The Board heard evidence that CCOM took quick action to contain the virus, based on what they learnt from Rydges, but that otherwise, CCOM's management and response to the outbreaks was the same.[707] Dr Looker's evidence was that both outbreaks were managed in accordance with the OMP and that she would not have done anything differently.[708] While this may sound unusual, given the consequences, it speaks to the importance of understanding what happened following each of the outbreaks, if the Board were to properly understand why the consequences of each outbreak were so different. Dr Looker gave evidence as to the long term steps taken to contain the virus in both outbreaks[709], which evidence went untested and ought thus to be accepted. Further, as outlined in 287 to 294 above, there are a range of matters that were not examined, and which are relevant to why each outbreak progressed so differently.

Outbreak Response Challenges

320. All public health witnesses called to give evidence spoke to the challenges in contact tracing. Their evidence was consistent with evidence from Prof Grayson. Prof Grayson gave evidence that:

> The version of SARS-CoV-2 which is linked to the latest upsurge in the Victorian outbreak does not appear to be behaving any differently to previous iterations of the virus in Victoria. In my view, the current increase in the rate of cases is most likely linked to human behaviour, including factors such as who contracted the virus, the demographic of those who contracted the virus, the behaviour that led them to contract the virus, and their behaviour after contracting the virus.[710]

321. Other than in relation to the PPE use expected of security guards and in some cases, examples of misuse of PPE, the Board has heard little evidence as to the behaviour of those who contracted the virus, the behaviour that led them to contract the virus and their behaviour after they did. Prof Grayson also noted that:

> If a person is asymptomatic, or has not yet begun to experience symptoms, there is a potential risk that they will transmit the virus to others unknowingly. This may be because those people tend to take fewer precautions (in not knowing they are infected) and may interact more freely with others. [711]

322. This presents a key challenge in the minimisation of COVID-19 transmission. Two of the 8 personnel working at Rydges were asymptomatic and it is likely that of those that were symptomatic, they were infectious before realising they were. Dr Looker gave evidence that another key limitation that arises in outbreak management is that the information relied on to inform actions depends on both the quality of information gathered from cases and the information about contacts that is available from other sources such as staff rosters. It is challenging for many individuals to recall all their activities and interactions during their infectious period.[712] Dr van Diemen also gave evidence of a security guard continuing to work while symptomatic and her consideration as to whether fear of loss of income was relevant to that conduct.[713]

323. Control of an outbreak also requires people comply with the instructions provided by the DHHS, including appropriate isolation or quarantine, and close contacts seeking testing if symptomatic. Many cases were identified in social and household contacts through day 11 testing. In some

[703] T712.5-.23.
[704] T723.35-.47 and 733.1-.3.
[705] T2267: 11-14 (Neal); McGuiness statement, [89].
[706] T2267: 16-20 (Neal)
[707] Ex 97, statement of Claire Looker [31]
[708] Ex 97, statement of Claire Looker [51], [94].
[709] Looker statement, question 9, questions [71]-[75].
[710] Grayson statement, [48].
[711] Grayson statement, [21].
[712] Ex 97, statement of Clare Looker [86]. Dr Sarah McGuinness also gave evidence that in a number of the households associated with the Rydges and Stamford outbreaks, household members were not well known to each other and/or undertook shift work at different times of the day to each other. T1103. 5-20 (Dr Sarah McGuinness) If accurate information is not able to be obtained, it can limit the ability to identify and act to control an outbreak.
[713] Ex 159 and T1555.38.

instances, close contacts who had been required to quarantine had not, and/or had developed symptoms but had not informed us or sought testing when earlier asked.[714]

324. To the extent that groups of security guards were more likely to have these characteristics, were less health-literate or had potential language barriers to them fully understanding and comprehending the level of infection control required and the need to physically distance, their use may have inhibited the control of the outbreak.[715] However, it would be difficult for the Board to find that this risk was predictable in the way put by counsel assisting.

325. Finally, counsel assisting's submission has an air of unreality when around the world, COVID-19 has proven catastrophically difficult to contain. It is put that hospitals should be an appropriate comparator but there is evidence of outbreaks in internationally[716] and in Victorian hospitals, including the Alfred, which, at the commencement of the program had the largest hospital outbreak at the time in Victoria with around 31 of their staff affected.[717] The Board heard evidence from the 25 August 2020 Protecting our Healthcare Workers' Report, that between 1 January 2020 and 19 August 2020, 2,497 healthcare workers acquired COVID-19.[718]

326. Ms Peake also gave evidence that following the Rydges outbreak, she had conversations with her NSW counterparts to consider a health service running the clinical governance, IPC and security arrangements for the COVID-19 positive cohort. She noted that at the time the program was established in March, this would not have been an option, because at that time, the hospitals were dealing with their own outbreaks, and was also, in the Alfred's case, . involved in planning with the DHHS on the stand-up of a contingent facility for an ICU at the Melbourne Convention Centre. All hospitals were involved in detailed capital planning work to enable there to be capacity for up to 4,000 emergency beds and were standing up new governance in clusters.[719]

327. Further, other hotel quarantine programs – New Zealand[720] and NSW, as noted in evidence, and more recently South Australia, have encountered transmission of the virus from quarantined travellers to security staff. The Board did not call evidence in relation to these programs or outbreaks, to understand whether sufficient similarities exist to enable specific conclusions to be made. It is the case however, that hospitals and hotels in quarantine programs with COVID-19 positive people have similarly experienced outbreaks.

G. Wellbeing and daily reviews

Health and welfare of detainees

328. The health and welfare of detainees was a primary focus of the Hotel Quarantine Program.

329. Dr van Diemen's evidence was that early in the hotel quarantine program a high priority for her was the welfare of returned travellers and ensuring that there were appropriate pathways for clinical care and clear and visible process to support operationalising the directions issued.[721] Prof Sutton acknowledged his responsibility for the welfare of those detained in quarantine.[722] Dr Finn Romanes also gave evidence that the healthcare and wellbeing of people in quarantine was a deep area of consideration and a focus of his involvement in the hotel quarantine program.[723] He gives evidence about the Physical Distancing Policy he was responsible for, which included policy and procedures to address the health and wellbeing of people in quarantine and included the requirement of welfare checks,[724] and which also provided for exemptions where it was possible to do so whilst appropriately minimizing infection risk.[725] Dr Romanes also gives evidence about the Interim Healthcare and Welfare Mandatory Quarantine Plan,[726] and the measures that were adopted in hotel quarantine relating to welfare and wellbeing.[727] These included an initial assessment of welfare, a welfare check requirement, smoking and fresh air breaks and exercise protocols, and protocols

[714] Ex 97, Looker statement at [86].
[715] T1104.6-48, T1105.1-12.
[716] Statement of Symonds, dated 18 September 2002, at [31] that it is "important not to overlook how pernicious this virus is and that outbreaks have occurred even in hospitals throughout Australia and internationally, despite their highly skilled and medically trained staff." See also HQU.0001.0030.0001 at pages 104.
[717] T2005.39.
[718] T2025.5. 22% were acquired at work in the first wave and this rose to 69% acquired at work in the second wave, particularly in aged care settings.
[719] T2005.35.
[720] Observa ion re recent observations from other hotel quarantine in other jurisdictions in our neighbourhood: T1226.43 - .T1227.1-3. (Skilbeck) Re NZ recent upsurge: T41.9-11 (Grayson).
[721] van Diemen Statement at [24]-[25].
[722] Sutton Statement at [159]. Early meeting at the State Control Centre: DHHS representatives were very much alive to the health aspects of the program and their obligations in relation to it: T2201: 9-12.
[723] Witness Statement of Finn Romanes dated 9 September 2020, [43].
[724] Witness Statement of Finn Romanes dated 9 September 2020, [46].
[725] Witness Statement of Finn Romanes dated 9 September 2020, [47].
[726] Witness Statement of Finn Romanes dated 9 September 2020, [48].
[727] Witness Statement of Finn Romanes dated 9 September 2020, [50].

relating to alcohol and drugs, nutrition and food safety, care packages and safety and family violence risks.[728]

330. Andrea Spiteri's evidence indicates that she knew that the DHHS had a responsibility to promote the health and wellbeing of detainees, including because of the requirements of the Charter.[729] She notes that the healthcare and wellbeing arrangements evolved over the course of the hotel quarantine program because of changes in the demographic of returning travellers and the DHHS's experience in running the program.[730] She notes the challenge that at no time did the DHHS have details of individuals prior to their arrival in Victoria,[731] which made it impossible to plan for their welfare ahead of time. Operation Soteria Commander Pam Williams gave evidence that the Department placed a high priority on providing for the health and wellbeing of guests within hotel quarantine and acknowledged that hotel quarantine was challenging for many guests, especially families with young children, those experiencing mental health issues, including claustrophobia and anxiety, smokers, and guests having made long journeys, and who in some instances had already been subject to restrictions in their country of departure.[732] Operation Soteria Commander Merrin Bamert also gave evidence that the health and wellbeing of returning passengers were always in the forefront of her mind and her focus at all times, recognising that the hotel quarantine program was a microcosm of the community supporting people with mild to significant health concerns, the spectrum of mental health disorders, family violence and other family and social issues.[733] Authorised Officer Mr Cleaves observed that AOs were empathetic and aware of the challenges people faced, and to the complexities of intersecting medical and behavioural issues.[734]

331. Counsel assisting accepted in closing submissions that the program did cater for the needs of most,[735] but made a range of submissions to the effect that the program did not always operate so as to meet the individual health and welfare needs of those who were detained, in particular those who had specific needs or vulnerabilities.[736] While there is some evidence before the Board to establish isolated instances of guests concerns, it is not open to the Board to make any general finding about the program not operating to meet the needs of the approximately 20,000 guests who were detained, in particular those who had specific needs or vulnerabilities. There is no sound basis to conclude that the evidence is representative of guests' experiences in hotel quarantine. That is particularly so in respect of evidence given by staff on-site in relation to their concerns about unidentified guests, which are not able properly to be tested.[737] There is no evidence from other witnesses, including nursing or Department staff, of such a requirement. Ms Williams' evidence was that there was no reason why such an instruction would have been given.[738]

332. The DHHS established a large range of welfare and wellbeing measures to meet the needs of those who were detained, including in particular those with specific needs and vulnerabilities. Although those measures were not featured in the oral evidence or given prominence in the selection of DHHS witnesses or questions asked of the DHHS's witnesses,[739] there is a significant body of evidence before the Board establishing the measures that were established and used to meet guest's needs. In light of that evidence, the Board should be cautious in making a finding, on the basis of Dr Gordon's evidence, that insufficient consideration was given to the likely psychosocial impact of detention.[740] That is particularly so where Dr Gordon's evidence was given without reference to the range of psychosocial support services outlined below,[741] and where the DHHS's witnesses were not invited to address those issues.

333. From the commencement of the Program, the DHHS consulted with the Chief Mental Health Nurse and established a mental health triage service by NorthWest Mental Health (to take calls and respond to any person referred to the service.[742] The DHHS also established a Crisis Assessment and Response Team (CART) on 28 March as an on call roster of Departmental staff (mostly qualified

[728] Witness Statement of Finn Romanes dated 9 September 2020, [50].
[729] Witness Statement of Andrea Spiteri dated 9 September 2020, [57].
[730] Witness Statement of Andrea Spiteri dated 9 September 2020, [58].
[731] Witness Statement of Andrea Spiteri dated 9 September 2020, [59].
[732] Williams statement at [116], [22(a)] and [22(c)]; see also at [63].
[733] Bamert statement at [92] and [93].
[734] T918: 8-23.
[735] T2252.2-4.
[736] T2268: 2-5 (Neal); T2268: 13-14 (Neal); T2268: 15-16 (Neal); T2268: 22-25 (Neal).
[737] Note also the difficulty of responding to or testing evidence (no ing the related submission by counsel assisting at T2260: 40-45) about unidentified persons having "made a rule that nursing staff were not allowed to give their name to a patient or to tell hem who they worked for".
[738] T1280.14-17.
[739] In particular, he Board did not seek evidence from the Deputy Commanders, Welfare, in Operation Soteria. Nor did the Board ask either of the Operation Soteria Commanders about welfare and wellbeing measures aside from specific questions about welfare checks.
[740] T2268: 7-11 (Neal).
[741] Statement of Rob Gordon, 14 September 2020 at [9].
[742] Bamert statement at [14]; see also Exhibit 136, email from Merrin Bamert to Anna Love and others dated 29 March 2020, DHS.5000.0075.1193; see also Exhibit 136, email from Merrin Bamert, "Handover notes to assist over the next couple of days", 4 April 2020, DHS.0001.0008.0504; evidence of Ms Peake, T2039: 25-27.

social and welfare workers) to respond to issues arising for guests in hotel quarantine and ensure guests had strategies and were able to access specialist support services to manage their psychosocial needs.[743] The DHHS's Mental Health branch within the Health and Wellbeing Division advised Operation Soteria on mental health screening for returned travellers entering quarantine and assisted Operation Soteria staff with engaging and coordinating mental health and wellbeing supports for people in quarantine hotels.[744] At the start of the program, the DHHS worked with Family Safety Victoria and the Chief Mental Health Nurse to develop and revise a script for welfare calls to detainees, which was designed to elicit high risk triggers and lead to either needs being met or the review by nurses onsite, medical review or review by a team of complex care specialist.[745] The DHHS appointed Deputy Commanders Welfare and a welfare coordinator within Operation Soteria.[746]

334. The DHHS also arranged for experienced nurses on site from the commencement of the program,[747] and mental health nurses on site from the second week of the program through YNA,[748] and subsequently contracted with Swingshift as a dedicated provider of mental health nursing.[749] The DHHS requested nursing staff to cater for particular needs of guests, including nurses with emergency department triage experience, general nurses and paediatric nurses.[750] Daily screening checks were conducted via phone calls from YNA nurses on site,[751] and also by Alfred Health nursing staff on site from 16 April[752] to check in with each guest and ask if they had any COVID symptoms and general questions about health and wellbeing.[753] Doctors were available on site at hotels from 4 April.[754] Complete nursing assessments, medical telehealth and medical visits occurred when clinically indicated as a result of self-reporting by guests, reporting by staff on site (whether hotel, security, Departmental or nursing staff or raised via the Government Support Service telephone line organised by DJPR) or escalation following a daily screening check, day 3 or 9 welfare check, or CART assessment.[755] Nurses were expected to record the contact in the nursing notes kept for each resident and subsequently in the electronic nurse health record developed by the DHHS as part of the COVID Compliance and Welfare Application.[756] Both Ms Bamert, Operation Soteria Commander, and Ms Curtain of YNA, gave evidence that nurses were expected and able to share or escalate concerns as necessary, including by handover to other nursing staff,[757] escalation to their agency's clinical and management teams,[758] or escalation to medical practitioners or the Hotel Team Leader.[759]

335. Physical screening was also conducted by nurses at the airport that screened for COVID and provided the first opportunity for arriving passengers to raise immediate health concerns.[760] Returning travellers were provided with a self-reported confidential questionnaire to be completed on the bus prior to arrival at the hotel to be handed to the nurse or AO on arrival at the hotel, along with other documents (including information about allergies, past medical history and medications) and provided to the team leader/nurse to review and escalate any concerns.[761] This was intended to capture guests' immediate health and wellbeing concerns upon arrival (for instance, any required medication, allergies, or immediate mental health concerns) and included questions about guests' support needs, concerns about going into quarantine, and ability to maintain contact with family and

[743] Bamert statement at [50]; Williams statement at [23(c)].evidence of Ms Peake, T2039: 21-25.
[744] Statement of Terry Symonds, DHHS dated 18 September 2020, (Symonds statement) at [15].
[745] Bamert statement 2020 at [13], [14] and [55]; evidence of Ms Peake, T2038: 45-T2039: 12.
[746] Williams statement at [18].
[747] Bamert statement at [52]; see also Exhibit 136, email from Merrin Bamert, "Handover notes to assist over the next couple of days", 4 April 2020, DHS.0001.0008.0504; Exhibit 85, Statement of Jan Curtain,YNA.0001.0001.0001, [33]-[35]; evidence of Ms Peake, T2039: 17-19. Note also the rosters of YNA nurses provided to the program – tendered as exhibit 223 by DHHS as counsel assisting did not include hese exhibits in the attachments tendered from Ms Curtain and Mr Smith's statements.
[748] Bamert statement at [52]; Exhibit 85, Statement of Jan Curtain,YNA.0001 0001.0001, [44]-[49]; FN 625 – Ex 135, statement of Merrin Bamert, [52]; Ex 85, statement of Jan Curtain, [44]-[49]; Ex 87, email chain 'FW: Additional Nurses for Plaza, Metropol 7 Parkroyal', 7 April 2020 [YNA.0001.0002.0028]; see also T2039: 27-28 (Peake).
[749] Exhibit 90, Witness Statement of Eric Smith, SWI-0001-0001-0013_0001, [6.1]-[7.1] and [14-2]-[14.3]. Nurse Jen's evidence that some YNA staff supplying mental health services were not qualified was disputed by YNA: see Statement of Nurse Jen, WIT.0001.0003.0001, para 136, page 16; T147: 37-T148: 45. Michael Tait accepted that his evidence that mental health nursing staff were not rostered on until after 11 April was wrong: T180: 29-33; T184: 11-36.
[750] Exhibit 85, Statement of Jan Curtain,YNA 0001.0001.0001, [44]-[49] and [60].
[751] Exhibit 85, Statement of Jan Curtain,YNA 0001.0001.0001, [44]-[49].
[752] Exhibit 100, Statement of Simone Alexander, ALFH.0001.0001.0001_R, [6]-[7]; Exhibit 85, Statement of Jan Curtain,YNA.0001.0001.0001 at [50].
[753] Bamert statement at [48]; Exhibit 136, DHHS Hotel Isolation Medical Screening Form, DHS.5000.0003.9706; and Exhibit 85, Statement of Jan Curtain,YNA.0001.0001.0001, [50]; Exhibit 100, Statement of Simone Alexander, ALFH.0001.0001 0001_R, [19]-[22].
[754] Exhibit 89, Statement of Dr Stuart Garrow, WIT.0001.0031.0001_R, paras 6-7, pp 1-2; see also Exhibit 136, email from Merrin Bamert, "Handover notes to assist over the next couple of days", 4 April 2020, DHS.0001.0008.0504.
[755] Bamert statement at [51].
[756] Bamert statement 2020 at [63], [68].
[757] Bamert statement at [64].
[758] Statement of Jan Curtain,YNA.0001.0001.0001, [80]-[82].
[759] Bamert statement at [68]-[69]; see also Exhibit 64, Statement of Jan Curtain,YNA.0001.0001.0001, [80]-[82].
[760] Bamert statement at [45].
[761] Bamert statement at [46] and [62]; Exhibit 136, Confidential Questionnaire DHS.5000.0003.0415 and DHHS Hotel Isolation Medical Screening Form, DHS.5000.0003.9706; see also Exhibit 136, "Operation Soteria Standard Operating Procedures (a guide for team leaders)" DHS.5000.0003.1053 at p 9.

friends.[762] Ms Serbest of DJPR gave evidence that on check-in, DJPR staff (on the instructions of DHHS) would ensure that all guests' details were collected, including important dietary requirements and other medical needs and that DJPR's role was to liaise with the hotel to make sure any dietary requirements were met.[763] Guests were able to and did escalate concerns to staff on arrival; for instance, guests gave evidence of being directed to see a nurse upon arrival because of their health conditions.[764]

336. Upon arrival, guests were given a welcome pack, containing information about their stay in hotel quarantine and contact details for the 24-hour GSS telephone line operated by DJPR.[765] Guests were able to contact GSS or hotel reception, who could pass on concerns to DHHS Team Leaders.[766] Ms Febey gave evidence that DJPR that the GSS was essentially an extension of what might ordinarily happen through a concierge, but which provided a clear and accountable point of contact for all people in quarantine to have their needs met.[767] DJPR was responsible for sourcing, funding, and providing essential supplies, which could be requested through the GSS.[768] Guests were also able to receive a weekly care package from family or friends.[769] Guests also connected with each other using social media such as Facebook groups,[770] which Dr Gordon described in his evidence as a great resilience resource.[771]

337. During the quarantine period, daily screening checks were conducted via phone calls from agency nurses on site, and then by Alfred Health nursing staff on site from 16 April. Ms Alexander of Alfred Health described the calls as welfare checks that provided opportunities to identify concerns about physical and mental health.[772] It is apparent from Operation Soteria Commander Bamert's evidence, and the documentary evidence provided to the Board, that the daily call included a more general check in with each guest to broadly identify how they are coping in hotel quarantine, including general questions about health and wellbeing, as well as questions about COVID symptoms.[773] Guests also gave evidence of the screening checks being conducted daily and of the calls including a check in on their mental state.[774] Both Ms Bamert, Operation Soteria Commander, and Ms Alexander of Alfred Health, gave evidence that nurses conducting the daily screening checks were expected to record the daily screening check, and share or escalate concerns to clinical staff onsite or the DHHS team leader.[775] If necessary, the guest could be referred for an in-room nursing assessment, specialist mental health assessment or GP assessment or CART referral.[776]

338. Several of the returned traveller witnesses, although noting significant difficulties they experienced in hotel quarantine, had positive things to say about the staff and the services provided. Mr de Kretser observed that nursing staff generally took their job seriously and seemed to genuinely care for the welfare of people being detained and that testing staff were professional and friendly.[777] Ms Ratcliff commented on nursing staff efforts to address their needs.[778] "Returned traveller 1" gave evidence of mental health nursing staff calling his wife daily because she was experiencing claustrophobia.[779]

339. In addition to the daily screening checks, day 3 and day 9 welfare checks were conducted by the DHHS's offsite welfare check team (under the supervision of the Deputy Commander Welfare) as a more comprehensive health and wellbeing assessment.[780] At the start of the program, this was established as a daily check-in; however, as the volume of guests increased rapidly, it was not

[762] Bamert statement at [54]; Exhibit 136, Questionnaire at DHS.5000.0003.0415; this is consistent with the evidence of Michael Tait of YNA at Exhibit 14, Witness statement of Michael Tait, WIT.0001.0008.0001, para 25-26, 30, 51-53.
[763] Exhibit 38, Statement of Gönül Serbest,DJP.050.009 0001 at [21] and [30].
[764] Bamert statement at [47]; Exhibit 20, Witness statement of Liliana Ratcliff, WIT.0001.0005.0001 at [22].
[765] Williams statement at [23]; Ms Serbest of DJPR confirmed that guests were provided with information relevant to their stay on check in: Exhibit 38, Statement of Gönül Serbest,DJP.050.009.0001 at [21].
[766] Williams statement at [23]; evidence of Ms Williams, T1315: 42-T1316: 6; evidence of Ms Bamert, T1314: 6-12.
[767] Exhibit 32, Statement of Claire Febey, DJP.050.010.0001 at [68].
[768] Williams statement at [22(a)].
[769] Williams statement at [22(a)].
[770] T189: 42-T190:4; T211: 10-14; T211: 42-T212: 6.
[771] T1736: 39-45; see also Gordon statement at [33].
[772] Alexander statement at [19]-[22].
[773] Bamert statement at [48]; Exhibit 136, DHHS Hotel Isolation Medical Screening Form, DHS.5000.0003.9706; Exhibit 136, "Opera ion Soteria Standard Operating Procedures (a guide for team leaders)" DHS.5000.0003.1053 at p 6. See also evidence of Prof Wallace who, although he described the call as "principally" to check COVID symptoms (see T1152: 10-26) also noted that nurses asked more general questions about how guests were going: see T1152: 40-42.
[774] Exhibit 16, Witness statement of Hugh de Kretser, WIT.0001.0009.0001, at [9]; Exhibit 20, Witness statement of Liliana Ratcliff, WIT.0001.0005.0001, para 31; Exhibit 18, Joint Statement of Kate Hyslop and Ricky Singh, WIT.0001.0002.0001, para 9, page 2.
[775] Bamert statement at [65]; Exhibit 100, Statement of Simone Alexander, ALFH.0001.0001.0001_R, [19]-[22].
[776] Bamert statement at [48], [59] and [65]; see also Exhibit 136, "Operation Soteria Standard Operating Procedures (a guide for team leaders)" DHS.5000.0003.1053 at p 6. This is consistent wi h the evidence of Nurse Jen that mental health concerns were sometimes raised with nurses during the daily check in call (and, presumably, escalated to nursing staff such from YNA who were providing on site services): Statement of Nurse Jen, WIT.0001.0003.0001, para 85, page 10].
[777] Exhibit 16, Witness statement of Hugh de Kretser, WIT.0001.0009.0001, at [9].
[778] Exhibit 20, Witness statement of Liliana Ratcliff, WIT.0001.0005.0001, para 67, page.
[779] Exhibit 13, Statement of Returned Traveller 1, WIT.0001.0001.0001, para 42 - 45
[780] Bamert statement at [49]; the evidence establishes that these checks were conducted by the Welfare team and were not as had been suggested outsourced to a travel agency: Evidence of Ms Williams, T1297: 23-26.

possible to achieve a daily welfare check call (although daily screening calls by nursing staff were expected to identify issues that required escalation).[781] The welfare team conducting the day 3 and day 9 welfare checks were expected to record the information in the Welfare Application, share or escalate concerns as necessary, for instance with: the onsite nurse for health or mental health related matters (by calling the nurses), the DHHS Team Leader on site or the CART team for more complex cases.[782] The day 3 check was a structured survey covering health, safety and wellbeing, including essential information about medications, allergies or health issues currently being treated to ensure they have access to continue their treatment, as well as questions about safety, emergency contacts, coping in quarantine and strategies for wellbeing, and exit planning.[783] The welfare team asked specific wellbeing questions such as whether guests had support needs not being met, whether guests were able to make contact with loved ones and what kinds of things they could do to stay occupied.[784] The call was made on day 3, rather than day 1, on the basis that guests arriving from overseas travel were often fatigued and overwhelmed and were better able to articulate their needs after having some time to settle in to the hotel environment.[785] The day 9 check was a shorter version of the day 3 check designed to focus on whether needs were being met, including asking how guests were coping, and providing an opportunity for feedback.[786]

340. Over time, the CART was established as a more enduring team of practitioners to assess, support and refer guests with psychosocial complexity in hotel quarantine (including family violence, child protection, care of the elderly and potential homelessness on departure from detention).[787] Checks by CART were on the basis of referrals from nurses, the welfare check team, or other staff involved in the hotel quarantine program, such as AOs, DHHS Team Leaders, hotel staff, DJPR site management or security. CART supported people with complex needs arising from either pre-existing personal, social, health or wellbeing needs, or needs that were likely to be significantly exacerbated by hotel quarantine.[788] Upon referral, CART made phone contact with the guest to discuss strategies and, where necessary, connected guests to specialist supports (e.g. family violence specialist assessment).[789] The CART team were expected to: record information in their own record-keeping systems; refer issues as necessary, for instance with the onsite nurse for health or mental health related matters, mental health triage, the GP on call, the DHHS Team Leader on site or the Quarantine exemptions team; and escalate issues to Deputy Commander Welfare and ultimately to the Commanders if necessary.[790]

341. Operation Soteria Commander Bamert (a registered nurse) gave evidence that these procedures were adequately and appropriately designed to provide a primary care model with escalation points as needed, and diversion to the hospital system for high-acuity concerns, while reducing face to face interaction with potentially COVID-positive guests.[791] Prof Wallace of Safer Care Victoria gave evidence that the components of the health and welfare system were established extraordinarily quickly, and that the initial lack of a central accessible repository for health and welfare information was wholly understandable given the complexity and rapidity with which the operation was established.[792]

342. In relation to the submission that there were inadequacies in the area of communication between those working within the program,[793] in addition to the evidence of the ways in which nursing, welfare and other staff shared and escalated concerns described above, DHHS witnesses gave evidence of the implementation of the COVID Compliance and Welfare Application and nurse health record, and steps taken by the DHHS to address uptake and functionality to allow better information collection and sharing about the health and welfare of guests.[794]

[781] Bamert statement at [13] and [55].
[782] Bamert statement at [66].
[783] Exhibit 136, Welfare Check – Initial long form survey, DHS.5000.0029.2919.
[784] Exhibit 136, Welfare Check – Initial long form survey, DHS.5000.0029.2919, questions 16 to 24; Exhibit 136, "Operation Soteria Standard Operating Procedures (a guide for team leaders)" DHS 5000.0003.1053 at p 7; see also evidence of Prof Wallace at T1152: 28-42.
[785] Bamert statement at [55(b)] and [56].
[786] Exhibit 136, Welfare Check – Subsequent short form survey, DHS.5000.0029.2927.
[787] Bamert statement at [50]; Williams statement at [23(c)].
[788] Bamert statement at [50].
[789] Bamert statement at [45(e)], [50]; see also Exhibit 136, "Operation Soteria Standard Operating Procedures (a guide for team leaders)" DHS.5000.0003.1053 at p 8.
[790] Bamert statement at [67].
[791] Bamert statement at [58]-[59].
[792] T1153: 35-T1154: 12; T1154: 25-33.
[793] T2268: 22-24 (closing submissions).
[794] Bamert statement at [53], [61], [63], [68] and [71]; Exhibit 136, Implementation Report, DHS.5000.0084.0699; Smith statement at [53]-[55], [60]-[65].

343. The DHHS worked to operationalize public health policy in relation to facilitating access to fresh air breaks if possible[795] within the constraints of the hotel environment.[796] The DHHS developed an exercise and fresh air implementation plan in mid-April and DJPR and DHHS safety officers worked with the hotels, AOs and security firms in April and May to develop specific fresh air procedures for each hotel.[797]

344. Access to fresh air breaks was a significant concern for guests, with some guests having limited or no access to fresh air breaks.[798] Priority for fresh air breaks given to people identified as a priority by mental health or nursing staff, families with children and smokers, and otherwise tried to provide equitable access to fresh air breaks.[799] Guests gave evidence of being prioritized for more frequent fresh air breaks after raising their needs with nursing staff.[800] There were, however, a range of practical constraints on the ability to provide fresh air breaks safely, including limiting contact between detainees and staff on site,[801] as well as practical limitations in the availability of safe, accessible outdoor space that differed between hotels.[802] The DHHS also worked with DJPR on future contractual engagement of hotels to encourage the selection of hotels with fresh air options where possible, with a priority on guest comfort, health, safety and wellbeing as an essential characteristic for the suitability of a hotel.[803] The DHHS commissioned a bespoke wellbeing program prepared by Peter MacCallum Cancer Centre which included exercise sessions suitable to undertake in a hotel room, activities for children and wellbeing resources, which became available from 12 June 2020.[804]

345. In closing, counsel appeared to rely on the evidence of "Nurse Jen" to the effect that DHHS staff treated guests who were vulnerable or had health needs as problematic.[805] One component of that evidence was based on an assumption that a whiteboard used to record guests names recorded those guests who the DHHS considered to be problematic; however, in oral evidence, "Nurse Jen" conceded that she "didn't know for what reason" the whiteboard was used and "didn't know if it was in relation to something else".[806] Ms Bamert gave evidence that whiteboards were used on site to record guests who required medical or nursing review.[807] The remaining components of that evidence related to "Nurse Jen's" impressions of statements made by unidentified DHHS staff and what she perceived as a failure to meet guests' needs.

346. The Board should be cautious in making findings on the basis of evidence that does not identify the alleged Departmental employee or guest with any precision, is vague on the details of what was said, and where there is no evidence that the guests' concerns were not in fact resolved (whether by the nurses who were contracted by the DHHS to meet guests' health and wellbeing needs or other DHHS or DJPR staff). There is no evidence from the guests concerned, and neither the Manager of

[795] See, for instance, Romanes Statement at [46]; Ex 114, COVID-19 – DHHS Physical Distancing and Public Health Compliance and Enforcement Plan, 4 April 2020, DHS.5000.0123.3241;van Diemen Statement at [80]-[81]; Ex 161, 'Annex 3 – Health & Wellbeing Standards for healthcare and welfare provision, DHS.5000.0118.2852; van Diemen Statement at [113]; Exhibit 161, Operation Soteria Plan v3.0 with annexes v2.0, 1 June 2020, DHS.0001.0001.1053; van Diemen Statement at [82].

[796] Exhibit 114, Email from Dr Romanes, 4 April 2020, DHS.5000.0095.9277; Bamert statement at [78]; Exhibit 136, Email from Finn Romanes dated 4 April 2020, DHS.5000.0095.9277; Exhibit 136, Email chain from Braeden Hogan dated 10 April 2020 "Re Supervised Rec Breaks", DHS.5000.0053.6758; Exhibit 136, Email chain from Merrin Barret "RE: [For Approval] Permissions for Temporary Leave" dated 4 April 2020, DHS.5000.0054.1812; Williams statement at [22(c)]; Exhibit 131, Fresh Air Policy, the COVID-19 – DHHS Physical Distancing and Public Health Compliance and Enforcement Plan dated 4 April 2020, DHS.0001.0008.0674; Smith statement at [99]-[101].

[797] Williams statement at [22(c)] and [45]; Exhibit 131, Exercise and Fresh Air Implementation Plan (v 1) dated 15 April 2020, DHS.5000.0003.2831; see also Exhibit 136, "Operation Soteria Standard Operating Procedures (a guide for team leaders)" DHS.5000 0003.1053 at p 10; the Implementation Plan included an Exercise Area Checklist which was to be completed by the Site AO, DJPR Site Manager, Hotel General Manager and Security General Manage: Exhibit 131, completed checklists for Mercure Welcome [DHS.5000.0023.6495], Crown Promenade [DHS.5000.0028.7672 and DHS.5000.0028.7670], Crown Metropol [DHS.5000.0028.7671], Crowne Plaza [DHS.5000.0024.5277], Four Points Hotel [DHS.5000.0022.7165], Travelodge Southbank [DHS.5000.0003.7519], Holiday Inn Melbourne Airport [DHS.5000.0028.7683], Holiday Inn Flinders Lane [DHS.5000.0028.7684], The Marriott [DHS.5000.0028.7695], Novotel Collins [DHS.5000.0028.7707], Pan Pacific Hotel [DHS.5000.0028.7718], Park Royal [DHS.5000.0028.7719], Rydges on Swanston [DHS.5000.0028.7720] and Stamford Plaza [DHS.5000.0028.7721]. Hotel managers gave evidence about liaising with DJPR in conjunction wi h the Department about fresh air policies: Mead statement at [27]; Statement of Karl Unterfrauner, STAM.0001.0004.0009, para 28. A DJPR policy officer also gave evidence of providing security contractors with a fresh air policy: Witness statement of Principal Policy Officer, DJP.050.004.0003 at [31]- [32] and [56]-[57]. See also Ex 24, statement of Security Guard 1 [31] – [34]; Ex 29, statement of Security Guard 2 [26]; Ex 31, statement of Security Guard 16 [35]; Ex 19, Joint statement of Sue and Ron Erasmus [25]; Ex 72, statement of Kann Ofli [18] to [20]; Ex 45, statement of Rosswyn Menezes [26]; Ex 53, statement of Ishu Gupta [20]; Ex 67, statement of Sam Krikelis [31] and [38]. Ex 41, Witness statement of Shaun D'Cruz, CML 0001.0014 0001 at [56] and [75]; Exhibit 61, Statement of Gregory Watson, WILS 0001.0015.0001, para 104(f); Exhibit 71, Witness statement of Mo Nagi, WIT.0001.0036.0001, paras 30 – 31 and [37]; Exhibit 63, Statement of Shaun Hogan, WILS.0001.0010.0001 at [48] and [49].

[798] Williams statement at [22]; Exhibit 16, Witness statement of Hugh de Kretser, WIT.0001.0009.0001, [10] and [34]-[36]; Exhibit 18, Joint Statement of Kate Hyslop and Ricky Singh, WIT.0001.0002.0001 at [9].

[799] Cleaves statement [109]-[112]; see also, Ex 77, Statement of Unnamed Senior Authorised Officer at [124]; Evidence of Cleaves, T910: 27-46. This evidence was consistent with Ashford statement at [19]-[21].

[800] Exhibit 13, Statement of Returned Traveller 1, WIT.0001.0001.0001 at [63]; Exhibit 19, Joint witness statement of Sue and Ron Erasmus, WIT.0001.0007.0001 at [25].

[801] Cleaves statement [109]-[112], [115]; see also, Ex 77, Statement of Unnamed Senior Authorised Officer at [124].

[802] Williams statement at [22(c)], [41(e)]; Ex 201. Statement of Learning Consultant DHHSat [13]; see also Ex 77, Statement of Unnamed Senior Authorised Officers at [116], [129]-[130]; Evidence of Ms Williams, T1272: T39: 47; see also evidence of Cleaves, T910: 1-21.

[803] Bamert statement at [87]; Exhibit 136, '"Policy – Hotel Suitability check list', DHS.5000.0096.3176.

[804] Williams statement at [22(c)].

[805] Exhibit 9, Statement of Nurse Jen, WIT.0001.0003.0001, para 141, page 16T2251: 20-22.

[806] T145: 7-8 and 16-17.

[807] Bamert statement at [64].

the Park Royal (who provided a statement to the Board) nor were the DHHS or DJPR invited to address the specific allegations (for instance, to identify whether there were in fact kettles available at the hotel[808] or whether the diabetic guest was provided with an alternate menu or reviewed by a medical professional). The Board has evidence before it that suggests, for instance, that hotel rooms did have kettles,[809] that DJPR through its concierge service worked with staff on the ground to provide access to what was needed where it was safe and appropriate to do so,[810] including by providing items such as kettles and toasters, and that such items were not required to be approved by the DHHS.[811]

Section 200(6) reviews

347. As noted above, the power by which returning travellers were held in hotel quarantine was the detention power in s 200 of the PHWA. Section 200(6) requires an AO to review at least once every 24 hours "whether the continued detention of the person is reasonably necessary to eliminate or reduce a serious risk to public health". Over 20,000 returning travellers were detained in hotel quarantine under this provision, and evidence was given as to how a centralized method of conducting these reviews were conducted was identified.[812]

348. In the final remarks, after the close of evidence, counsel assisting, while apparently accepting that it was not a part of the Board's function to make any conclusions about the matter,[813] made adverse submissions about the adequacy of the s 200(6) reviews and what this "probably" meant with respect to the ongoing lawfulness of the detention of quarantined persons.[814] These submissions referred to advice provided by counsel to the DHHS as to the method of review that could be adopted to comply with s 200(6) in the circumstances at the time. Counsel assisting's conclusions with respect to the probable legal effect of the evidence as to how the reviews were conducted were based on counsel assisting's own interpretation of the advice and the PHW Act.

349. It is surprising for these submissions to have been made in closing, in circumstances where the DHHS witness whose written statement contained evidence that advice was given by the DHHS legal team on the method of s 200(6) reviews, which was informed by counsels' advice, was not called to give oral evidence.[815] This deprived the DHHS and the witness of any opportunity to address the issue before counsel assisting's serious assertions were made.

350. The DHHS was not given the opportunity to address in evidence, or otherwise respond to the opinion of counsel as to the legal advice and the asserted effect on the lawfulness of detention. The requirements of s 76 of the Inquiries Act – that if a finding is to be made that is adverse to a person the Board must be satisfied that the person is aware of the matters on which the proposed finding is based and has had an opportunity to respond on those matters s 76(1) so that the Board can consider that response before making any finding – are plainly not met, and it is not open to make any adverse finding to the effect of the observations made by counsel. Given that it must have been apparent that the statutory preconditions for the Board to make a finding consistent with the submission made on these matters had not and could not be met,[816] it is difficult to see how counsel assisting regarded it as appropriate to make these serious allegations in closing submissions.

351. Notwithstanding that it is not open to make adverse findings as to the lawfulness of the Direction and Detention Notice or the compliance with the s 200(6) reviews, in light of the adverse submissions made, it is important to identify why the legal reviews did satisfy the requirements of s 200(6), and why there is no basis on which to question the lawfulness of the detention.

The requirements of s 200(6)

352. The requirement in s 200(6) is on "an authorised officer" to review whether the continued detention of the detained person is reasonably necessary to eliminate or reduce a serious risk to public health.[817] The use of the indefinite article "an" indicates that this does not need to be the same authorized officer that exercised the power to detain in s 200(1)(a).

---

[808] Noting Ms Williams was invited to speculate why a kettle was not provided: T1278: 41-43 (Williams).
[809] T1278: 45-46; Williams statement at [22(a)].
[810] T414: 3-11.
[811] Serbest statement at [30]; T490: 25-49.
[812] Statement of Jacinda De Witts dated 10 September 2020; Statement of Murray Smith dated 1 September 2020.
[813] T2245 (counsel assisting).
[814] T2245: 26-30 (Ihle).
[815] Nor was the fact that a statement had been provided which addressed the legal advice even acknowledged in counsel assisting's submissions. Statement of Jacinda de Witts at [23]-[24]. The DHHS legal team's advice is referred to at fn 3 and attached, DHHS.0001.0014.1789; templates at DHS.0001.0014.1806. While the counsel advices were not attached to the statement, they were referred to at [24] of the advice. The documents were disclosed to Solicitors Assis ing and tendered by counsel on the basis.
[816] This might have been implicitly acknowledged by counsel assisting when stating "it is not incumbent upon this Board of Inquiry to make legal conclusions as to the lawfulness of what was undertaken." T2245.27-28.
[817] PHWA, s 200(6).

353. The legislation is silent as to the nature of the "review" that is to be conducted, but the purposes of that review are made clear: namely to come to a conclusion about "whether the continued detention of the person is reasonably necessary to eliminate or reduce a serious risk to public health". The purpose of the review is not to monitor the health of the individual, but the risk to public health, although of course it was important to the exercise of the detention power that the persons detained be frequently checked with respect to their welfare.[818] This interpretation of s 200(6) of the PHWA is consistent with the consideration that these powers can only be exercised when a state of emergency has been declared, and are unlikely to have been intended by the legislature to be construed in any overly narrow, technical way which may be present unfeasible or untenable barriers to their exercise.

354. The context of the relevant advice on the s 200(6) review was that following the National Cabinet agreement for 14 day quarantine for returning travellers, advice was provided by the DHHS legal team on Saturday 28 March as to the options for implementing that quarantine, including a Charter assessment as to the options.[819] The advice referred to by Ms De Witts relating to the s 200(6) review process to the effect "that an AO could complete could complete the daily review function in a centralised way" [820] was provided on the same day. That advice was based on legal advice also provided on 28 March by counsel.[821] It is that advice to which counsel assisting referred to four considerations:

> 1. An authorised officer must ask themselves "is the continued detention of this person reasonably necessary to eliminate or reduce a serious risk to public health?"
>
> 2. In doing so, the authorised officer must engage in an "active intellectual" process.
>
> 3. This need not be time consuming because the question in (1) above will be a simple one to answer if the medical advice is clear about what is necessary to reduce the risk that travellers returning from overseas pose to public health (they are entitled to rely on that advice although they should not consider themselves bound by it).
>
> 4. It could involve reviewing the information on a database that identifies where a person has come from, when they arrived in Australia, whether they had any symptoms when they arrived, whether they have a 2019-nCov diagnosis. This database should have a field in which those collecting information note any other relevant information about the person (for example – had 2019-nCov six weeks ago and has been cleared by a doctor overseas).
>
> 5. Ideally there would be a way of checking off on that database that the authorised officer has reviewed that person's entry for the day. That record could be used to compile the reports required to the CHO under s 200(7) and to the Minister under s 200(9).

355. The key element of the advice is found in points 1 to 3: that the AO must engage in an active intellectual process in considering whether the continued detention of the person is reasonably necessary to eliminate or reduce a serious risk to public health, in which process they are entitled to rely on the medical advice. As noted in the DHHS legal team email advice based on counsel's advice,[822] and shown in the evidence before the Board, the expert medical opinion of the DCHO and CHO was that travellers returning from overseas pose a significant health risk, and that to reduce the risk public health it was necessary that they quarantine for 14 days.[823]

356. The further matters in the counsel advice, in 4 and 5 posited further information about what the review "could" or would "ideally" involve, and are not necessary components of a valid review. As the evidence has shown, neither evidence of country of origin nor whether a person was showing symptoms would alter their risk profile in a reliable way.

357. The key issue, on the medical advice of the CHO and DCHO was that returned travellers should spend 14 days in quarantine, "because the 14 day period is the maximum incubation period for the coronavirus" and "going the entire 14 days is the only absolute assurance or relatively strong assurance you can have that someone isn't infectious".[824] It was therefore entirely appropriate that the key consideration to inform the review, taking into account the medical advice as to what was

---

[818] See in particular Memorandum of Legal Advice – Sean Morrison to Anneliese Van Diemen DHS 0001.0004.1872. (provided under cover of memorandum to Dr Van Diemen from Jacinda de Witts: DHS.0001.0004.1702).
[819] Statement of Jacinda de Witts at [20(a)]. The memorandum of advice is attached at DHHS.0001.0004.1702. Attachments to that advice which were omitted were separately tendered: DHHS.0001.0011.0658 (Charter assessment); DHS.0001.0004.1844 (Instrument of Authorisation signed by Professor Brett Sutton on 11 May 2020 ; DHS.0001.0004.1694 (Revocation of Airport Arrivals Direction). See exhibit 226.
[820] Jacinda De Witts statement at [24].
[821] DHS.0001.0104.0094, email dated 28 March 2020 from counsel to Ed Byrden, Jacinda de Witts and others; DHS.0001.0103.0007 email dated 28 March 2020 from senior and junior counsel to (Exhibit 226).
[822] Exhibited to Statement of Jacinda de Witts, at [24] (doc DHS.0001.0014.1789).
[823] Statement of Annaliese van Diemen dated 9 September 2020, [37]-[38]. Statement of Prof Brett Sutton, [112].
[824] T463.12-31; T1481.10-16; 39-T1482.1; T1483 .7-19 (Prof Sutton).

required to manage the serious public health risk, was whether the person was a returned traveller and whether they were within the required 14 day period. This was the criterion used when Senior AOs conducted the review of the spreadsheet containing the details of the travellers, their location and how long they had been in quarantine.[825] While that criterion was implicitly criticised by counsel assisting in closing submissions,[826] it is entirely understandable when the immediate context of the medical advice and the legal advice is properly understood.

358. Dr van Diemen gave evidence that she was aware of the requirements of s 200(6) requiring a review of detention every 24 hours.[827] Prof Sutton gave evidence that he understood the obligation in s 200(6) was met by a senior authorized officer undertaking a daily review against the criteria of the mandatory 14 day quarantine period, noting how many days individuals had been in quarantine.[828] Further, the Senior AOs, in conducting their s 200(6) review were aware that daily nursing checks, including for COVID-19, as well as detailed welfare checks were being conducted as a separate safeguard on the health and wellbeing of the traveller.

The requirements of the Charter relevant to s200(6)

359. Section 21 of the Charter requires that when a person is deprived of liberty their detention must be both lawful and not arbitrary. The performance of the checks required by s 200(6) ensured that the detention was lawful and, because that assessment required a consideration of whether detention remained necessary to eliminate or reduce a serious risk to public health, they also ensured that the detention was not arbitrary and also that it was likely to be proportionate in most cases (noting that exceptions could be made if detention was disproportionate in specific cases, taking into account human rights).[829]

360. The requirements of s 200(6) were performed in addition to other checks that were also taking place. Dr van Diemen gave evidence that the review of detention for the purposes of s 200(6) differed from the welfare and other checks that were also conducted.[830] The performance of those welfare checks ensured that the inevitable hardship of hotel quarantine did not have an impact on individuals that was so severe as to be considered inhumane, and that the conditions and circumstances of detention were humane, as required by s 22 of the Charter.[831]

361. The s 200(6) review requirement was complied with. The basis of the detention under s 200(1)(a) - to eliminate or reduce a serious risk to public health – was the subject of expert public health advice and was satisfied. In combination, with the welfare checks and services available to detainees it also ensured that the detention was compatible with both ss 21 and 22 of the Charter.

H. Exemptions

362. Throughout the hotel quarantine program, exemptions (as well as permissions for temporary leave) were determined on a case by case basis, having regard to policies and guidance material. Dr van Diemen described the process of considering exemptions as involving consultation with the CHO, from a starting point that exemptions to mandatory quarantine would only be granted in limited circumstances.[832] It was understood by Dr Van Diemen that there had not been full compliance with the home isolation requirement for returning travellers[833] which was consistent with the experience of Victoria Police when monitoring people who were required to be quarantining at home, when as observed by Mr Ashton in his evidence,

> … daily reports were given to me and there were regular occasions when people were found not to be home when they were checked upon and that we then had to go through on exercise of locating them, working out where in fact they were when they were supposed to be at home.[834]

363. The proposition that the exemption process ought to have been more available and exemptions granted in more situations, which is one of the findings proposed by counsel assisting,[835] was not put to the Commander, Enforcement and Compliance, Murray Smith, either when he gave evidence to the Board on 10 September or in preparing his witness statement prior to that date. Notwithstanding

[825] Witness Statement of Murray Smith, [68]-[71].
[826] T2246.10-15 (counsel assisting).
[827] Witness Statement of Annaliese van Diemen dated 9 September 2020, [65].
[828] Witness Statement of Brett Sutton dated 13 August 2020, [251].
[829] Witness Statement of Annaliese van Diemen dated 9 September 2020, [60] – [62].
[830] Witness Statement of Annaliese van Diemen dated 9 September 2020, [65].
[831] Witness Statement of Annaliese van Diemen dated 9 September 2020, [48] – [49].
[832] van Diemen Statement at [42].
[833] T1537.10-.14.
[834] T1681.20-23.
[835] T2268: 26-31 (Neal).

the decision-making role of Enforcement and Compliance Command with respect to exemptions, the Commander, Enforcement and Compliance was not given an opportunity to comment on this proposed finding.

364. It is the case that there were differing views expressed by non-Departmental witnesses in respect of whether temporary leave or exemptions were granted appropriately.[836] However, there is no evidence before the Board of any specific cases where an exemption would have been warranted in all the circumstances but was not granted. For example, evidence was given by Michael Tait in general terms about his opinion that it would have been 'better if the AOs had provided more exemptions to people and allowed them to self-isolate at home', without any specificity. Whilst Mr Tait made broad comments about many guests having existing illnesses that they had learned to live with, and which were more difficult to manage in a hotel,[837] he gave no specific evidence of individual examples. Mr Tait gave oral evidence about seeking an exemption for a woman who had escaped domestic violence and had recently given birth, but being 'told that nothing had been done'.[838] However, there was no evidence given as to the identity of the guest or whether she had access to a safe, secure and reliable place to quarantine outside of the hotel context. It is possible that it was a guest who was granted an exemption, see for example, the statement of Merrin Bamert at 15(g). The only other evidence from Mr Tait as to exemptions was in respect of a woman for whom he 'had grave concerns' but who he says was ultimately given an exemption from hotel quarantine.[839]

365. This section sets out DHHS's position on both 'exemptions' and temporary leave permissions.

Policies and procedures

366. From the beginning of the hotel quarantine program there were protocols for exemptions to hotel quarantine and permissions to leave. These were documented by 4 April 2020, and initially recorded in the Physical Distancing Policy prepared by Dr Romanes, with the substance of the policy remaining through later iterations of policy documents.[840] The process for assessing and managing exemption requests had regard to the public health objectives of minimising the spread of COVID-19 and, thus, the consideration of whether to grant an exemption while minimising the risk of exposure of people who could be infected with COVID-19 to others.[841]

367. The documented protocols used in making decisions to grant exemptions (and to grant approvals for temporary leave, discussed further below) were the:[842]

(a) Draft COVID-19 – DHHS Physical Distancing and Public Health Compliance and Enforcement Plan dated 4 April 2020;[843]

(b) Draft COVID-19 Policy and Procedures – Mandatory Quarantine (Direction and Detention Notice) v1 dated 8 April 2020;[844]

(c) Annex 1 COVID-19 Compliance Policy and Procedures – Detention Authorisation (v1) dated 30 April 2020;[845]

(d) Annex 1 COVID-19 Compliance Policy and Procedures – Detention Authorisation (v2) dated 25 May 2020;[846]

(e) Annex 1 – Detention Compliance and Enforcement (c2) dated 1 June 2020.[847]

Exemption decisions

368. Early in the program, Dr van Diemen, as PHC and DCHO, was responsible for assessing whether persons should be excused from the Direction and Detention Notice (exemptions).[848] Though commonly known as 'exemptions', these were in reality a change of the conditions of a person's quarantine, allowing them to quarantine at another location, rather than true exemptions the requirement.[849] Exemption requests were generally made either prior to the arrival of a returned

[836] Ashford statement at [24]-[26]. FN 809 - Ex 23, Statement of Luke Ashford, [24]-[26]; Ex 16, Statement of Hugh de Kretser [83]-[87]; T200.23-46 (Hugh de Kretser).
[837] See Tait statement, WIT.0001.0008.0001 at [55]-[56].
[838] T178:20-24 (Michael Tait).
[839] T176:45-47 (Michael Tait).
[840] van Diemen Statement at [27] and [41]; T2037:11-27; Romanes statement at [36].
[841] Romanes statement at [47].
[842] van Diemen Statement at [28]; Smith statement at [57].
[843] Exhibit 161, COVID-19 – DHHS Physical Distancing and Public Health Compliance and Enforcement Plan, 4 April 2020, DHS.0001.0001.0729.
[844] Exhibit 161, draft COVID-19 Policy and Procedures – Mandatory Quarantine (Direction and Detention Notice) v1 dated 8 April 2020, DHS.5000.0075.0010.
[845] Exhibit 161, Annex 1 COVID-19 Compliance Policy and Procedures – Detention Authorisation (v1) dated 30 April 2020 DHS.5000.0025.4759.
[846] Exhibit 161, Annex 1 COVID-19 Compliance Policy and Procedures – Detention Authorisation (v2) dated 25 May 2020, DHS.0001.0013.0006.
[847] Exhibit 161, Annex 1 – Detention Compliance and Enforcement (c2) dated 1 June 2020, DHS.0001.0001.1053.
[848] van Diemen Statement at [43].
[849] Smith statement at [11], [21]; Cleaves statement at [85]; T927:25-928:3 (Noel Cleaves).

traveller or during the course of mandatory quarantine, with each required to be considered individually on its own merit, balancing risk to the public against personal circumstances and human rights.[850] Charter considerations were also required to be taken into account.[851]

369. As Deputy Public Health Commander – Planning, Dr Romanes was also involved in exemption requests until about mid-April. During this period his role included sitting on an informal panel with the then Enforcement and Compliance Commander (then known as the Compliance Lead) and DHHS's Legal Services branch to consider 'priority 2' (complex, lower/medium urgency) hospital visitor or other exemption requests. He was also involved in assessing submissions for exemptions considered reasonable by the Enforcement and Compliance Commander and recommending outcomes required by the Public Health Commander.[852]

370. From about mid-May 2020, decisions as to exemptions could also be made by DHHS's Enforcement and Compliance Commander.[853] This would be done in consultation with the Deputy Commander, Welfare, who provided an assessment of whether it would be possible for the guest to be supported within hotel quarantine.[854] Complex cases were still escalated to Public Health Command and the decision continued to be made on a case by case basis with regard to the balancing the risks of transmission of COVID-19 with the rights in the *Charter*.[855]

371. Nurses, AOs and Department Team Leaders in hotels would make sure that any detainees who had indicated that they thought they were not suited to hotel quarantine would be made aware of the process and the web-based form to apply for an exemption from quarantine.[856] Applications for exemption were sufficiently common that a considerable amount of time and resourcing was involved in dealing with exemption requests. Additional staffing was required to manage the scale of claims from people seeking to avoid hotel quarantine. This required considerable resources for the exemptions team to identify genuine claims for a variation to the Detention Notice for consideration by Public Health Command (and then later, under delegation by the COVID Enforcement and Compliance Commander).[857]

372. Although many guests applied to be allowed to home quarantine, including due to their health conditions or complex personal circumstances, these permissions were not often granted.[858] There were more than 439 temporary leave permits, and 426 exemptions to people to enable them to complete their quarantine in an alternative setting, including on medical and compassionate grounds,[859] often on the basis of assessments of either the mental health nurses or the CART team that the hotel setting was not appropriate for a particular person with complex needs.[860] If a request for exemption was not approved in circumstances where a Senior AO was concerned for a detainee's welfare, the matter would be escalated to the team leader in the exemptions team.[861] It was also part of the welfare role of the CART team to refer issues to the Exemptions team where necessary.[862] (In some limited circumstances, a guest with a confirmed diagnosis of COVID-19 could receive an exemption and be released prior to the expiry of the 14 day detention period. The exemption had to be approved by the Public Health team and guests had to have been afebrile for the previous 72 hours, at least ten days must have elapsed from the onset of acute illness, and there must have been noted improvement in symptoms.[863])

373. The Exemptions team in Enforcement and Compliance Command received many hundreds of letters and emails about the Program concerning claims for exemptions from quarantine.[864] Exemptions requests from quarantined travellers could sometimes be a way of complaining about the fact of being detained. However, they could also reveal health treatment requirements that warranted consideration of additional health support on site or an amendment to the Detention Notice to change the place of detention.[865]

---

[850] van Diemen Statement at [59]-[61]. There was a more general exemption for quarantine applying to air crews, in respect of which Dr van Diemen gave evidence: T1546:25-1548:12 (Annaliese van Diemen).
[851] van Diemen Statement at [62] quoting from page 21 of he Physical Distancing Plan.
[852] Romanes statement at [26]-[28], [72].
[853] van Diemen Statement at [54] referring to Exhibit 161, Annex 1 COVID-19 Compliance Policy and Procedures – Detention Authorisation (v2) dated 25 May 2020, DHS.0001.0013.0006, Appendix 17, page 87.
[854] Statement of Pam Williams, DHHS, dated 9 September 2020 at [23(b)].
[855] van Diemen Statement at [56].
[856] T928:28-929:3 (Noel Cleaves).
[857] Skilbeck statement at [85].
[858] Statement of Pam Williams, DHHS, dated 9 September 2020 at [23(b)].
[859] See Minter Ellison lawyers to Solicitors assisting dated 25 September 2020, exhibit 228.
[860] T1975:10 and T2039:30 (Kym Peake).
[861] Cleaves statement at [85].
[862] Statement of Merrin Bamert, DHHS dated 9 September 2020 at [67].
[863] Ex 205, statement of Senior Project Officer at [17(c)].
[864] Skilbeck statement at [122].
[865] Skilbeck statement at [111].

374. Decision-making on exemptions was guided by the Operation Soteria Plan and particularly Annex 1 to the Operation Soteria Plan (**Annex 1**).[866] Annex 1 provided guidance including a list of circumstances that had been identified as open for consideration of early release or change of detention location. This included people whose health and welfare could not be accommodated in a hotel environment.[867] Prior to the first version of Annex 1 being published on 29 April 2020, there were other policies in place that provided processes for assessing and managing exemption requests, as discussed above.[868]

375. An example of a guest who was granted an exemption is provided by Merrin Bamert. In the first week of the program, before she became COVID-19 Accommodation Commander, Ms Bamert was involved in case managing an extremely complex guest and her family by negotiating with mental health staff, the mental health branch, and the maternal child health nurse program to address their significant support needs, and working with members of DHHS's Enforcement and Compliance team and Tracy Beaton (the Chief Practitioner Human Services), to arrange an exemption for the guest and her family to complete isolation in their own home.[869]

376. Ms Williams, COVID-19 Accommodation Commander gave evidence accepting that had technology been available to permit people to quarantine at home, but ensure compliance with that quarantine, this would have been desirable and would have reduced the distress of some guests in quarantine. That technology, which being developed in other countries was not available on a mass scale in Australia.[870]

Temporary leave decisions

377. Where returned travellers were not granted an 'exemption', they may nonetheless have been able to access temporary leave from hotel quarantine. As distinct from 'exemptions', temporary leave was a separate process that was more readily available to detainees, and enabled them to temporarily leave the place of detention, including for fresh air breaks.[871] Requests would be made in a number of ways by detainees and it was the responsibility of AOs to complete the form granting permission for temporary leave.[872] Annex 1 provided guidance to AOs on the making of decisions relating to temporary leave, including where decisions should be made in consultation with AO Team Leaders, Senior AOs or the Deputy Commander Authorised Officer Operations.[873]

378. Temporary leave was provided to detainees to enable receipt of medical care off-site, for compassionate reasons, where it was reasonably necessary for physical or mental health, or in emergency situations.[874] Medical care included emergencies where ambulances were used and travel to appointments (eg cancer treatments) where non-emergency patient transport (NEPT) was used; compassionate leave was provided for people to, for example, attend funerals and visit dying relatives.[875] In these cases, taxis were mostly used with the taxi companies implementing specific PPE and infection control and cleaning strategies.[876] PPE was available to detainees when they were on temporary leave and detainees were asked to wear PPE from the time they left their rooms.[877]

379. Not all temporary leave requests were accommodated. Each quarantine location presented with different resource and site specifications which affected how many detainees and at what frequency could be granted permission to leave temporarily. When considering leave requests, those with serious medical needs, persons who were seeking to attend a funeral or who had a family member who was terminally ill would generally be granted with permission to attend to those matters. The AOs were tasked with confirming the details of the request prior to issuing the permission to leave. If medical care was deemed urgent by an on-site nurse or medical practitioner or attending paramedic, the AO was expected to prioritise and approve leave immediately. For all other applications for temporary leave, including smoking and exercise breaks, the AOs were tasked with assessing and

[866] T1204:27-1205:37 (Murray Smith); Exhibit 123, Operation Soteria Plan dated 26 May 2020 at 3.5 (Exemptions and exceptional circumstances), DHS.0001.0001.1053.
[867] See, eg, Annex 1 v1 dated 29 April 2020 (DHS.5000.0025.4759) at 6 (Exemp ion requests).
[868] See Romanes Statement at [47]; Exhibit 114, COVID-19 – DHHS Physical Distancing and Public Health Compliance and Enforcement Plan, 4 April 2020, DHS.5000.0123.3241.
[869] Bamert statement at [15(g)].
[870] Williams statement at [99].
[871] Smith statement at [98]. See above paragraphs 343 and 344 for discussion of fresh air breaks.
[872] Smith statement at [98].
[873] Smith statement at [103].
[874] Williams Statement at [41(e)]; Smith statement at [99]; Ex 77, Statement of Unnamed Senior Authorised Officer at [135], [144]; T911:42-T912:19 (Noel Cleaves); van Diemen statement at [44] and [46]-[47]; Exhibit 161, COVID-19 – DHHS Physical Distancing and Public Health Compliance and Enforcement Plan, 4 April 2020, DHS.0001.0001.0729 at page 22.
[875] Williams Statement at [41(e)]; Ex 77, Statement of Unnamed Senior Authorised Officer at [142].
[876] Williams Statement at [41(e)]; Exhibit 131, "Operation Soteria Positive Diagnosis Guidance", DHS.0001.0001.1348.
[877] Cleaves statement at [132].

permitting the applications on a case by case basis. Any arrangement for leave would need to meet public health and human rights requirements and balance the needs of the person.[878]

380. Given the public health risk associated with allowing people in quarantine to access the broader community, it was expected that AOs would consult with an AO Team Leader before authorising a permission. Requests by returned travellers to visit family members in an aged care or medical facility were only to be considered where the family member they wished to visit was in palliative care or receiving end of life treatment. Any such requests to visit family members were not to be authorised until the relevant facility had been contacted and permission had been given, by someone authorised to do so, for the detainee to visit the premises.[879] The duration of temporary leave was not to exceed two hours (excluding travel time) to minimise the risk of infection.[880]

381. When making decisions on temporary leave, in practice AOs were to consider:

(a) those that require exercise or fresh air breaks or those who may be at risk without these breaks, which was the most important consideration for fresh air and exercise breaks;

(b) willingness and availability of security to oversee and facilitate exercise or other fresh air breaks, which included consideration of the number of security available and the ability to ensure small groups by room are appropriately socially distanced;

(c) the site layout, safety and capability to ensure persons are in a cordoned off area;

(d) adherence to exercise and smoking procedures; and

(e) in the case of a request for a person to visit a terminally ill family member in hospital, whether the medical facility will accept the person.[881]

382. Dr van Diemen, as PHC and DCHO, was on occasion personally involved in assessing if returned travellers could be given temporary leave.[882] By way of example, her evidence is that in the case of medical treatment, she would consider the relevant circumstances, including onsite advice from a nurse and consult with the CHO.[883] In the case of medical treatment, the person was to be accompanied by an on-site nurse, an Authorised Officer, security or a Victoria Police member, with social distancing principles applying.[884] She also refers to the policy documents referenced at paragraph 367 above in relation to her decision-making on these matters.

383. There was very detailed guidance to AOs and other decision makers in applying the Charter provided in Operation Soteria and other manuals,[885] which guided them in practice.[886] These commenced from 8 April, with the draft COVID-19 Policy and Procedures – Mandatory Quarantine (Direction and Detention Notice) v1.[887]

384. Mr Smith gave evidence that the Charter rights on which Annex 1 focussed were identified on the basis that "they were the rights that were most likely to be affected as the result of the detention process. And equally in terms of the determination process, to undertake quarantine in an alternate location".[888]

---

[878] Smith statement at [104].
[879] Ex 77, Statement of Unnamed Senior Authorised Officer statement at [146].
[880] Ex 77, Statement of Unnamed Senior Authorised Officer statement at [148].
[881] Smith statement at [107]-[108]; see also Ex 77, Statement of Unnamed Senior Authorised Officer at [148]. AOs were also generally required to consider the Charter in making decisions: EX 122, Smith statement at [16].
[882] van Diemen Statement at [43], [53].
[883] van Diemen Statement at [47(a)].
[884] van Diemen Statement at [51].
[885] See statement of Murray Smith, at [16], [22], [57] and Ex 124, Documents referred to in Smith statement where examples of Charter guidance are included at DHS.0001.0039.0006 (Workforce Plan for AOs); DHS.0001.0001 0729 (Physical Distancing plan dated 4 April) at 21 (Charter considerations in decision-making process), 31 (Victoria's Charter), and Appendix 8 (Unaccompanied minors); DHS.5000.0075.0010 (COVID-19 Policy and Procedures – Mandatory quarantine dated 8 April) at 10 (Charter obligations), 15 (regular review of detention), 17 (Grant of leave from detention), and 26 and Appendix 4 (Unaccompanied minors); DHS.5000.0025.4759 (Annex 1 COVID-19 Compliance policy and procedures v1 dated 29 April 2020) at 3.3 (AO and CHO obligations), 5.7 (daily review and reporting), 6.3 and Appendix 5 (unaccompanied minors), Appendix 10 (Charter of Human Rights obligations), and Appendix 12 (Exceptions to General Quarantine Policy); DHS.0001.0013.0006 (Annex 1 COVID-19 Compliance policy and procedures v2 dated 24 May 2020) at 3.3 (AO and CHO obligations), 5.7 (daily review and repor ing), 6.4 and Appendix 8 (unaccompanied minors), Appendix 16 (Charter of Human Rights Obliga ions), and Appendix 23 (Guidelines for considering exemptions), DHS.0001.0001.1053 (Operation Soteria Plan v3) at 3.6 (Obligations under the Charter), 5.2 (Health and Welfare Standards), Annex 1 (Compliance policy) and Annex 2 (Health and Wellbeing); DHS.5000.0111.3590 (Guidelines for AOs ensuring physical and mental welfare of international arrivals in individual deten ion – unaccompanied minors). See also T.1194-1195 and T 1204-T1205 (Murray Smi h) noting that the rights upon which there was a focus in the guidance material were those which had been identified as most likely to be engaged in the hotel quarantine program.
[886] T1272.27-30. Pam Williams.
[887] Murray Smith Statement, par [57](a)(ii), exhibit to statement DHS.5000.0075.0009 and DHS.5000.0075.0010 – Charter guidance at page 10.
[888] T1206.4-5.

I. Other models

Other models to hotel quarantine for 14 days for all returned travellers

385. Counsel assisting have submitted that mandatory home quarantine, or a hybrid model, would have been less of an imposition on the lives and freedoms of returned travellers.[889]

386. The COVID-19 Accommodation Commanders also both gave evidence that the hotel environment was not an optimal location for quarantine.[890] The use of hotels for quarantine was not a matter over which any part of government had realistic control or alternative options, there being no other realistic options[891] for large scale accommodation of unpredictable numbers of people than hotels, and no bespoke quarantine facilities in Victoria.[892]

387. However, in considering whether any other model was in fact available at the time, there is insufficient evidence before the Board to understand the consequences of such models. Rather, there is evidence that alternatives were considered and were rejected.

388. Further, the Board issued notices to produce to Prof Sutton and Dr van Diemen in which it put numerous questions. The question of consideration of alternative quarantine arrangements was not put to them as questions to be answered. For this reason, the matter was not raised in a way most calculated to assist the Board, and the witnesses were not afforded a full opportunity to address the questions put, which raise complex issues and the need to consider what options may have been appropriate by reference to the state of knowledge about COVID-19 at the relevant time. Notwithstanding, both witnesses gave compelling evidence that they had in fact considered alternatives and rejected them as not being appropriate in the circumstances of the time.[893] Their evidence should be accepted.

Scope of considerations in determining the appropriateness of a 14 day mandatory quarantine period

389. Dr van Diemen gave evidence that in making the Direction and Detention Notice, she gave the matter careful consideration.[894] Her decision gave effect to National Cabinet's policy decision, but was a decision she took pursuant to s 200(1)(a) of the PHWA, which provides for the power to "detain any person or group of persons in the emergence area for the period reasonably necessary to eliminate or reduce a serious risk to public health."

390. Dr van Diemen and Prof Sutton both gave evidence that 14 days was the standard period and was based on advice from the Australian Health Protection Principal Committee (**AHPPC**) and Communicable Diseases Network of Australia (**CDNA**) that 14 days was the incubation period.[895] This evidence is consistent with that of Dr Alpren and Prof Grayson.[896] National Cabinet's decision was that its policy be implemented in across Australia, pursuant to state legislation. Dr van Diemen gave evidence as to the decision to issue the Detention and Direction Notice as follows:

> In making the decision, I took advice about my obligations under the Charter of Human Rights and Responsibilities Act 2006 (Vic) (Charter) and undertook a consideration of the effect of the Direction and Detention Notice on human rights. While the Directions curtailed rights of returned travellers, those rights needed to be weighed and considered in the context of the outbreak of a highly infectious viral pandemic in which there was (and is) no vaccine. At the relevant time, overseas travellers were by far the largest source of infections in Victoria. I was acutely aware of the susceptibility of all Victorians to being infected with the virus if this source was not strictly controlled, and further that a failure to control this source of the virus would have a disproportionately severe effect on certain people (namely, elderly persons and those with poor immune systems). In my view, although I accepted that the limits on rights was a serious matter, I considered those limits to be necessary to protect the health of large numbers of Victorians and prevent significant loss of life.[897]

[889] T2268: 34-38 (Neal); see also T2268: 17-20 (Neal).
[890] Ex 135, Statement of Merrin Barnert, [93]; Ex 130, Statement of Pam Williams, [21]-[23], T1271.37-39 (Pam Williams)
[891] Ms Williams, COVID-19 Accommodation Commander gave evidence accepting that had technology been available to permit people to quarantine at home, but ensure compliance with that quarantine, this would have been desirable and would have reduced the distress of some guests in quarantine. That technology, which being developed in other countries was not available on a mass scale in Australia: Williams statement at [99].
[892] T1271.24-26 (Pam Williams).
[893] T1220.35-44 (Melissa Skilbeck), T1481.27-44 (Professor Brett Andrew Sutton), T1538.11-43 (Dr Annaliese van Diemen)
[894] van Diemen, [34].
[895] See van Diemen at [38] and Ex 15, Statement of Professor Brett Andrew Sutton, [181].
[896] T98.5-20, T99.40-45 (Dr Charles Alpren); T36.5-20 (Professor Lindsay Grayson).
[897] van Diemen Statement at [36]-[37].

391. Dr van Diemen gave evidence that the decision to require mandatory quarantine was a complex decision requiring her to take into account a number of factors,[898] some being very significant public health considerations and others human rights related factors and legal freedoms:[899]

> At that particular time, both Dr Sutton and I agreed with the decision, and Victoria had been obviously party to the National Cabinet decision and in agreement with the National Cabinet decision.[900] […]
>
> "…on balance, at that particular time, the most appropriate thing was to require people to undertake their quarantine in a hotel scenario so that we could be absolutely certain that incoming importations were being contained in the hotel environment rather than having an opportunity to spread into the community with less control."[901] […]
>
> "… I considered this at great length. I was not unaware of the significance of detaining people. However, I was acutely aware that as every day went by, we were seeing cases from countries who in some scenarios had not reported any cases yet, yet we were seeing cases in returned travellers from these countries. If memory serves, at one point Melbourne had more cases from Aspen, Colorado, than Aspen had reported, which just doesn't make any sense whatsoever.
>
> So I was very aware that we could not rely on the reports out of many countries for what the level of infections were in those countries, and that this was spreading incredibly quickly. So therefore we needed to assume that every country at this point in time had significant numbers of infections and that it was taking off slowly in a lot of those countries --- slowly or quickly in a lot of those countries, without it necessarily being detected."[902]
>
> "So, as we discussed, I think that this was necessary to mitigate a very significant public health risk to the community of Victoria and a risk that was unable to be mitigated by other pharmaceutical or vaccination processes, that spread rapidly and had a high, a relatively high mortality rate amongst cases, and for which we had very few other controls and for which there was no real delineation in terms of people being susceptible, that we had an entire population who was susceptible to it."[903]
>
> " … I'm aware that you discussed whether other Chief Health Officers were in agreement. And I suppose in terms of the Victorian situation, it was less relevant to me whether a Chief Health Officer in another jurisdiction was in agreement that this was necessary in their jurisdiction. As the Chief Health Officer of Victoria, Dr Sutton was in agreement that this was a necessary step for Victoria."[904]
>
> "[The Premier and the National Cabinet position] played a part in my decision. Clearly a very large program such as this has very significant policy implications and I think it was important and reasonable that the major elected officials of our State are in agreement with a policy such as this. It wasn't the only factor by any stretch of the imagination, and I, in my consideration as to whether I would sign the order, took it into account but didn't --- it was not the completely driving factor that determined whether I would or wouldn't sign those orders."[905]

392. Prof Sutton's evidence was that the decision to quarantine returning travellers might be considered in the context of the anterior steps taken to reduce transmission risks. These steps began with isolation and social distancing, and subsequently:

> The DCHO (Dr van Diemen) and I came to a common view about how best to take forward the necessary intervention to prevent cases of community transmission. We formed the view that balancing the constraint on liberty, other human rights and other considerations, hotel quarantine was seen as the least restrictive means reasonably available to stem the spread and effect of the COVID-19 virus. At that time, more than 60% of cases in Australia were attributable to international arrivals and quarantine was the most robust way of implementing an effective intervention.[906]

393. Further, Prof Sutton gave evidence that:

---

[898] T1544.25-28.
[899] T1544.30-33.
[900] T1538.7-9 (van Diemen).
[901] T1541.37-41.
[902] T1542.7-25.
[903] T1543.33-38.
[904] T1543.46 – T1544.6.
[905] T15T44.11-17.
[906] Sutton at [95] and [112].

> "I think, given where we were at with the pandemic in Australia, the rapidly rising numbers of cases and the likelihood that control of numbers would get beyond us in a relatively short period of time, it was my view that the initial implementation of hotel quarantine should be for all travellers, especially given the emergent risk in countries where we didn't necessarily see that risk until it arrived on our shores.
>
> You'd be aware that after restrictive travel from mainland China into Australia or a recommendation that all of those from mainland China quarantine at home, countries such as Italy, Iran and South Korea were added to that list, but it took some time for consideration of United Kingdom and the United States. But we did see a number of travellers arriving who were clearly infected in those countries. So one of the considerations about not discriminating with a kind of risk-stratified approach is that it's very difficult to know what's been identified within a country.
>
> Are they testing enough? Had they identified whether there is significant transmission? What we know one week doesn't look the same the following week. So I think, yes, initially, that broad approach to quarantining everyone was certainly one that I supported."[907]

Relevance of AHPPC's position on hotel quarantine

394. The question of the AHPPC's views on the model of hotel quarantine was also a matter of evidence before the Board. Prof Sutton's evidence was that the deliberations of the AHPPC were matters of cabinet-in-confidence for National Cabinet and he was unable to speak to their specific deliberations.[908] The evidence about AHPPC views on the program must thus be assessed by the Board with the recognition that there has not been a waiver by the Commonwealth of its privilege and this placed a restriction on Prof Sutton's ability to speak fully to the deliberations of AHPPC. On 26 March 2020, the AHPPC recommended to governments that the single most important thing that could be done was to stop the capacity for any returning traveller transmitting the virus.[909] That recommendation was made in the context of the following AHPPC statements about measures to minimise the risk of transmission:[910]

(a) on 18 March 2020, that following a recommendation from CDNA, it strongly supported the continuation of a 14 day quarantine requirement for all returning travellers, as the most important public health measure in relation to case importation;[911] and

(b) on 22 March 2020,[912] in response to continued growth in cases from cruise ships, the AHPPC recommended stronger action on enforcement of quarantine and isolation of returning travellers, including to case contacts in quarantine.

395. Prof Sutton's evidence was that the question of hotel quarantine did not come to AHPPC as a specific question in terms of a recommendation to National Cabinet[913] and there was not a formal recommendation made to National Cabinet about it[914] or endorsement of the idea.[915] However, there had been discussions about quarantine within AHPPC prior to the announcement by the Prime Minister on 26 March 2020[916] and Prof Sutton had raised the issue of mandatory emergency accommodation for returning international travellers with the AHPPC in the third week of March 2020, based on the New Zealand model but that idea was not progressed at that time.[917]

396. Counsel assisting took Prof Sutton to the press conference transcript[918] where the Prime Minister announced mandatory quarantine on 26 March 2020. Prof Sutton's evidence was that he was not aware of the program announcement prior to this press conference[919] and that following the announcement, AHPPC met to discuss the matter but there was no agreement or resolution to the

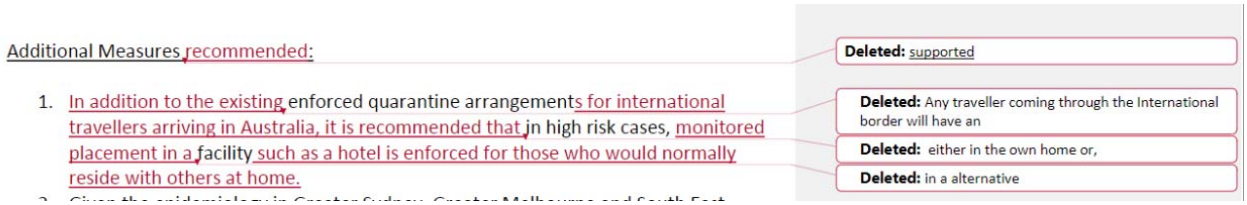
---

[907] T1481.27-44.
[908] T1474.44-46 (Sutton); T1483.44-45.
[909] Sutton at [178]; Exhibit 157, Transcript of Press Conference with the Australian Prime Minister and the Chief Medical Officer, Prof Murphy summarising the recommendations and views of the AHPPC, 27 March 2020.
[910] Sutton at [179].
[911] Sutton at [179(a)] referring to AHPPC Statement, 18 March 2020 published at https://www.health.gov.au/news/australian-health-protection-principal-committee-ahppc-coronavirus-covid-19-statement-regarding-travel-restrictions-on-18-march-2020-0
[912] Sutton at [179(a)] referring to AHPPC Statement, 22 March 2020 published at https://www.health.gov.au/news/australian-health-protection-principal-committee-ahppc-coronavirus-covid-19-statement-on-22-march-2020-0.
[913] T1474.30-1.
[914] T1474.37-8.
[915] T1475.4.
[916] T1476.40-1.
[917] Sutton at [117].
[918] Exhibit 157, Press Conference Transcript, 27 March 2020, HQI.0001.0002.0001.
[919] T1475.36.

effect of National Cabinet's decision.[920] As discussed below, the AHPPC later endorsed hotel quarantine.

397. Counsel assisting took Prof Sutton and Ms Peake to a draft AHPPC document with tracked changes.[921] There is no evidence this draft document was put to AHPPC and Ms Peake's evidence was that she was not sure it had.[922] To the extent the document records a position, the Board should resist making findings that the views were those of Prof Sutton or the DHHS because "There were multiple individuals editing… including Prof Murphy, Ms Peake…" and Prof. Sutton.[923] While the email attaching the document sent by Prof Sutton refers to edits he had made, there is no evidence that those edits were in tracked changes or some other edits in the document. Ms Peake gave evidence that the document moved a lot during a 48 hour period.[924] If the Board is minded to find that the tracked amendments were those made by Prof Sutton, the Board should place little weight on the content because the document is a draft document being prepared potentially for the use in the AHPPC. The tracked amendments show that the words "in high risk cases" have continued unamended.[925] The relevant paragraph, with full tracked changes, is:

> Additional Measures ~~supported~~ recommended:
>
> 1. In addition to the existing ~~Any traveller coming through the International border will have an~~ enforced quarantine arrangements for international travellers arriving in Australia, it is recommended that ~~either in the own home or,~~ in high risk cases, monitored placement in a ~~in an alternative~~ facility such as a hotel is enforced for those who would normally reside with others at home.



398. Prof Sutton's evidence was that the content of the draft AHPPC document recommending that "high-risk cases" be " monitored placement in a facility such as a hotel is enforced for those who would normally reside with others at home." was his preferred position in respect of quarantining of returned passengers[926] at this time and that he was "supportive of the National Cabinet's determination that all returned travellers should be in hotel quarantine."[927] Prof Sutton's evidence should be accepted and is consistent with the decision made by the CHO and DCHO to ultimately give effect to hotel quarantine. While the effect of that decision was to achieve the nationally agreed approach, it was one which the CHO and DCHO agreed was necessary with respect to the balancing of public health considerations with human right and charter considerations.

AHPPC endorsement of hotel quarantine

399. In any event, it appears likely that the views of the AHPPC were at relevant times, in support of hotel quarantine. On 26 June 2020, the AHPPC issued a public statement about Hotel Quarantine recording its recommendation "that all international travellers continue to undertake 14 days quarantine in a supervised hotel" and that there was “not enough data to justify reducing the current need for hotel quarantine”, suggesting a pre-existing view supporting hotel quarantine was held by the AHPPC. AHPPC stated its support for hotel quarantine, in its 26 June statement, in the following strong terms.

> "Since 28 March, Australia has required all incoming travellers to undertake 14 days quarantine in a hotel. AHPPC notes that this measure has been a key part of Australia’s successful response to COVID-19.
>
> AHPPC recommends that all international travellers must continue to quarantine for 14 days after entry into Australia. The risk of COVID-19 in travellers returning from many countries is increasing, reinforcing the importance of quarantine as a protection

[920] Sutton at [176]-[177]; T1477.39.
[921] Exhibit 192, Email from Prof Sutton to Ms Peake, 26 March 2020, DHS.0001.0040.0001, along with the attachment DHS.0001.0040.0002.
[922] T1890.7-8 and T1891.24-25.
[923] T1480.5-6 (Sutton).
[924] T1888.47 – T1889.3.
[925] The nature of the amendments, when read with the other amendments, can be seen to be making the draft paper's position more robust. This is consistent with Prof Sutton's evidence that he supported mandatory hotel quarantine.
[926] T1480.28.
[927] T1480.33-34.

> measure. On the advice of the Communicable Diseases Network Australia (CDNA), AHPPC considered two options:
>
> 1.Reducing the time of quarantine in a hotel for international travellers. This includes most spending part of the time in home quarantine; or
>
> 2.Continuing the current model of 14 day quarantine in a hotel.
>
> **AHPPC considered that there is not enough data to justify reducing the current need for hotel quarantine. AHPPC recommends that all international travellers continue to undertake 14 days quarantine in a supervised hotel."** [928]

400. Prof Sutton gave evidence that the AHPPC determined the 14 day period on the basis that most people would exhibit symptoms or become infected (including without symptoms) within that period given that the median incubation period for the virus is 4.9-7 days.[929] Prof Sutton further explained in oral evidence that the 14 day period is:

> "…because testing cannot tell you that you won't develop symptoms in that 14-day period. If you're tested on day 3 or day 5 or day 7, it can tell you that you haven't developed illness in that seven-day period, which is when the majority of people develop illness, but it won't tell you about the remaining seven days and the 10 or 20 or 25 per cent of people who might still become unwell in that subsequent week. So going the entire 14 days is the only absolute assurance or relatively strong assurance you can have that someone isn't infectious."[930]

Consideration of alternatives

401. Prof Sutton and Dr van Diemen gave evidence both in their statements and in oral evidence as to the measures that were implemented prior to hotel quarantine to limit the spread of COVID-19. Prof Sutton, Dr van Diemen and Ms Skillbeck gave evidence as to their consideration of alternative models to 14 day hotel quarantine.[931] This included adopting a mixture of home based and hotel quarantine and also reducing the length of time.

402. The Board heard evidence that part of the aim for hotel quarantine included significant reductions in the transmission of COVID-19.[932] In Prof Sutton's and Dr van Diemen's views, as expressed above, no other alternative model was considered as robust as hotel quarantine, in terms of its capacity to reduce transmission. Dr van Diemen was asked whether she had considered alternative approaches that would have reduced the number of days and provided for quarantine either in a medi-hotel or at home. Dr van Diemen gave the following evidence:

> So bearing all of those things in mind, there were a number of discussions around potential alternative mechanisms for hotel quarantine, and I think it was prudent that all potential options were considered. It became apparent very quickly that an entire a complete home-based quarantine system would not be feasible simply by virtue of the fact that we were receiving large numbers of interstate arrivals, and again a number of arrivals of individuals or families who had been out of Australia for a long time and therefore didn't have a home to go to. So it became apparent that there would always need to be a degree of hotel quarantine. And so then discussions moved to whether there was any opportunity to implement models that had combinations of people staying in hotels or going to other facilities. Things were considered such as if we were to get large cohorts of returning international students, whether we could look at some of the international student accommodation that may be empty at the time, or people going into home quarantine.
>
> All of this relied on rapid testing of people on arrival, which I believe Ms Skilbeck discussed, and was not going to be available as quickly as we had hoped. And some of this always was contingent on the consideration that we may be required to quarantine larger numbers of people than we were at the time. Again, that hasn't eventuated.
>
> But I suppose the overarching theme is that there were a large number of things being considered across the board, including home-based quarantine and whether there

[928] Sutton at [182] referring to AHPPC Statement, 26 June 2020 published at https://www.health gov.au/news/australian-health-protection-principal-committee-ahppc-statement-on-hotel-quarantine.
[929] Ex 15, Sutton at [181], T1483.09-16 (Sutton).
[930] T1483.11-19 (Sutton).
[931] T1220.35-44 (Melissa Skilbeck), T1481.27-44 (Professor Brett Andrew Sutton), T1538.11-43 (Dr Annaliese van Diemen)
[932] T1482.27.

> was electronic means for compliance and enforcement. Again, we were aware --- and having had, by that point, quite a number of weeks of restrictions --- that a small minority of people, regardless of the fines at hand, were always at risk of not adhering to the quarantine requirements and that therefore there would need to be quite strict compliance and enforcement mechanisms in place; and that again one of the reasons why some of this was not progressed at the time was that those mechanisms were not well developed at the time.[933]

403. Given the consequences of transmission events from one family and two other travellers – the risks relating to thousands of people self-isolating would be considerable; even if - which the evidence does not establish – returned travellers were completely compliant in not leaving home, questions arise about a range of matters including potential deliveries or visitors to the home and how they would be managed where people are unsupervised. Dr van Diemen gave evidence that at that time, it was not possible to consider allowing home quarantine for travellers from some jurisdictions,

> … We considered this at --- I considered this at great length. I was not unaware of the significance of detaining people. However, I was acutely aware that as every day went by, we were seeing cases from countries who in some scenarios had not reported any cases yet, yet we were seeing cases in returned travellers from these countries. If memory serves, at one point Melbourne had more cases from Aspen, Colorado, than Aspen had reported, which just doesn't make any sense whatsoever.
>
> So I was very aware that we could not rely on the reports out of many countries for what the level of infections were in those countries, and that this was spreading incredibly quickly. So therefore we needed to assume that every country at this point in time had significant numbers of infections and that it was taking off slowly in a lot of those countries --- slowly or quickly in a lot of those countries, without it necessarily being detected. …
>
> But we were not in a regular scenario and we were very, very aware of what we were seeing happen in many other jurisdictions and very aware of the epidemiological curve that we were seeing in Victoria and in Australia, and that we were quite literally weeks away from our systems being completely overwhelmed with thousands of cases.[934]

404. Prof Sutton was asked whether he considered if a more tailored, individualised approach should have been adopted. Echoing Dr van Diemen's views, at the time, rapidly rising numbers of cases meant that control measures were going to "get beyond us in a relatively short period of time", so the preferred view was that all travellers should quarantine. This was also because there were emerging risks for travellers from countries where that risk did not materialize under the traveller arrived. So while Australia limited travel from China, Italy, Iran and South Korea, it took some time for the UK and USA to be considered, despite travellers coming from those countries that were infected. Further, it was difficult to confidently discriminate to determine risk without understanding the sufficiency of testing in the country of departure. What was known one week looked different the following week. For these reasons, Prof Sutton supported hotel quarantine for all travellers.[935]

405. Prof Sutton was also asked whether he considered using non-emergency PHWA powers, such as individual public health orders and stated that they were not considered appropriate for a class of persons across an entire state.[936]

406. Prof Sutton was asked whether he had considered invoking powers under the Biosecurity Act 2015 (Cth). Prof Sutton agreed that he had consider the role it might play for international travellers arriving in Victoria but that it has always been applied to individuals and with regard to the assessment of those individuals to the community. The orders that apply under the Act apply for the purpose of managing that individual who might be a risk by virtue of having a listed human disease or being suspected of having that listed human disease and has not historically, and as far as he knows in any other jurisdiction in Australia, applied to a class of persons more broadly.[937] Further, that the Act is intended to apply to ports of entry and to enable transfer of persons to a hospital and that the legal advice he received was that the powers in the PHWA were more appropriate.[938]

---

[933] T1157.37-1156.
[934] T1542.7, 1542.30.
[935] T1481.17-44.
[936] 1462.28.
[937] 1458.39.
[938] T1459.30.

J. Ministerial briefing, and themes of accountability and responsibility

407. One of the submissions of counsel assisting was that the failure of departmental secretaries to keep Ministers informed:

(a) demonstrates an attitude to transparency and accountability that likely manifest in its practices that contributed to problems within the Hotel Quarantine Program; and

(b) likely contributed to a loss in opportunities to identify and address issues which may have prompted better, fuller and more finally action.

408. These allegations are of the utmost gravity, and would if accepted have serious, sustained and significant effect on the individuals against who the allegations are made. A finding to the effect above:

(a) offends the requirements of procedural fairness which, noting the requirements of s 76 of the Inquiries Act, will preclude the making of any findings to the suggested effect;

(b) is not open on the evidence; and

(c) fails to appreciate the legal and conventional framework in which the relationship between departmental heads and ministers operates.

Procedural fairness

409. Taking first the considerations of procedural fairness, in a situation where witnesses before the Board do not have the option to call evidence of their choice but are compelled to provide witness statements on various issues (Ms Peake relevantly having done so many weeks before her evidence), it could be expected that any important matters would be raised in the questions identified for her statement, to enable the most complete information to be put before the Board. In relation to ministerial briefing and accountability to the Minister, Ms Peake was asked no such questions.

410. Certain matters were raised in cross-examination (referred to further below). Raising matters for the first time in cross examination may produce a forensic advantage for the cross examiner, and may be appropriate in an adversarial environment. However it is unlikely to provide the best forum for the Board to hear all relevant evidence on the issues, and does not constitute a proper opportunity to respond to allegations which may result in adverse findings.

411. To this end, it was not put to Ms Peake that she had failed to discharge her obligations and duties of office, nor that she had an unsatisfactory attitude towards transparency and accountability[939]. Counsel assisting raised certain matters as to how Ms Peake briefed the Minister but did not establish with any clarity, or at all, what he submits "responsible Government"[940] (the term relied on in submissions) requires, nor identify in any meaningful way what it means for Secretaries to be accountable[941]. For a submission now to apparently to have been made of a failure to discharge an obligation which rested upon Ms Peake amounts to a most serious departure from obligations of procedural fairness.

The wider context

412. The *Public Administration Act 2004* s 12 provides that each Department shall have a Departmental Head.[942] Section 13 provides:

> *A Department Head is responsible to the public service body Minister or Ministers for the general conduct and the effective, efficient and economical management of the functions and activities of—*
>
> *(a) the Department; and*
>
> *(b) any Administrative Office existing in relation to the Department—*
>
> *and must advise the public service body Minister or Ministers in all matters relating to the Department and any such Administrative Office.*

413. In the day-to-day operation of the DHHS , secretaries will escalate key operational matters to ministers, for example those that are high risk, complex, or are otherwise a government priority.

---

[939] T2261.42-44 (Closing submissions by Mr Ihle)
[940] T2262.26-29 (Closing submissions by Mr Ihle); T2268.45-T2269.1 (Final closing submissions by Mr Neal QC)
[941] T2268.46.
[942] The Secretary to DHHS is such a Department Head: *Public Health and Wellbeing Act 2008* s 3(1) definition of 'Secretary'.

However, if all operational matters were escalated to ministers, the sheer volume of information would overwhelm their capacity to focus on strategic and policy responsibilities.

414. Secretaries draw on their considerable operational and public administration experience and expertise when deciding when to inform and when not to inform – but this is ultimately a judgement call that must take into account a range of considerations that are not always clear cut. Key considerations may include whether the operational issue has been resolved by the DHHS, its importance relative to other priorities at any given time, and whether the minister has previously been advised on as issue in response to which they have expressed a view.

415. This is a significant observation in the context of this Inquiry in so far as it highlights an area of decision making that is highly sensitive to context.

The circumstances of the pandemic

416. The evidence is that ordinarily the Secretary to DHHS reports to five ministers, and from 3 April 2020 took on the role of Mission Lead Secretary — Health Emergency which reported directly to the Premier.[943] This was all in the throes of the most serious health emergency of the past century. The practical opportunity to brief the Premier about relatively specific matters under the DHHS portfolio was understandably limited, given the multiple demands on the Premier's time then as now. These contextual matters should be considered by the Board, the conduct cannot be viewed without the light of the immense pressure and demands placed upon the Secretary.

417. Ms Peake in her evidence accepted that one of her responsibilities was to keep Ministers informed of significant issues within their portfolio.[944] Ms Mikakos, unsurprisingly, agreed with this, noting that as a Minister she dealt with high-level policy and funding issues,[945] and that:

> *I think there is a judgement call that needs to be made in any particular instance about the types of things that get escalated to a Minister. There are, sadly, incidents that happen from time to time, whether they're in the Hotel Quarantine Program or in a health service, and they're actioned in an appropriate way. They're not always escalated to a Minister.*[946]

418. The Minister herself disagreed with Counsel Assisting that other matters not brought to her attention should have been.[947]

419. There has been frequent engagement by Ms Peake with the Premier, the Minister, the Minister's office, with the CCC and with the Premier's Private Office throughout the pandemic, including about the hotel quarantine program. For example, as at 4 October 2020 there have been 86 CCC meetings (since 6 April 2020), involving 410 submissions across the whole of government. Of these, 166 submissions have been led and/or lodged by the Secretary on behalf of DHHS (which accounts for approximately 40% of the overall number). The Minister's office (and the PPO and frequently the CCC) were briefed numerous times a day by Ms Peake, both formally and informally. Had Ms Peake been asked about the overall level of engagement and her broad approach to providing transparency to Ministers and taking accountability for the department she leads, she could have informed the Board about this overall picture. It is simply not accurate to say that there was a lack of transparency or accountability in the way that the Secretary to the Department approached the manner in which the hotel quarantine program was undertaken.

Specific Issues

420. It is accepted that the Minister agreed in examination by Counsel Assisting to some limited matters that she had not been briefed by Ms Peake about in respect of hotel quarantine, being the operational structure,948 the lines of responsibility,[949] issues raised in the 9 April 2020 email950 or that there had been two Safer Care Victoria reports commissioned that were not provided to her.951 Whilst she agreed that these limited matters were not briefed to her, she did not agree that each of them should have been briefed to her. She was not asked if they should. The Minister instead sought to explain why she believed she was not briefed, being that her:

> … understanding of how the program was operating was that there was a coordination role by DHHS working together with the State Control Centre, bringing all of those departments

[943] T1909.4 – 42 (Peake).
[944] T1965.29 – 32 (Peake).
[945] T2053.35 – 45 (Mikakos).
[946] T2078, 12-14.
[947] T2101.15 – 45; T2104.15 – T2105.6 (Mikakos).
[948] T2085.18.
[949] T2085.23.
[950] T2085.28.
[951] T2085.33; T2085.38.

and agencies which we've referred to, which are referred to in the CCC sub. That also makes reference to the State Control Centre and all of those agencies working together.[952]

421. It was hardly remarkable the Minister was not briefed on these matters in the context of the State of Emergency: they were an application of the pre-existing emergency management framework referred to above in accordance with long-standing plans under the EM Act, SERP and SHERP.

422. Whilst the COVID-19 emergency and its effect on those affected by it was undeniably significant, the Minister for Health did not play an operational role in the emergency,[953] and would not ordinarily sign off on an operational plan.[954] There was no reason to expect the Minister to be separately briefed on the operational plan, and in particular one which was in constant development and version replacement as time progressed.[955] Indeed, Ms Mikakos expressly said so herself, in response to cross-examination by Counsel for Unified Security Group (Australia) Pty Ltd.[956] The high level arrangements regarding Operation Soteria, including roles and responsibilities, were also matters regarding which the Minister (and other Ministers) was made aware via submissions to the CCC and numerous verbal briefings provided by Ms Peake to the Minister and the Minister's office. It was in that sense a routine operational response to an emergency. Had the transmission events not led to the significant outbreak that it did, no one would have questioned that any Minister was not briefed on a purely operational plan.

423. Counsel Assisting questioned Ms Peake about briefing the Minister (for Health and Human Services) or Premier about concerns raised by members of Public Health Command about Operation Soteria,[957] and also about the Safer Care Victoria reports.[958] It was not put to Ms Peake in relation to any of these issues that she failed to discharge an obligation which rested upon her, which amounts to a most serious departure from obligations of procedural fairness.

424. In relation to the concerns of members of the Public Health Command, these were rapidly addressed immediately after Mr Romanes' email, as part of the rapid issue resolution and program improvement activity underway in the first 2-3 weeks of Operation Soteria. As such, there was nothing remarkable about the Minister not being briefed on concerns and their rapid resolution within the administration and operations of the DHHS. Indeed, open discussion and challenge followed by rapid resolution is a hallmark of effective operational management. The evidence before the Board showed that in fact there had been an immediate response to Mr Romanes' request by the State Controller;[959] those concerns had been rapidly considered, and addressed including by the appointment of a Public Health Liaison Officer and incorporation in to the Operation Soteria plans.[960] Dr van Diemen was involved in a "series of meetings that occurred almost daily for the following several weeks, and then less frequently after that", attended by her, Dr Romanes and other members of the team, who "continued to have ongoing in the development of further iterations of what began as the health and wellbeing section of the Operation Soteria plan."[961] That evidence was referred to in the witness statement of Dr van Diemen, and although not the subject of questioning by counsel assisting, it was the subject of re-examination,[962] and Dr Romanes in his statement also gave evidence as to his involvement in a meeting on 10 April and subsequent involvement in reviewing the operating plan.[963]

425. In relation to the submission made about failure to brief the Minister about reports of Safer Care Victoriait is accepted that the Minister gave evidence that there had been two Safer Care Victoria reports commissioned that were not provided to her.[964] Importantly, beyond clarifying with Ms Peake that she did not provide the reports and why:

(a) Ms Peake was not asked, and was not given the opportunity to confirm to the Board, that she briefed the Minister's office about each of the incidents, including for example the provision of incident reports on 13 April to the offices of both the Minister for Health and the Minister for Mental Health;

---

952 T2086.3-7.
953 Ibid.
954 T2071.21 – 26 (Mikakos).
955 The statement of Pamela Williams contains the four versions of the plan effective from 28 March 2020 (v 1) across version 2, 26 April 2020 (DHS.5000.0079.0865), Version 2.1 of 8 May 2020 (DHS.0001.00008.0517) to version 3 of 26 May 2020 (DHS.0001.0001.2245).
956 T2101.15 – 45 (Mikakos).
957 T1977.9 – 34.
958 T1995.18 – 34.
959 Statement of Anneliese van Diemen, exhibit 160, at [68]. See also email 10 April 2020 State Controller Health to Finn Romanes and Anneliese van Diemen referred to at [68] and fn 25 of the Statement.
960 Statement of Anneliese van Diemen, exhibit 160, at [68]. See also draft Operation Soteria plan provided to Dr Van Diemen referred to at [68], fn 26: DHS.5000.0053.6652 attaching DHS.5000.0053.6655;
961 T 1562.10-26 (van Diemen).
962 T1561. 42 --1562.8 (Van Diemen)
963 Statement of Finn Romanes [86]-[87].
964 T2085.33; T2085.38.

(b) Ms Peake was not asked, and was not given the opportunity to confirm to the Board that she briefed the most relevant Ministers' offices at the time that each Safer Care review was commissioned, including for example a conversation with the relevant Ministerial office;

(c) Although put to Ms Peake that she did not brief the Minister on the SCV reports it was not put to her by counsel assisting that she should have briefed the Minister at the time that the reports were received and that she was remiss in not doing so; and

(d) for a submission now to apparently to have been made of a failure to discharge an obligation which rested upon Ms Peake amounts to a most serious departure from obligations of procedural fairness and the meaningful right of response in s 76 of the *Inquiries Act*.

426. Secondly, in relation to the Safer Care reports received by Ms Peake, she received those by 10 June,[965] or perhaps 17 June.[966] Recalling that by 8 July 2020 DJCS had assumed responsibility for the Hotel Quarantine Program, and that by mid-June discussions about those transitions in role and responsibilities had already commenced, briefing the Minister for Health about those reports would have made little to no difference to the operation of the Hotel Quarantine Program, or any other shortcomings both real or imagined. Later in her evidence Ms Mikakos noted that Ms Peake had passed the reports to the Secretary to DJCS as the responsibility for the Hotel Quarantine Program had passed to that Department.[967] It is, however now accepted that it is appropriate for a practice now to be adopted that future SCV final reports should be provided to the Minister as soon as practicable after they are finalised.

427. We make the final observation that it is not necessary or appropriate for Departmental Heads to routinely advise their Ministers about matters outside their department, including whole-of-government matters. On this aspect, the Royal Commission on Australian Government and Administration said:

> While we recognise the need of ministers to look for briefing on many matters, we set ourselves firmly against any arrangements which would lead to substantial additions to the staff of departments simply to provide each minister with information and comments on proposals submitted by his colleagues, where these are not of direct relevance to the work of his own department. That is wasteful of resources and leads to a build-up in departmental capacity that may well not be needed by the next minister.[968]

428. The assertion by counsel that these matters should have been brought to the attention of the Minister may, with respect, be affected by the perfect clarity of hindsight, rather than the circumstances as known at the time. Had appropriate evidence been adduced on this issue, there would have been extensive evidence of the Secretary and other senior officials engaging with Ministers, their offices and Cabinet, raising issues and seeking decisions and guidance, at an astonishing frequency and pace throughout the pandemic. For such a serious allegation to be made without according procedural fairness is of the greatest concern and the Board is strongly urged to reject such a submission.

Ombudsman response

429. In closing submissions, when addressing the Board with respect to responsibility and accountability, counsel assisting asserted that the conduct of those involved in implementing and operationalising the Hotel Quarantine Program raised concerns as to '*their attitudes to transparency and accountability in general*'.[969] This submission inevitably is directed to individuals involved in the program, including those who gave evidence.

430. Counsel assisting relied, when making that submission upon three matters, the first of which was following example:

> …. in its response to a complaint about fresh air raised with the ombudsman, the DHHS misquoted the extant policy. The policy in existence at the time of the that response provided, amongst other things, that:
>
> Individuals in mandatory quarantine should be allowed one hour of suitable exercise or leisure time in open air daily, where it can be safely and practically implemented at the hotel, weather permitting, taking into account infection control and physical distancing precautions.[970]

[965] T2013.28 – 39 (Peake).. Ex 186, statement of Kym Peake, 14 August 2020, [206], DHS.9999.0009.0001.
[966] T2014.6 – 9 (Peake).
[967] T2078.40 – T2079.10 (Mikakos).
[968] Ibid, 4.1.5.
[969] T2260.15-20 (closing submissions).
[970] T2260.20 -35.

431. It was submitted by counsel that this section of the policy was omitted from the Department's response to the ombudsman "for reasons that were not convincingly … or completely explained". This was apparently a reference to questions put by counsel assisting in cross examination of Ms Skilbeck. That cross examination, and the closing submission was, however unfortunately based on an incorrect proposition – the policy quoted in closing submissions and relied on in cross examination was not in existence at the time of the response to the Ombudsman.[971] Counsel assisting (no doubt entirely inadvertently) referred to and relied on a later version of the policy, rather than the version of the policy which existed at the time.

432. DHHS's response to the Ombudsman to which counsel assisting refers was sent by email dated 15 May 2020.[972] The response quotes a paragraph that was extracted from "Annex 3.2, Health Standards" which was included in Version 2.1 of the Operation Soteria Plan (current at 8 May 2020).[973] The policy quoted by counsel assisting was from a draft of version 2.0 of "**Annex 2**, Health and Wellbeing" which was provided to Dr Garrow on 21 May 2020 and included in version 3 of the Operation Soteria Plan. Version 3 of the Operation Soteria Plan was not introduced until 26 May 2020[974] (11 days after the response in question) and version 2.0 of Annex 2 was not introduced until 1 June 2020.[975]

433. The issue relating to the email to the Ombudsman was raised for the first time in cross examination of Ms Skilbeck – while the response was an annexure to her witness statement,[976] it was certainly not apparent from the questions she was asked to address that this issue would be raised in cross examination, and given the complexity of recalling particular versions of documents quoted it was unsurprising that Ms Skilbeck said, in response to a question as to "why the reference to individuals in mandatory quarantine should be allowed one hour of suitable exercise or leisure time in open air daily formed no part of your response to the Ombudsman", was "I'm not aware that it didn't. I thought we had appended the standard as it applied at the time to our response to the Ombudsman in full."

434. The third of the matters raised in support of the contention that as to concerns as to "attitudes to transparency and accountability in general" was:[977]

> …the Department had a view, expressed in an email which was tendered before the Board, that the Government helpline established by the DJPR ought not proffer advice to detainees that they reach out to parliamentary representatives to raise concerns about their treatment.

435. Although not clearly identified in closing submissions, this is apparently a reference to an email raised in the cross examination of Merrin Bamert about a complaint raised by the office of Police Minister Lisa Neville.[978] The email itself is not in evidence, and was not to our knowledge tendered. When Ms Bamert was asked if she remembered the details of the complaint, she answered "Vaguely, but yes" and was asked if she recalled responding saying "that was not appropriate at all" and said it would be necessary to "bring up the email" although it would be necessary to be "careful about the contents of that email in relation to someone's privacy". She agreed that she had responded "via email saying it was not appropriate at all", and when asked why responded:

> You know, there are two vague recollections, you might need to bring it up for me, but one is it's not appropriate to ring local Members. There should be internal mechanisms, which we 5 do have in place, where they could either go to the team leader, or the person could speak to the nurse about their particular concerns, and then we could address the needs of that person, and rather than their own health and safety being risked by them taking an overdose of medication, which would be completely awful and inappropriate, we would much rather them address their needs and support them with 10 both a nurse assessment and, if required, an escalation of that treatment to our triage service or a physical assessment at the hospital as required. To just

---

[971] Contrary to the understanding of counsel assisting who told Ms Skilbeck she had been shown ":the health and wellbeing standards that applied to the Hotel Quarantine Program from 8 May": T1232.29-30; she is then asked about them on the following page of transcript, stating hat the response was provided "one week after this policy had been proliferated and adopted": T1233:16-19. The relevant part of the document at WIT.0001.0031.0052 commenced on page 3 and is titled "Annex 2 – Health and Wellbeing" and commences It was exhibited to the statement of Dr Stuart Garrow at [16(c)] as the Quaran ine Health and Welfare Standards he received by email on 21 May 2020. The first two pages of Annexure 5 to Dr Garrow's statement are titled "5. Health and Welfare" being section 5 of Version 2.1 of the Operation Soteria Plan dated 8 May 2020. Pages 3 to 20 are he Health and Wellbeing Standards (undated). See WIT 0001.0031.0052 at 0054.

[972] DHS.0001.0001.0040; aRachaele
panying Email: DHS.0001.0001.0037; Annexure 126, Department of Health and Human Services response to enquiries from the Victorian Ombudsman under section 13A of the *Ombudsman Act 1973*.

[973] The draft policy had not been tendered (noting hat DHHS was not on no ice of counsel's intention to make a submission based on the response to the Ombudsman, nor of the misapprehension with respect to the versions of the policies. However, it was contained within Version 2.1 of the Operation Soteria Plan (current at 8 May 2020 (DHS.0001 0008.0517), paired with 'Annexures 3.2 – Health Standards').

[974] Exhibit 163, DHS. DHS.0001.0001.1053

[975] Exhibit 126, DHS.0001.0001.2245, Annex 2 – Health & Wellbeing, V2.0 1 June 2020.

[976] Exhibit 125, Witness statement of Melissa Skilbeck, [129]; Exhibit 126, attachment: DHHS0001.0001.0040.

[977] T2260: 34-38 (Ihle).

[978] T1314.20.26.

> direct someone to a GSSS or to your MP is not an appropriate response. There is a more timely response that this particular guest would have required.[979]

436. This does not constitute an answer which could properly be characterised (as it was in closing submissions) as evidencing that the "Department had a view… that the Government helpline established by the DJPR ought not proffer advice to detainees that they reach out to parliamentary representatives to raise concerns about their treatment." It was, as explained clearly in Ms Bamert's evidence, an expression of a view that it was inappropriate to refer people with specific medical or welfare needs to an MP rather than first to refer them to the internal mechanisms available to have the matter escalated to nurses or the triage service and if necessary a hospital. Further, despite the request of the witness, the email was not shown to her, which precluded a proper opportunity to respond.

437. Counsel assisting's submission on this issue was unfair to the witness. Nor does it provide support for the broader proposition put by counsel assisting, referred to above, that "the conduct of those involved in implementing and operationalising the Hotel Quarantine Program raised concerns as to '*their attitudes to transparency and accountability in general*'.[980]

Closing Observation

438. In closing, DHHS wishes to reiterate that it accepts that there were issues that arose in the course of this complex program, which were responded to as those involved in its operation identified the issues and the opportunities for improvement in response. DHHS refers to the evidence of Ms Peake in response to the proposition in cross examination that the deficiencies in the program were because DHHS did not discharge the functions that had been provided for in the Operation Sotera Plan:

> It is a matter of profound regret to me as the Secretary of the Department of Health and Human Services that we experienced a second wave in Victoria and all of the consequences that came with that. But I know that my staff and the staff of DJPR spent thousands and thousands -- hundreds of hours seeking to prevent that outcome. I know that there was enormous care and diligence, it wasn't perfect but there was enormous care and diligence to continually address risks as they arose and I am of the view that the control structures that were in place were appropriate. There are absolute lessons and improvements to take but the way that you put that proposition to me, I could not accept.[981]

MinterEllison
Solicitors for the Department of Health and Human Services
5 October 2020

[979] T1315.1-14 (Bamert).
[980] T2260.15-20 (closing submissions).
[981] T2029.35-44.

Comparison between Mandatory Quarantine Health and Welfare Plan and Operation Soteria Plan

The table below identifies in summary form where matters addressed in Dr Romanes' 18 April 2020 draft Mandatory Quarantine Health and Welfare Plan[1] have been incorporated into Operation Soteria v 3 Annexes.[2]

Issue in Health & Welfare Plan	Where that issue is set out in the Operation Soteria Plan v 3.0
Provision of healthcare	
Medical care (p 8).	Annex 2 – Health & Wellbeing, Criterion 3.1 Meeting the needs of people in mandatory quarantine (p 92).
Pathology and pharmacy services (p 9).	Annex 2 – Health & Wellbeing, Criterion 3.2 Provision of on-site clinical services (p 92).
Pharmacy arrangements and prescriptions (p 9).	Annex 2 – Health & Wellbeing, Criterion 3.4 Provision of pharmacy and pathology services (p 95).
Prescribing benzodiazepines (p 9).	Annex 2 – Health & Wellbeing, Criterion 3.2 Provision of on-site clinical services - Prescribing benzodiazepines/anxiolytics (p 92).
Pathology arrangements (p 9).	Annex 2 – Health & Wellbeing, Criterion 3.4 Provision of pharmacy and pathology services (p 95).
Nursing Care (p 10).	Annex 2 – Health & Wellbeing, Criterion 3.2 Provision of on-site clinical services (p 92).
Mental health care (pp 11–13)	Annex 2 – Health & Wellbeing, Criterion 3.2 Provision of on-site clinical services (p 92).
Emergency services (p 13).	Annex 2 – Health & Wellbeing, Criterion 3.2 Provision of on-site clinical services (p 92).
Transport to/from hospital (pp 13–14).	Annex 3 – COVID–19 Operational guidelines for mandatory quarantine, 7. Transport of COVID-19 positive, close contact and other guests (p 123).
Anaphylaxis (pp 14–15).	Annex 2 – Health & Wellbeing, Standard 6. Allergies and dietary requirements (p 99).
Provision of welfare	
Airport Screening (p 16).	Annex 3 – COVID–19 Operational guidelines for mandatory quarantine, 2.1 Airport screening and assessment of immediate health and wellbeing risk factors (p 115).
Management of an unwell person at the airport (p 16)	Annex 3 – COVID–19 Operational guidelines for mandatory quarantine, 2.3 Management of an unwell person (Suspected or positive COVID-19) and 2.5 Management of an unwell person (not COVID-19) related (p 115).
Transfer of uncooperative individuals (p 16).	Annex 3 – COVID–19 Operational guidelines for mandatory quarantine, 2.4 Refusal of testing (p 117).
Assessment at the hotel (p 16).	Annex 2 – Health & Wellbeing, Criterion 2.2 Schedule for screening (p 89).
Initial information on options for accommodation (p 17).	Annex 3 – COVID–19 Operational guidelines for mandatory quarantine, 3. Quarantine and isolation arrangements (p 117).
Assessment during detention (p 17).	Annex 2 – Health & Wellbeing, Criterion 2.2 Schedule for screening quarantine (p 89).
Tiers of risk for people in mandatory quarantine for welfare checks (p 18).	Annex 2 – Health & Wellbeing, Criterion 2.5 Risk assessment and follow up of persons 'at risk' (p 90).
Requirement for a welfare check (p 18).	Annex 2 – Health & Wellbeing, Criterion 2.2 Schedule for screening, Criterion 2.3 Methods of screening and Criterion 2.4 Staff undertaking screening (p 89).
Smoking (p 18).	Annex 2 – Health & Wellbeing, Criterion 4.1 Smoking (p 96).
Fresh air and exercise (p 19).	Annex 2 – Health & Wellbeing, Criterion 4.2 Fresh air and Criterion 4.3 Exercise (p 97).
Alcohol and drugs (p 19).	Annex 2 – Health & Wellbeing, Criterion 4.4 Alcohol and drugs (p 97).

[1] The Mandatory Quarantine Health and Welfare Plan, 18 April 2020, is DHS.5000.0110.7943 [Ex 114, statement of Dr Finn Romans [40]; Ex 160, statement of Annaliese van Diemen [79]].

[2] The Operation Soteria Plan v 3, DHS.0001.0001.1053, comprises: Annex 1 – COVID-19 Compliance Policy and procedures – Detention authorisation outlines the respons bilities of Authorised Officers at ports of arrival and hotels; Annex 2 – Health & Wellbeing Standards and Annex 3 - COVID–19 Operational guidelines for mandatory quarantine [Ex 122, statement of Murray Smith [57] and [110(a)(iv)]; Ex 162, statement of Andrea Spiteri [33]; Ex 160, statement of Annaliese van Diemen [27], [29], [42], [113]; Ex 130 statement of Pam Williams [20]].

Issue in Health & Welfare Plan	**Where that issue is set out in the Operation Soteria Plan v 3.0**
Nutrition and food safety (including allergies) (pp 19 – 20).	Annex 2 – Health & Wellbeing, Standard 6. Allergies and dietary requirements (p 99).
Care packages (p 20).	Annex 2 – Health & Wellbeing, Criterion 3.3 Provision of welfare services (p 94). Annex 3 – COVID–19 Operational guidelines for mandatory quarantine, 11. Hotel delivery policy and acceptance (p 124).
Safety and family violence (p 20).	Annex 2 – Health & Wellbeing, Criterion 2.1 Health and welfare risk factors (p 89) and Criterion 3.3 Provision of welfare services (p 94).
Social and communications (p 20-21).	Annex 2 – Health & Wellbeing, Criterion 3.3 Provision of welfare services (p 94).
Requests for exemption from mandatory quarantine (p 21).	Annex 2 – Health & Wellbeing, Criterion 1.1. Charter of Human Rights and Responsibilities (p 87). Annex 1 – Detention Compliance and Enforcement, 5 Exemptions (p 47).
Negative permission/exemption outcomes (p 21).	Annex 1 – Detention Compliance and Enforcement, 6 Permissions (p 51).
Temporary leave from mandatory quarantine (pp 21–22).	Annex 1 – Detention Compliance and Enforcement, 6 Permissions (p 51).
Assessment in preparation for exit (p 22).	Annex 1 – Detention Compliance and Enforcement, Chapter 4.8 Departure – Release from mandatory detention (p 44). Annex 3 – COVID–19 Operational guidelines for mandatory quarantine, 17.2.1 Release from detention of a confirmed case.
Infection control and hygiene.	
COVID floors/ hotels (p 22).	Annex 3 – COVID–19 Operational guidelines for mandatory quarantine, 4.3 COVID-19 positive hotels (p 119).
PPE (p 22).	Annex 2 – Health & Wellbeing, Criterion 5.1 Personal protective equipment (PPE) (p 97).
Laundry (p 22).	Annex 2 – Health & Wellbeing, Criterion 5.3 Laundry (p 98).
Cleaning (p 23).	Annex 2 – Health & Wellbeing, Criterion 5.2 Cleaning and waste disposal (p 98).
Room sharing (p 23).	Annex 2 – Health & Wellbeing, Criterion 5.4 Isolation protocols (p 98).
COVID 19 in people in mandatory quarantine.	
Actions for confirmed cases (p 24).	Annex 2 – Health & Wellbeing, Criterion 5.4 Isolation protocols (p 98). Annex 2 – Health & Wellbeing, Case and contact management (p 111).
Release from isolation (p 25).	Annex 2 – Health & Wellbeing, Isolation and exit arrangements (p 112).
Exit planning for individuals with confirmed COVID-19 (p 26).	Annex 1 – Detention Compliance and Enforcement, 4.8 Departure – release from mandatory detention (p 44). Annex 2 – Health & Wellbeing, Isolation and exit arrangements (p 112). Annex 3 – COVID–19 Operational guidelines for mandatory quarantine, 17.2 Process for release from detention of a confirmed case (p 126).
Reporting / escalating concerns.	
Clinical escalation (p 28).	Annex 1 – Detention Compliance and Enforcement, 4.5 Emergency health and welfare incidents (p 42). Annex 2 – Health & Wellbeing, Criterion 3.2 Provision of on-site clinical services (p 92). Appendix 4, DHHS COVID-19 Quarantine – incident reporting (p 26).
Escalation for Mental Health concerns (p 28).	Annex 1 – Detention Compliance and Enforcement, 4.5 Emergency health and welfare incidents (p 42). Annex 2 – Health & Wellbeing, Criterion 3.2 Provision of on-site clinical services (p 92).
Escalation for medical reasons (p 29).	Annex 1 – Detention Compliance and Enforcement, 4.5 Emergency health and welfare incidents (p 42). Annex 2 – Health & Wellbeing, Criterion 3.2 Provision of on-site clinical services (p 92).
Daily health and welfare report to Public Health Commander (p 30).	Annex 2 – Health & Wellbeing, Standard 8. Health and welfare reporting to the Public Health Commander (p 102).