STATE OF VICTORIA
***Inquiries Act 2014* (Vic)**
BOARD OF INQUIRY
INTO THE COVID-19 HOTEL QUARANTINE PROGRAM

SUBMISSIONS OF MSS SECURITY PTY LTD

TABLE OF CONTENTS

A. INTRODUCTION **2**

B. MSS SECURITY PTY LTD - BACKGROUND **3**

C. SUBMISSIONS **4**

TOPIC 1: The decisions and actions of Government agencies involved in implementing the Program (see Term of Reference 1) **4**
- *Emergency Management Commissioner* 5
- *Control Agency* 5
- *Public Health and Wellbeing Act 2008 (Vic) Delegation* 7
- *Consequences of structure - Mix of decision-makers and Decision to engage private security* 7

TOPIC 2: The contractual arrangements and related discussions, between the DJPR and MSS, and between MSS and its subcontractors (see Term of Reference 3) **13**
- *DJPR contracting arrangements* 13
- *MSS subcontracting arrangements* 17
- *The speed with which the Program was established and the implications upon MSS* ... 20

TOPIC 3: The information, guidance, training and equipment provided to MSS, whether such guidance or training was followed, and such equipment properly used (see Term of Reference 4) **21**

TOPIC 4: The policies, protocols and procedures applied by Government agencies (see Term of Reference 5) **27**
- *New and reviewed policies during the Program - the Government perspective* 28
- *New and reviewed policies during the Program - the MSS perspective* 31
- *Other infection-control policy and procedure changes* 34
- *Onsite experience of changing policies - hotels* 38

TOPIC 5: Communications between Government agencies, hotel operators and MSS relating to COVID-19 testing, symptomatic guests and positive results (see Term of Reference 2) **39**
- *Stamford Outbreak* 46

TOPIC 6: Any other matters (Term of Reference 6) **47**
- *Alternative operational models for quarantine in other States* 47
- *MSS reflections upon the Program and recommendations for future improvement* 48

A. INTRODUCTION

1 The Coronavirus has created a global health crisis like no other in our lifetime. It has crossed international boundaries. It has disrupted the world as we know it. Above all, it has caused tragic and devastating loss of life. Our thoughts are particularly with the families who have lost loved ones. While pandemics are rare events, it is precisely because of their potential for such widespread catastrophe, that preparedness, risk communication plans, an appropriately trained health workforce and infection control prevention strategies, supported by adequate foundational structures, are vital. In establishing the Victorian COVID-19 Hotel Quarantine Program (the **Program**) the government had one job: to prevent COVID-19 being transmitted from infected overseas travellers into the Victorian community. It failed. These failures meant that the Program created the very circumstances it was intended to prevent - an outbreak of COVID-19 across the state.

2 MSS Security Pty Ltd (**MSS**), one of the security contractors engaged in the Program, accepts and endorses the overarching conclusions drawn by Counsel Assisting in their closing submissions.

3 A failure of a complex system is often attributable to a similarly complex set of circumstances. This case is no different: ultimately no single shortcoming or oversight led to the Program's failure. These submissions address the Program's failings and the major implications it had for those detained in hotel quarantine and for those working at the frontline, having regard to the Terms of Reference.[1]

4 From the outset the decision to use private security was not a decision at all, nor was it made by one person or body with ultimate accountability for it. It was, as described by Counsel Assisting in closing submissions, the eventuality of a series of "creeping assumptions".

5 The Program was heavily focused on mass logistics and enforcement directed at restricting the movement of detainees. The very real health consequences facing both the detainees and those working within the Program (including private security), were simply not front and centre as they properly ought to have been. The Victorian Department of Health and Human Services (**DHHS**) - a Department with specific public health expertise and experience - having been appointed the control agency for a human disease emergency - did not discharge its paramount duty and obligation to the Victorian community to ensure the virus was contained. The Program that the community might have hoped for, was not the Program that eventuated.

6 First, there was a lack of preparedness by all levels of government for a pandemic of this scale and severity. This translated into a lack of an appropriate structure for the Program. It also resulted in a lack of appropriately qualified people to manage the Program and inadequate operational resources at the frontline.

[1] See Order in Council, 2 July 2020, Responsible Minister: The Hon. Daniel Andrews MP, Premier, Signed by C Chisholm, Clerk of the Executive Council.

7 Second, there was a lack of appreciation of the nature and level of risk posed by COVID-19 transmission to security staff and all personnel working within the Program, notwithstanding that such risk was known by the DHHS by late March 2020.

8 Third, communication structures were inadequate. Information about COVID-19, its likely modes of transmission, and how to prevent the risk of its spread, was largely absent or not shared. Communication protocols between Government agencies and personnel working at the hotels, were not attune to the importance of sharing COVID-19 test results. Similarly, the identity of symptomatic guests, or those awaiting results, were not disclosed to security personnel - the very people who were at the frontline and interacting with such guests on a day-to-day basis. Strict isolation protocols were not triggered until a guest returned a positive COVID-19 result. Communication of critical information by the DHHS to security personnel, concerning the safety of detainees and personnel working within the Program, was inadequate, infrequent, and not given the primacy it required.

9 Fourth, policies and procedures concerning infection control measures changed frequently, were inconsistently disseminated and were confusing in their execution.

10 Fifth, the DHHS provided no specialist training in infection control measures and the use of PPE until after the outbreaks at the Rydges and Stamford had occurred.

11 Sixth, cleaning practices were woefully inadequate and inconsistent across the Program, having regard to the virility of COVID-19.

12 Seventh, the standard and facilities of hotels used for the Program were not always sufficient, appropriate of fit for the purposes of the Program.

13 Finally, the duties security personnel were required to undertake during the Program changed regularly, and extended well beyond that which could reasonably have been anticipated.

14 Together, these were all critical factors which ultimately contributed to the spread of the virus both within the hotels, and eventually to the community.

15 MSS commenced its service delivery in the Program believing it would be organised, thought-out and underpinned by clear policies and procedures, and an identifiable governance structure. This was not to be, rather MSS was required to operate under challenging circumstances, in a system which was critically flawed in its design, methodology and lack of expert health-focused oversight. Nevertheless, the overarching theme of every interaction and involvement that MSS staff and its subcontractors had with the Program was one of high integrity, legal compliance and simply doing the very best they could -- by their client, their staff, subcontractors and all Program stakeholders.

B. MSS SECURITY PTY LTD - BACKGROUND

16 MSS is one of the largest security services suppliers in Australia. The business has been operating since 1896 and provides services in all states and territories in Australia. It employs over 6,400 personnel nationwide and as at 27 March 2020 employed 1,103 permanent and directly employed

personnel in Victoria, supported by a further workforce engaged through long-standing subcontractor partners that are used for specified contracts, including those with its Major Events business clients.[2] MSS has held a private security licence ever since it has been a requirement to do so in Victoria.[3] On the guarding side of the business, the services the company supplies include the provision of licenced security officers to perform static guarding, access control, concierge and front of house, control room and monitoring and event security and customer service.[4] Its services are provided across a broad range of sectors including State and Federal Government, defence, aviation, tertiary institutions, finance, healthcare, manufacturing, transport and logistics, courts, the events and recreation sector and blue-chip major corporations including banks.[5]

17 MSS has enjoyed long-standing partnerships providing security for large-scale events, predominantly in the sporting and festival fields and related services. The coordination of these major events requires significant pre-planning for up to 6 months at a time.[6] As part of a specialised and experienced management team in the MSS Major Events business unit, Mr Krikelis is employed in the role of MSS Business Manager, and is tasked with the managerial aspects of event management. [7]

18 When approached about providing security services to support the Program, MSS' scale, operational capability, strong training and recruitment practices, alongside its specialised large-scale event management experience, and longstanding Government relationships, made MSS a strong and suitable candidate.

C. SUBMISSIONS

TOPIC 1: The decisions and actions of Government agencies involved in implementing the Program (see Term of Reference 1)

19 The conclusions drawn by Counsel Assisting as to the emergency management framework which underpinned the Program, together with related governance structures within Departments, and by reason of the Public Health command, were in our submission correct and accurate.[8]

20 The evidence establishes that the Emergency Management Commissioner (**EMC**) had primary responsibility before the outset of the COVID-19 pandemic, for ensuring the emergency was efficiently coordinated, with effective controls and structures in place across all agencies (including appropriate inter-agency management structures).[9] The DHHS was the designated control agency for a Class 2 human disease emergency. It had overall ultimate operational control of response activities. Separately, it had responsibility under the *Public Health and Wellbeing Act* 2008 (Vic) (**PHWA**).

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[2] Exhibit 65 Statement of Jamie Grant Lachlan Adams (MSSS.0001.0014.0002) at [7], [30].
[3] Exhibit 65 Statement of Jamie Grant Lachlan Adams (MSSS.0001.0014.0002) at [14].
[4] Exhibit 65 Statement of Jamie Grant Lachlan Adams (MSSS.0001.0014.0002) at [15].
[5] Exhibit 65 Statement of Jamie Grant Lachlan Adams (MSSS.0001.0014.0002) at [10], Exhibit 67 Statement of Sam Krikelis (MSSS.0002.0014.0001) at [6]-[7]. See Adams T812:9-28.
[6] By contrast with the Program, see Krikelis T814, T817:14-38.
[7] Exhibit 67 Statement of Sam Krikelis (MSSS.0002.0014.0001) at [7]-[11], Krikelis T812:43-T813:10.
[8] Counsel Assisting, Ms Ellyard T2202:14-42, T2204:3-47-T2208:1-2, Counsel Assisting, Mr Ihle T2245:7-15.
[9] See also Victoria, Parliamentary Debates, Legislative Council, 31 October 2013 at 3470.

21 An appropriate framework for the delivery of emergency services is vital when faced with the management of a pandemic crisis. It provides the foundation for planning and preparation and enables the development and implementation of appropriate systems to coordinate and manage the response of Government agencies. It is incumbent on Government to ensure that such foundational structures work, in order to protect the public against the consequences of a crisis.

22 A number of key structures underpinned the way in which the Program was arranged and functioned.

Emergency Management Commissioner

23 The Program was underpinned by traditional emergency management structures under the *Emergency Management Act* 2013 (Vic) (**EMA**) for the purposes of a Class 2 emergency, with the appointment of an Emergency Management Commissioner (**EMC**), in this case Commissioner Andrew Crisp.[10] Commissioner Crisp sat at the apex of the EMA governance structure,[11] and held a leadership role charged with overseeing a cohesive approach to an emergency. He had primary responsibility for ensuring the emergency was efficiently coordinated, not just upon the outbreak of an emergency, but well before,[12] with effective controls in place across all agencies for major emergencies.[13]

24 Commissioner Crisp's role before the outset of the COVID-19 pandemic emergency, was to ensure that proper structures existed for the management (including appropriate inter-agency management structures) and control of such an emergency, so that in the event one occurred there would be no doubt as to who was responsible, and no ambiguity as to who was accountable.[14] More than that though, the EMC, was responsible for ensuring effective control arrangements were in place for the coordination of the activities of onsite teams, to work in support of the control agency.[15] This suggests an appreciation on the part of the EMC that his role extended, at least in that sense, also to the management of an emergency. The EMC, however, did not have operational oversight or control in relation to the wider emergency response activities and responsibilities of either the control or the support agencies.

25 To the extent the EMA, when introduced into Parliament, foreshadowed an 'all-agencies' approach to emergency management, to allow for agencies and departments to share resources and maximise efficiency;[16] this was not a change introduced to provide a vehicle for a particular government department to divest itself of responsibility by reference to 'shared accountability.'

Control Agency

[10] *Emergency Management Act 2013* (Vic), s 32(1). See also Exhibit 177 Witness Statement of Chris Eccles (DPC.0017.0001.0001) at 0008, [38].
[11] See Exhibit 167 State Operational Arrangements - COVID-19.
[12] *Emergency Management Act 2013* (Vic), s 32(1)(a) and (b).
[13] See also Victoria, Parliamentary Debates, Legislative Council, 31 October 2013 at 3470.
[14] Exhibit 140 Witness Statement of Craig Lapsley (WIT.0001.0049.0001) at 0021. See further, Exhibit 131 Attachments to Witness Statement of Pam Williams at DHS.0001.0027.0108 at 0324.
[15] Crisp T1354:35-40, T1357:4-6. See Exhibit 144 First Statement of Andrew Crisp dated (DOJ.600.002.008) at 0010.
[16] Victoria, Parliamentary Debates, Legislative Council, 31 October 2013 at 3470.

26 The State Emergency Response Plan (**SERP**),[17] as listed in Part 7 of the Emergency Management Manual Victoria (**EMMV**), designated the DHHS as 'control agency' for the COVID-19 pandemic emergency.[18] This meant that under the emergency management framework, the DHHS had ultimate operational 'control' for the COVID-19 pandemic emergency – in this case the implementation of the Program. It had primary responsibility for setting the strategic direction, and developing and executing a management plan that involved all agencies supporting the response to the emergency.[19]

27 Acting in accordance with the SERP, the officer in charge of an agency having overall control of response activities may, with the consent of the officer of another agency and in accordance with the SERP, transfer control of any response activity in relation to a Class 2 emergency. This simply means that <u>operational</u> control for a particular response activity may be transferred to a support agency (provided the support agency consents and the transfer is in accordance with the SERP). It does not mean that <u>ultimate</u> control of the emergency shifts. The intention of the EMA remains clear; that there should be a single control agency with overall ultimate responsibility for the management of an emergency - the 'control agency'. The DHHS was at all times the 'control agency' for the management of the COVID-19 pandemic emergency, regardless of how many particular activities within the sphere of operational control it sought to transfer.

28 In her evidence before the Board, Secretary to the DHHS, Ms Kym Peake agreed that the EMMV, being the authoritative guide from a policy perspective on the role of control and support agencies, provided that the control agency was the single agency "responsible for the collaborative response of all the agencies".[20] Importantly, Ms Peake confirmed, after much resistance, that "the control agency was responsible for determining for each of the operations that it was clear, the scope was clear, the roles and responsibilities was clear and the governance was clear".[21]

29 Similarly, the Board heard evidence from the Hon. Minister Neville MP, Minister for Police and Emergency Services. Minister Neville had extensive practical experience of emergency management structures and procedures under the EMA in the course of other large-scale Victorian emergencies. She gave evidence about the emergency management structures which underpinned the Program. The Minister resolutely confirmed that in the normal emergency management framework, where the DHHS is assigned as control agency for the COVID-19 health emergency, the State Controller will have the overall lead and management of the emergency and responsibility to hold people to account at an operational level – such management extending to the work of support agencies, irrespective of

[17] Exhibit 144 Witness Statement of Andrew Crisp (DOJ.600.002.0008) at 0010, Exhibit 145 Annexures to First Statement of Andrew Crisp at DOJ.600.0001.0271. See also Exhibit 144 Witness Statement of Andrew Crisp (DOJ.600.002.0008) at 0014, Exhibit 145 Annexures to First Statement of Andrew Crisp at DOJ.600.0001.1026.
[18] Exhibit 144 Witness Statement of Andrew Crisp (DOJ.600.002.0008) at 0014, Exhibit 145 Annexures to First Statement of Andrew Crisp at DOJ.600.0001.0271. See also Exhibit 131 Attachments to Witness Statement of Ms Pam Williams at DHS.0001.0027.0108 at 0324.
[19] See Exhibit 144 First Statement of Andrew Crisp dated (DOJ.600.002.008) at 0010, Exhibit 140 Witness Statement of Craig Lapsley (WIT.0001.0049.0001) at 0021. See also Exhibit 177 Witness Statement of Chris Eccles at 00016-0017, [65] and Exhibit 32 Statement of Claire Alana Febey (DJP.050.010.0001) at 0015, [63], Exhibit 33 Attachments to Witness Statement of Claire Febey at DJP.101.004.4571. See further Peake T1904:20-47-T1906:1-40.
[20] Peake T1988:32-47-T1991:1-35.
[21] Peake T1991:37-43.

their own particular command structures.[22] Minister Neville's evidence in relation to the allocation of accountability within the emergency management framework should be accepted by the Board.

Public Health and Wellbeing Act 2008 (Vic) Delegation

30 The Program relied upon a power to detain exercisable under the PHWA and regulations, and related powers under the *Public Administration Act*,[23] by the Chief Health Officer, Professor Brett Sutton (**CHO**)[24] and his delegates, in the context of a public health emergency having been declared by the Minister.[25]

Consequences of structure - Mix of decision-makers and Decision to engage private security

31 The Program, through these structures, allocated multilayered decision-making powers to a range of Government agencies notionally under the banner of a central control agency. However the evidence revealed that the dispersion of decision-making powers led to inconsistencies and confusion in relation to power, control and accountability. The foundational structure of the Program was flawed at every level for several reasons.

32 First, the Program lacked an appropriate governance framework. It should have been capable, if the emergency management framework had been working as it was designed, to have identified who was 'in charge'. The fact that this pandemic was 'unprecedented' is beside the point. The collaborative governance framework adopted in the Program, is not unique to an emergency response of the scale and magnitude required for the COVID-19 pandemic.[26]

33 There was no clear understanding of who was relevantly 'in charge' or indeed, what was the relevant governance framework. The evidence in this regard demonstrated the fundamental uncertainties.

(a) The State Controller confirmed that the CHO was in charge.[27]

(b) The evidence of the CHO was that he had an inadequate line of sight over the operational aspects of the Program, and was not for example, aware of the engagement of private security.[28]

(c) The EMC gave evidence that it was Deputy State Controller who bore ultimate control and responsibility for the emergency response.[29] The Deputy's own evidence was that he did not exercise such control during the Program.[30]

(d) In her evidence, the Hon. Minister Mikakos, Minister for Health and also Minister for the Co-ordination of Health and Human Services – COVID-19, conceded that there was a "structural

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[22] Neville T1950-T1951:1-2.
[23] *Public Health and Wellbeing Act* (2013) Vic, s 30(1) and 30(3)(b).
[24] *Public Health and Wellbeing Act* (2013) Vic, ss 189, 190, 198(1), 200. See also Exhibit 164a Witness Statement of Jason Helps (WIT.0001.0050.0001) at 0007 [31], Exhibit 165 Annexures to Witness Statement of Jason Helps, at DHS.5000.0032.1850.
[25] *Public Health and Wellbeing Act* 2008, s 200(1)(a).
[26] See Exhibit 186 Witness Statement of Kym Lee-Anne Peake (DHS.9999.0009.0001) at 0061 [325].
[27] Helps T1583:31-47-T1584:1-5, Exhibit 164a Witness Statement of Jason Helps (WIT.0001.0050.0001) at 0006-0007. See further Peake T1895:9-20.
[28] Sutton T1493:20-28, T1493:40-43.
[29] Crisp T1376:18-33.
[30] Eagle T1435: 35-47-T1436:1-17, T1436:30-37.

weakness" in how the Program had been designed and structured, matters about which she said she had no input.[31]

(e) Dr Simon Crouch, Deputy Public Health commander, a role which originated in the PHWA procedural structure, conceded that he was not aware of the precise manner in which the Outbreak Management Squad performed its function, nor under which protocols they operated.[32]

(f) Dr Sarah McGuinness, seconded to the DHHS as a senior medical advisor in the Case Contact and Outbreak Management Team, reflected that there was not one single source of information available for information onsite.[33]

34 Certainly, each agency had its own command structure (with onsite supervisory roles),[34] together with experience and expertise relevant to their support function.[35] These did <u>not</u> however absolve the EMC of his overarching responsibility and accountability for their involvement in the Program.[36] Nor did it absolve the DHHS of its responsibility as 'control agency', for the overall direction and implementation of the emergency response for infection control.

35 MSS' contact (and contract) was with neither the EMC, nor the DHHS as control agency. Rather it was with a 'support agency', the Department of Jobs, Precincts and Regions (**DJPR**). The evidence of the DJPR Secretary, Mr Simon Phemister was that security contractors were "subject to the ultimate direction and responsibility of DHHS, as control agency (…)" and so too was the DJPR.[37] While this may have been the intent, in practice there was no clarity about this for the private security companies.

36 Second, there was a range of views as to whose decision it was to engage private security firms,[38] in combination with a range of views as to the role that Victoria Police would play onsite.[39] The inevitable consequence of this was that the role and responsibilities that private security would assume during the Program, were not properly considered from the outset.[40]

37 Those involved at a high-level believed the private security firms had the agility, flexibility, and capacity to scale up quickly and provide a surge workforce of guards to facilitate the Program, almost

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[31] Mikakos T2081:5-18.
[32] Crouch T1064:31-47-T1065:1-23.
[33] McGuiness T1106:1-5.
[34] Crisp T1354:12-24.
[35] Crisp T1359:31-37, T1365:17-25, Patton T1645:35-47-T1646:1-10.
[36] Crisp T1376:40-43, T1376:15-23, T1417:34-42, T1417:44-47-T1418:1.
[37] Exhibit 184 Witness Statement of Simon Phemister (DJP.050.001.0001) at 0034 [152](b)].
[38] Crisp T1380:28-40, Febey T397:24-42, T399:27-T400:29, T401:13-42, T401:44-47-T402:1-18, T402:20-39, Currie T445:10-20, T445:44-47-T446:1-6, Patton T1648:35-47-T1649:1-40, Ashton T1666:12-21, T1667:13-21, Eccles T1769:6-47-T1770:1-21, Phemister T1825:31-47-T1826:1-10, Neville T1952:15-47-T1954:1-12.
[39] Febey T396:24-36, T401:13-42. T403:24-33, Serbest T487:9-27, Tully T932:40-T933:9, T934:14-19, T936:10-19, May T:965:34-47-T966:1-10, Ashton T1665:46-47-T1666:110. See also, Exhibit 78 Statement of Timothy Austin Tully (VPOL.0027.0001.0001) at 0002, 0004-0006, Exhibit 125 Statement of Melissa Skilbeck (DHS.9999.0010.0001) at 0026 [140], Exhibit 78 Statement of Timothy Austin Tully (VPOL.0027.0001.0001), Exhibit 164a Witness Statement of Jason Helps (WIT.0001.0050.0001) at 0027.
[40] See Exhibit 184 Witness Statement of Simon Phemister (DJP.050.0001.0001) at 0025-0026, 0029-0030 [116]-[121], [135]-[137] as to the uncertainty concerning the role of private security.

immediately.[41] This was true, however, the speed with which the Program was commissioned and the hotels were activated (namely, within approximately 48 hours)[42] meant that a large number of factors in relation to the type and standard of facilities were not initially considered. These included the size and location of facilities, appropriate infection control capacities, evacuation procedures and space for fresh air walks (which later became a source of concern). These were all matters which did not receive any, or any sufficient, attention or forethought, given the tasks that security would ultimately be required to perform, and given the accommodation of COVID-19 positive guests at the hotels.[43]

38 The ultimate decision-maker as to which hotels would be selected was the DHHS.[44] It became apparent, as the Program evolved, that the facilities were sub-optimal. For example, there were occasions when the segregation between common lifts,[45] or the isolation of guests from the public on exercise breaks, were not always feasible at the hotels.[46] Moreover, practices of sharing common facilities (toilets, lifts, break rooms, conference rooms) between staff from various organisations were risk factors which were not properly considered at the outset.

39 Of particular importance to the Inquiry is the inadequate state of air-conditioning facilities and access to natural ventilation in particular hotels, and particularly in 'hot hotels' following confirmed outbreaks in May/June 2020.[47] Professor Grayson, Director of the Infectious Disease Department, Austin Hospital, in his evidence to the Board explained the importance of adequate ventilation and the risk posed by inhalation of COVID-19, having regard to the potential for aerosol particles of viruses remaining in the air, if air flow is low.[48] Indeed, the DHHS, the decision-maker on hotel selection and facilities (albeit contracted by the DJPR), was acutely aware of the emerging risk factors for acquisition and secondary transmission of COVID-19 through aerosol transmission as early as late March, but certainly by 4 April 2020,[49] yet did not adequately assess facilities involved in the Program against this infection control criteria.[50]

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[41] Tully T934:21-43, T946:3-8, Crisp T1380:28-40, T1377:20-47-T1380:1, T1380:9-16, T1383:1-5, T1412:1-7, T1401:31-35, T1401:45-47-T1402:1-15, T1404:33-37, Phemister T1831:42-47-T1832:1-23, see further Exhibit 59 Statement of Principal Policy Officer (DJP.050.004.0001) at 0009 [35], Exhibit 78 Statement of Timothy Austin Tully (VPOL.0027.0001.0001) at 0003, Exhibit 144 First Statement of Andrew Crisp dated (DOJ.600.002.008) at 0025-0026, Exhibit 164a Witness Statement of Jason Helps (WIT.0001.0050.0001) at 0026, and Exhibit 32 Statement of Claire Alana Febey (DJP.050.010.0001) at 0002-0003, at 0010-0012 [40]-[41].

[42] Menon T631:15-19.

[43] See Exhibit 130 Witness Statement of Pam Williams (DHS.9999.0016.0001) at 0019-0020 [41(e)], Erasmus T240:18-47, Grayson T61:45-46-T62:1-3, Menon T657:42-47-T678:1-9, Bamert T1321:30-33.

[44] Menon T634:31-47-T635:1-26. See also Exhibit 49 Statement of Unni Menon (DJP.050.006.0001) at 0009. See also May T961:10-47.

[45] See Grayson T61:45-46-T62:1-3.

[46] See Erasmus T240:18-47.

[47] Peake T2025:31-47-T2027:1-43. See further Exhibit 200 (HQI.0001.0030.0001) Document Titled "Protecting Our Healthcare Workers" dated 25 August 2020 at 0009.

[48] Grayson T57:24-47-T58.

[49] See Exhibit 76 Annexures to Statement of Noel Cleaves, "COVID-19 - DHHS Physical Distancing and Public Health Compliance and Enforcement Plan" at DHS.0001.0001.0729. See further, earlier draft of the Plan at Exhibit 131 Attachments to Witness Statement of Pam Williams at DHS.0001.0008.0674-0728. Subsequently, it would seem the Exercise and Fresh Air Implementation Plan (v 1) dated 15 April 2020 was developed, see Exhibit 131 Attachments to Witness Statement of Pam Williams at DHS.5000.0003.2831-2841.

[50] Peake T2025:31-47-T2027:1-43. See further Exhibit 200 (HQI.0001.0030.0001) Document Titled "Protecting Our Healthcare Workers" dated 25 August 2020 at 0009.

40 Victoria Police, because of a range of factors, ultimately assumed a support role in the day-to-day running of the Program;[51] a 24/7 presence was considered an inefficient use of resources.[52] Resultantly, there was no oversight of MSS and its staff by Victoria Police, nor any particular ongoing site support (including for example, cordons being provided on exercise walks where the public was nearby), as might have been contemplated at the commencement of the Program.[53] The evidence of Chief Commissioner Shane Patton as to the current police presence which exists at the Brady and the Grand Chancellor hotels,[54] sits in stark contrast to the absence of police oversight and the very limited support which existed, or was provided, to security personnel, at the time the Program was operative.

41 Third, the lack of an individualised, clear pyramid structure embedded within one Department, overseeing the Program onsite day-to-day,[55] meant that those working within it had no consistent or clear direction or ability, at a practical level, to effect change if problems were detected.

42 The delineation of onsite authority and responsibility as between the DHHS and the DJPR and other agencies, was a key source of confusion and tension as the Program progressed. The distinction between responsibility for onsite logistical support and operational control, was too abstract to be meaningful. It led to an authority vacuum at the hotels, which gave rise to reactive and ad-hoc decision-making, a lack of, or arbitrary enforcement of, policies and minimal regard for consistency.

43 The relevant decisions were to be made by the DHHS, with staff from the DJPR effectively available as a resource to ensure that those decisions were given operational effect. [56] To that end, whilst the DJPR was to contract hotels and other services such as catering, cleaning and security,[57] the DJPR-appointed site leader had limited involvement with those services, and would only assist on an 'as needs' basis with entry and exit procedures.[58] Although a clear reporting structure through to the State Controllers was intended by the emergency management structures, the DJPR personnel did not understand there to be one.[59]

44 The communication channels between the Departments, which it was hoped would be collaborative, in practice were chaotic, and at times quite strained.[60] For example, as to the question of PPE use, Ms Claire Febey, Executive Director, Priority Projects Unit at the DJPR, came to understand that whilst her Department took the view that PPE should be worn at all times, the DHHS, on the other hand, wished to conserve the use of PPE. In this regard, the DHHS she said, sought to rely where

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[51] Tully T937:28-36, 935:29-35. See also May T966:16-19.
[52] Tully 939:1-29.
[53] See Tully T942:36-41. See also Erasmus T240:18-47.
[54] Patton T1656:27-47-T1657:1-6.
[55] Cleaves T915:18-41, T898:17-39, T923:22-26.
[56] Febey T398:39-42, T404:33-42, T405:16-47-T406:1-3, T411:1-5, T411:18-36, T418:22-28, May T958:35-47-T960:1, T975:43-47-T976:1-3. See also Menon T659:12-19, T634:31-47-T635:1-26, Crisp T1376:1-5, T1372:19-26. See further Exhibit 32 Statement of Claire Alana Febey (DJP.050.010.0001) at 0015-0016, [63], Exhibit 33 Attachments to Witness Statement of Claire Febey at DJP.101.004.4571, Exhibit 49 Statement of Unni Menon (DJP.050.006.0001) at 0009.
[57] Febey T400:21-24. See also Crisp T1415:15-27.
[58] May T975:43-47-T976:1-3, T960:3-46-T916:1-8, T623:28-40, T966:21-40, Phemister T1849:12.
[59] Febey T408:24-47-T409:7-47. See also Crisp T1375:41-46, T1355:30-34, Eagle T1440:41-43.
[60] May T976:21-43, T962:20-47-T963:1-39. See also Williams T1230:2-32, Menon T638:16-47, Williams T1230:2-32.

possible, on principles of social or physical distancing[61] - a concept that was never reduced to a clear, articulated written policy for private security or other contracted staff.[62] This position was not necessarily based on independent medical advice,[63] and the evidence does not support that it was. A further example referred to in the evidence was generic advice concerning cleaning.[64]

45 The evidence also made plain that there were varied and inconsistent practices between hotels as to the way in which the roles of Authorised Officers (**AO**) and DHHS team leaders were executed.[65] Where an AO's operational mandate was to focus on the detention aspects of the Program, AOs also assumed management and control over other aspects of the Program.[66] Despite the DHHS having an expert medical and infection control role in the Program, evidence suggested that DHHS team leaders were not responsible for infection prevention and control, nor management control of the AO.[67] The Board heard evidence from Ms Pam Williams, the DHHS COVID-19 Accommodation Commander, who explained that the team leader's role was, she thought, "to coordinate and problem solve".[68] Further, a lack of specialised training, experience and knowledge in infection prevention and control in both DHHS team leaders and AOs led to frustrated and confused decision-making processes day-to-day.[69]

46 The critically flawed onsite arrangements that underpinned the Program, created significant confusion and inconsistency in respect of instructions and reporting lines; particularly for frontline private security firms like MSS.[70]

47 The Board received evidence from Mr Jamie Adams, General Manager of Victoria and Tasmania, and Mr Sam Krikelis, Business Manager, Event Services, on behalf of MSS. [71] Their evidence was almost entirely uncontested. They were both honest, reliable and careful witnesses, whose evidence revealed their extensive experience, knowledge and training in security services. They each had an excellent recall of events, discussions, working assumptions and dates. It was evident that they both

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[61] Febey T421:7-33.
[62] See Exhibit 76 Attachments to Statement of Noel Cleaves at DHS.0001.0001.0729 and following - "COVID-19 – DHHS Physical Distancing and Public Health Compliance and Enforcement Plan. See further, earlier draft of the Plan at Exhibit 131 Attachments to Witness Statement of Pam Williams at DHS.0001.0008.0674-0728. Subsequently, it would seem the Exercise and Fresh Air Implementation Plan (v 1) dated 15 April 2020 was developed, see Exhibit 131 Attachments to Witness Statement of Pam Williams at DHS.5000.0003.2831-2841. This document remained at all times an internal DHHS document and was never disseminated to the private security firms. Mr Adams and Mr Krikelis gave evidence about the policies provided to MSS and they did not state that a social distancing policy or guidance in writing was provided. They were not challenged to the effect that it was.
[63] Febey T434:25-41.
[64] Febey T422:5-40.
[65] Cleaves T902:18-39.
[66] Cleaves T898:25-39, T898:20-23,T924:4-14. See also May T964:44-46, T965:1, Smith T1188:1-33.
[67] Cleaves T899:31-47. See also Exhibit 125 Statement Melissa Skilbeck (DHS.9999.0010.0001) at 0018-0019.
[67] Cleaves T897:10-46-T898:1. See also Smith T1188:35-45-T1189:1-8.
[68] Williams T1286:7-47-1287:1-18.
[69] Gupta T743:35-47-T744:1-21, T757:15-46, Cleaves T903:4-47-T904, T904:15-16, Smith T1192:30-47-T1193:1-14, T1189:39-47-T1190:1-18 as to the areas from which AOs were recruited. See also Exhibit 122 Witness Statement of Murray Smith (DHS.0000.0007.0002) at 0004, [16], Exhibit 125 Statement Melissa Skilbeck (DHS.9999.0010.0001) at 0018, Exhibit 53 Statement of Ishu Gupta (WIT.0001.00015.0001) at [49].
[70] Febey T419:28-47-T420:6-22. See also Exhibit 32 Statement of Claire Alana Febey (DJP.050.010.0001) at 0019 and Exhibit 33 Bundle of Annexures to Claire Febey's Statement at DJP.102.001.3602-3603.
[71] Adams T810:1-19, Krikelis T811:5-23.

took their roles in the course of the Program seriously and undertook their responsibilities professionally.

48 Mr Krikelis and Mr Adams gave the following direct evidence in relation to their experience of the onsite organisational structures of the Program and how these impacted upon MSS.

49 Mr Krikelis said that what he came to understand, through discussions with MSS staff and contractors, was that they received conflicting messaging and requests from all parties with managerial functions onsite. Mr Krikelis said that the DJPR representatives looked after more than one hotel and would rotate between them. He recalled that in the event there were conflicting messages onsite, MSS personnel and contractors took their direction from the AO onsite.[72] Insofar as there were concerns that needed to be raised, with regards to security, the hotel, cleaning or catering, MSS would go to the DJPR representative. Further to that structure, Mr Krikelis understood that the DHHS team leader was responsible for nursing staff and the medical side of the operation. His overarching observation was that this multilayered management model, was confusing and inconsistent not only for MSS supervisors, but for the guards as well. He confirmed that his experience, and that of MSS, was that AOs would change very frequently.[73] Thus, even if the roles had been clear (which they were not), the persons who filled them changed frequently which led to an inconsistent provision of guidance and support.

50 Mr Adams explained that he understood the MSS customer was the DJPR and that the DJPR was the party with whom MSS had contracted; however, the DJPR representative was often not present onsite. Each hotel had a DHHS AO, to whom MSS reported at a day-to-day operational level. He said that the fact MSS staff were operationally accountable to the AO day-to-day, but contractually accountable to the DJPR, created difficulties.[74] There was no clear person in charge of all decisions that were made at each facility.[75]

51 The Board received evidence from other witnesses to this effect:

(a) Mr Phemister, in his evidence conceded that it might have been better if there had not been a division between the contractual responsibility and day-to-day supervision of security; such division being a source of confusion.[76]

(b) Minister Mikakos conceded that, in hindsight, one of the weaknesses that arose from the multi-agency response with shared accountability, was the difficulty associated with identifying who made particular decisions and when.[77]

[72] Exhibit 67 Statement of Sam Krikelis (MSSS.0002.0014.0001) at [53]-[56].
[73] Krikelis T822:19-45. See also Exhibit 67 Statement of Sam Krikelis (MSSS.0002.0014.0001) at [55]-[56], Security 1 T298:33-40.
[74] Phemister T1848:45-47-T1849, T1850:1-17, Mikakos T2083:14-19.
[75] Adams T821:35-47-T822:1-17, Phemister T1849:46-47-T1850:1-17.
[76] Phemister T1849:46-47-T1850:1-17.
[77] Peake T2012:24-31, Mikakos T2081:5-18, T2083:6-12, 44-47-T2084:1-15, particularly how the DHHS was entirely reliant on another Department to enforce contracts.

(c) Both Ms Peake and Minister Mikakos, specifically conceded that throughout the operation of the Program it was open to the DHHS to transfer the administration of contracts which lay with the DJPR.[78] Ms Peake explained that the DHHS however did not do so, as the Department considered it to be of benefit to have the support and assistance of a joint operation.[79]

52 Clearly the decision not to transfer the contract from the DJPR to the DHHS was wrong. The DHHS was abundantly aware of a range of operational concerns from the inception of the Program, and indeed as the Program progressed. It was aware of the difficulties associated with accountability and operational management as between the DHHS and the DJPR in respect of such contracts. In those circumstances, as control agency, it was incumbent upon the DHHS to intervene to alleviate such problems. That it failed to do so, is both unfortunate and difficult to understand.

53 The Board also received examples of evidence from witnesses who relayed similar confusion and inconsistency in their experience of the onsite organisational structures which existed during the Program.[80] The evidence collectively identified a distinct lack of clarity as to the responsibilities and authority of personnel who put the Program into effect. The structures put into place were inherently convoluted in their execution and contributed to operational confusion throughout the Program.

TOPIC 2: The contractual arrangements and related discussions, between the DJPR and MSS, and between MSS and its subcontractors (see Term of Reference 3)

54 Counsel Assisting submitted that the contractual arrangements between the DJPR and private security companies, insofar as they related to the responsibility for infection prevention and control measures, were not the subject of specific consideration or assessment as to whether that was an appropriate allocation of risk as between the Government and private providers. MSS agrees that there was insufficient consideration given, at the highest levels of the Government, to understanding what risks existed in the Program and the role of private security in the mitigation of those risks.[81] This lack of consideration meant that there was a lack of attention to the contracting arrangements. It also resulted in a failure by those responsible within the DHHS and the DJPR to properly consider how such contracts would operate day-to-day.

DJPR contracting arrangements

55 At the commencement of the Program, MSS had for many years, been involved in providing security services to various state and federal Governments and was a member of the Victorian Government Panel for security service suppliers. A State Purchase Contract (the **SPC**) between MSS and the Department of Treasury and Finance on behalf of the State of Victoria dated 1 February 2018 was in

[78] Mikakos T2081:5-18.
[79] Peake T2012:24-31.
[80] Ashford T263:46-47-T264:1-7, T264:24-38, T265:1-27, T265:25-26, T267:20-35, T270:6-44, T280:36-45, T281:40-46. See also, Mandyam, Ferrigno T530:15-43, T535:1-13.
[81] Counsel Assisting Ms Ellyard T2225:33-38, T2226:8-13.

place.[82] By reason of its position on the Panel – a matter which should have been known to the DJPR staff tasked with engaging private security services for the Program - MSS was effectively 'pre-approved' for the engagement by the DJPR. It was certainly open for the DJPR to engage MSS under a Purchase Order Contract that sat beneath the SPC.[83]

56 The Board heard and received substantial evidence concerning the way in which the Program's contracts were formulated with private security and in particular with MSS. Mr Adams' and Mr Krikelis' evidence sat in stark contrast to the evidence of Ms Katrina Currie, who at the Program's inception, was the Executive Director, Employment Outcomes at the DJPR.

57 To the extent Ms Currie's evidence is inconsistent with Mr Adams' evidence, Mr Adams' evidence should be preferred. Ms Currie appeared to have no memory of critical conversations and relied on notes to reconstruct events. Ms Currie appeared to have little experience of the security industry and common practices. Ms Currie did not appear to properly understand the seriousness, nor the effect, of the crucial conversations she was having with Mr Adams during which the question of the involvement of MSS in the Program was first being considered. Nor indeed did Ms Currie appreciate the existence of the Government Panel of preferred security providers.[84] These observations were particularly apparent when Ms Currie was questioned about the use of subcontracted staff in the Program. She demonstrated no appreciation of the role and need for subcontractors despite multiple references to subcontractors in her own notes.

58 In his statement and related annexures and evidence before the Inquiry, Mr Adams outlined the way in which MSS came to be contracted for the Program, and what he understood at the time.[85] There were clear differences between what was initially contemplated and what actually occurred as the Program evolved. For example, Mr Adams' and Mr Krikelis' evidence established that:

(a) the provision of PPE was not always forthcoming from the DHHS in the early days, despite assurances to that effect from Ms Currie and the DJPR Principal Policy Officer;[86]

(b) there did not end up being a Victoria Police presence onsite to support MSS in its working arrangements, as was originally contemplated and communicated to Mr Adams;[87]

(c) the nature of the 'security services' which MSS had, at the outset, agreed to provide to the DJPR, expanded and changed extensively as the Program evolved. In the end they extended well

[82] Exhibit 65 Statement of Jamie Grant Lachlan Adams (MSSS.0001.0014.0002) at [20], see Exhibit 66 Annexures to Statement of Jamie Grant Lachlan Adams at MSS.0001.0009.0002.
[83] Adams T812:21-28. See also Exhibit 65 Statement of Jamie Grant Lachlan Adams (MSSS.0001.0014.0002) at [20], [21].
[84] Phemister T1833:28-47-T1834:1-31.
[85] Exhibit 65, Statement of Jamie Grant Lachlan Adams (MSSS.0001.0014.0002) at [42]-[90].
[86] See Exhibit 67 Statement of Sam Krikelis (MSSS.0002.0014.0001) at [109]-[119], Exhibit 68 Attachments to Statement of Sam Krikelis at MSSS.0001.0004.0447.
[87] See Exhibit 65, Statement of Jamie Grant Lachlan Adams (MSSS.0001.0014.0002) at [50], [55]. See further, Tully T935:29-35, T936:10-19, T939:1-29, See also Exhibit 78 Statement of Timothy Austin Tully (VPOL.0027.0001.0001) at 0004-0006. See also May T966:16-19.

beyond the services originally contemplated during contracting, or that which would commonly be considered 'security' services; [88] and

(d) contrary to what Mr Adams had been told by Ms Currie would be the case during contracting; guests with symptoms, those undergoing testing, and those who had potentially refused testing, were all brought to, and quarantined at the hotels - residing on common floors frequented by MSS personnel, agency nurses, hotel staff and departmental staff. [89]

59 Ms Currie confirmed she was tasked with recruiting private security firms, of which MSS was one, into the Program.[90] WhatsApp text messages between members of the DJPR, including Ms Currie,[91] discussed which security firms would be engaged for the Program. MSS was described as reputable and respected in the industry.[92] Ms Currie was not aware of the existence of a panel of providers, or the procurement policy.[93] Ms Currie accepted that the possibility of the Program providing employment for people was a secondary consideration when recruiting private security firms.[94]

60 Mr Adams first became involved in discussions with Ms Currie on 29 March 2020.[95] Based solely on his conversations with Ms Currie, Mr Adams understood, as at 29 March 2020, that the Program would (or already had) come into effect, and that a security presence was required at each of the hotel facilities to man the floors, to make sure people didn't abscond, to check packages, and to deal with people who might turn up to deliver meals. Overall, he understood that the role of security was to provide a general onsite presence on each hotel floor.[96] Mr Adams' evidence was that Ms Currie explained to him that the Victorian Police would have a presence at each hotel site to deal with any issues arising if people absconded, or attempted to abscond, or became agitated or aggressive.[97]

61 Mr Adams gave further evidence that Ms Currie, in the course of discussions on the weekend of 29 March 2020, specifically explained to him that anyone with symptoms of COVID-19 would **not** be brought to the hotels.[98] He was assured that his staff would not have to directly interact with symptomatic or COVID-19 positive guests, and if a guest became COVID-19 positive, medical staff would manage the transfer of the guest from the hotel to a medical facility.[99] This was contrary to what MSS security staff in fact encountered onsite.

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[88] Adams T818:1-22. See further, Exhibit 65, Statement of Jamie Grant Lachlan Adams (MSSS.0001.0014.0002) at [103]-[108], Exhibit 66 Annexures to Statement of Jamie Grant Lachlan Adams at MSSS.0001.0005.0592, MSSS.0001.0005.1213, Exhibit 67 Statement of Sam Krikelis (MSSS.0002.0014.0001) at [23].
[89] Adams T829:22-38.
[90] Currie T441:23-47, T442:4-5, T443:13-34, T445:10-20.
[91] Currie T439:23-31, 44-47, T440:8-15.
[92] See Exhibit 182 Whatsapp Messages between Officers of DJPR (DJP.361.002.0001) at 0007. See further Phemister T1831:5-47-T1832, T1833:1-2.
[93] Currie T442:36-47, T443:12, T443:23-27, 43-47, T444:1.
[94] Currie T452:28-39.
[95] Currie T469:24-47, T470:1-7.
[96] Adams T815:9-40. See also Exhibit 65, Statement of Jamie Grant Lachlan Adams (MSSS.0001.0014.0002) at [42]-[50], [85], [87], Exhibit 66 Annexures to Statement of Jamie Grant Lachlan Adams at MSSS.0001.0013.0028, MSSS.0001.0013.0030, MSSS.0001.0010.0017. See also, Krikelis T818:37-47.
[97] Adams T815:42-47-T816:1-6. See also Exhibit 65, Statement of Jamie Grant Lachlan Adams (MSSS.0001.0014.0002) at [50].
[98] Exhibit 65, Statement of Jamie Grant Lachlan Adams (MSSS.0001.0014.0002) at [51].
[99] Adams T816:8-21, T840:36-42.

62 Mr Adams also had further discussions with Ms Currie as to a range of practical features of MSS' involvement, including the ability to immediately resource staff, COVID-19 online training, sourcing of PPE, the entities with which MSS could expect to interact onsite and the expected hourly rates MSS would charge. Importantly too, although Mr Adams understood from Ms Currie that MSS personnel would need some infection control awareness - in accordance with the Commonwealth government COVID-19 online training package - Ms Currie told Mr Adams that the DHHS as the infection control experts, would be responsible for infection control and would be onsite and would conduct an induction of MSS personnel.[100] Mr Adams, at this early stage, explained to Ms Currie that he envisaged a difficulty with sourcing PPE and was assured that the DHHS would also supply this.[101]

63 Mr Adams' evidence was that following his discussions with Ms Currie, the DJPR Principal Policy Officer took over the contracting of private security including MSS. By 2 April 2020, the DJPR Principal Policy Officer had confirmed with Mr Adams that MSS would be contracted and that the Principal Policy Officer would be taking operational control of the Program. In early discussions with the DJPR Principal Policy Officer, Mr Adams was advised that MSS would need to be prepared to cover their own PPE.[102] The Purchase Order Contract with respect to the Program, was executed by MSS on 17 April 2020[103] and by the DJPR on 23 April 2020 (**POC**).[104]

64 Mr Adams' evidence was that no variations were made to the POC as between when the contractual obligations were explained to him on 29-30 March 2020, and when the schedules in the POC were ultimately executed. His evidence was that the scope of duties identified in the POC were reasonably generic, and they did not fundamentally change from his initial conversations with Ms Currie. However, in practice, Mr Adams explained that the nature of the services did change as the Program evolved,[105] including with regard to when MSS was required to provide services at a particular hotel, the number of passengers arriving, when PPE was required to be worn, and a varied application of infection control protocols between facilities.[106]

65 In the foregoing circumstances, MSS commenced services on Monday 6 April 2020 at the Park Royal at Melbourne Airport, on 7 April 2020 at the Four Points by Sheraton, on 8 April 2020 at the Holiday

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[100] Currie T471:10-36. See also Exhibit 37 Attachments to Witness statement of Katrina Currie at DJP.101.002.1076-1077.
[101] Adams T828:45-47-T829:1-20. See also Exhibit 65, Statement of Jamie Grant Lachlan Adams (MSSS.0001.0014.0002) at [52]-[61], [93]-[96], [103], Exhibit 66 Annexures to Statement of Jamie Grant Lachlan Adams at MSSS.0001.0008.0004, MSSS.0001.0013.0028, MSSS.0001.0013.0030, MSSS.0001.0010.0017, MSSS.0001.0005.2752. See further Currie T448:4-11, 20-21.
[102] Adams T816:23-44. See Exhibit 65, Statement of Jamie Grant Lachlan Adams (MSSS.0001.0014.0002) at [63]-[65], Exhibit 66 Annexures to Statement of Jamie Grant Lachlan Adams at MSSS.0001.0005.0061.
[103] Exhibit 65, Statement of Jamie Grant Lachlan Adams (MSSS.0001.0014.0002) at [77]-[80], [91], Exhibit 66 Annexures to Statement of Jamie Grant Lachlan Adams at MSSS.0001.0002.0014, MSSS.0001.0005.3709, MSSS.0001.0005.1518, MSSS.0001.0005.0147, MSSS.0001.0005.0054, MSSS.0001.0002.0049, MSSS.0001.0002.0050.
[104] See Exhibit 65, Statement of Jamie Grant Lachlan Adams (MSSS.0001.0014.0002) at [80], Exhibit 66 Annexures to Statement of Jamie Grant Lachlan Adams at MSSS.0001.0002.0049, MSSS.0001.0002.0050.
[105] Adams T818:1-22.
[106] Exhibit 65, Statement of Jamie Grant Lachlan Adams (MSSS.0001.0014.0002) at [103]-[108], Exhibit 66 Annexures to Statement of Jamie Grant Lachlan Adams at MSSS.0001.0005.0592, MSSS.0001.0005.1213.

Inn Melbourne Airport, on 10 April 2020 at the Travelodge Docklands and on 30 April 2020 at the Stamford Plaza.[107]

MSS subcontracting arrangements

66 For the vast majority of MSS permanent and ongoing contracts, MSS recruits and deploys directly employed, permanent, full-time security officers. MSS undertakes a rigorous and thorough recruitment process for its permanent staff.[108] It requires all employees to hold a private security provider's licence, and where required undertake specific clearances, as a condition of their employment.[109]

67 For a small number of specified contracts, MSS also utilises the services of long-standing subcontractors to supplement directly employed staff for specified contracts. One such example are contracts for Major Events business clients, which could be described as seasonal or 'surge' work, but through which MSS is able to utilise the same staff year after year, given its long-standing relationships with its events partners.[110]

68 MSS utilises a formal tender and assessment process for its subcontractors in Victoria. Subcontractors selected to work with MSS are required to enter into a Services Subcontract Security Services (the **Services Subcontract**), which details requirements MSS subcontractors are expected to comply with.

69 Mr Adams foreshadowed and explained these subcontracting arrangements in conversations with Ms Currie. In providing security services to the Program, MSS used four subcontractor firms. Each subcontractor firm, with whom MSS had worked closely over a number of years, had executed Services Subcontracts which covered their provision of services for the Program.[111] MSS received confirmation that each of these subcontractors were approved by the DJPR on 10 June 2020.[112]

70 The Board heard evidence from Ms Currie which suggested that at the time of contracting, she was not aware of the subcontracting arrangements which private security firms contemplated and discussed with her. Her evidence in this regard lacks credibility. She remarked that she "didn't think that they would use subcontractors"[113] and that she "wasn't aware of the subcontracting arrangements".[114] Her evidence sat in contradistinction to her own handwritten notes which marked,

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[107] Exhibit 65, Statement of Jamie Grant Lachlan Adams (MSSS.0001.0014.0002) at [91] and [109].
[108] Exhibit 65 Statement of Jamie Grant Lachlan Adams (MSSS.0001.0014.0002) at [33]-[40].
[109] Exhibit 65 Statement of Jamie Grant Lachlan Adams (MSSS.0001.0014.0002) at [17]. See Exhibit 53 Statement of Ishu Gupta (WIT.0001.00015.0001) at [22], Exhibit 52 Statement of Mina Attalah (URM.0001.0001.0204) at 005, Exhibit 58 Statement of Abdul Hamid Eddie Chakik (WIT.0001.0011.0001) at 0004. See also Exhibit 65 Statement of Jamie Grant Lachlan Adams (MSSS.0001.0014.0002) at [111]-[115] and Exhibit 66 Annexures to Statement of Jamie Grant Lachlan Adams at MSS.0001.0013.0034.
[110] Adams T813:12-19. See also Exhibit 65 Statement of Jamie Grant Lachlan Adams (MSSS.0001.0014.0002) at [23].
[111] Gupta, Attalah T708:9-26, T708:45-46-T709:1-23. Exhibit 66 Annexures to Statement of Jamie Grant Lachlan Adams at MSSS.0001.0001.0006 (with attached Notices of Intent), MSSS.0001.0001.0007, MSSS.0001.0001.0008, MSSS.0001.0001.0009, MSSS.0001.0001.0010.
[112] Exhibit 65, Statement of Jamie Grant Lachlan Adams (MSSS.0001.0014.0002) at [116]-[117]. See also Exhibit 59 Statement of Principal Policy Officer (DJP.050.004.0001) at 0013.
[113] Currie T448:23-42, T448:44-47, T449:1-25, T450:1-2, T450:41-47, T451:1-13. See Exhibit 183 Extract from the website "buying for Victoria" (HQI.0001.0005.0001) as to publicly available information concerning Government panel providers.
[114] Currie T451:27-32, T451:41-43.

at various places, references to subcontracts, subcontracting and names of subcontractors - reflecting that issues relating to subcontracting were clearly raised with her in those early conversations.[115]

71 Under cross-examination, Ms Currie conceded that subcontracting was permitted and that the possibility of subcontractors, including the specific identity of some possible subcontractors, was communicated to her between 28 - 29 March 2020.[116] Further, Ms Currie conceded, that whilst she had no recollection of conversations, she did have discussions with Mr Adams with respect to subcontracting; her own notes making reference to "[p]reserving subcontract network, IR licensing, wage rates" in relation to MSS.[117] She also conceded that by reason of communications she had with Mr Adams, in which he specifically referred to the 'SSIA requirements' which MSS subcontracts all stipulate, that she was certainly made aware that MSS might possibly use subcontractors.[118]

72 From 1 April 2020 when the DJPR Principal Policy Officer assumed responsibility for arranging the security contracts, he was also on notice of the fact that MSS would engage subcontractors. He had been sent, by Ms Currie on 30 March 2020, the entire chain of email correspondence between Ms Currie and MSS,[119] including the correspondence sent by Mr Adams to Ms Currie specifically referring to subcontracting.[120] Importantly, this documentary evidence is the precise opposite of the evidence which the DJPR Principal Policy Officer, by his witness statement at [36] - [37], seeks to have the Board accept. To the extent that MSS was not afforded an opportunity to test this evidence (as he was not called to give evidence), and demonstrate that it was false, we invite the Board to reject the evidence at these paragraphs insofar as it relates to MSS. The DJPR Principal Policy Officer's understanding was at best mistaken, but at worst contrived. It was at least incorrect. It was not supported by the other evidence and ought to be rejected.

73 The Board also heard evidence from Mr Ishu Gupta, Mr Mina Attalah, and received evidence of Mr Eddie Chakik, each directors of subcontracting firms which MSS engaged for the Program.[121] Each of Mr Gupta and Mr Attalah gave evidence of their experiences during the Program. Like MSS personnel, they too took their roles in the provision of security services, the safety and training of their staff, as well as the broader infection control framework in which their services were provided, very seriously.

74 MSS subcontractors had entered into existing agreements with MSS in mid-2019 – well before their engagement in the Program. Entry into those agreements involved a negotiation and discussion process as to rates.

[115] Exhibit 37 Attachments to Witness Statement of Katrina Currie at DJP.208.002.0079.
[116] Currie T462:3-14.
[117] Currie T471:38-47, T472:1-28, T472:32-47, T473:34-47-T474:1-13, T474:24-47, T475:1-19.
[118] Currie T474:24-47, T474:1-19.
[119] Exhibit 37 Attachments to Witness Statement of Katrina Currie at DJP.110.001.4863 at 4875 and following.
[120] Exhibit 37 Attachments to Witness Statement of Katrina Currie at DJP.110.001.4863 at 4876. See further, Phemister T1846:38-47.
[121] Exhibit 58 Statement of Abdul Hamid Eddie Chakik (WIT.0001.0011.0001), Exhibit 53 Statement of Ishu Gupta (WIT.0001.00015.0001), Exhibit 52 Statement of Mina Attalah (URM.0001.0001.0204).

75 When the Program presented as an opportunity, MSS provided its subcontractors an opportunity to provide to MSS a revised schedule of rates for the Program to ensure its subcontractors were able to fulfil their obligations. In his evidence Mr Adams explained that each subcontractor made a commercial decision about what it believed was an appropriate rate in order to run the Program.[122] All subcontractor personnel were to be remunerated in accordance with the prevailing Security Award or a relevant and valid industrial instrument. Mr Gupta and Mr Attalah each confirmed this to be the arrangement in place, and that MSS paid the subcontractor's invoices on 7 day terms[123] – notably faster than MSS paid its own employees, who are paid fortnightly.[124] It was a term of the Security Services Subcontract that all staff employed in the Program had successfully undergone a police check and held and kept up to day all required Authorisations. Further, that all staff would hold a current Victorian Individual Operator Licence,[125] which carried with it a currency in First Aid certification[126] and would complete the Commonwealth government's COVID-19 online training.[127]

76 MSS required its subcontractors to directly employ all staff. The Services Subcontracts specifically prohibited MSS subcontractors from further subcontracting security officers from other providers or labour hire without the consent of MSS. Further, all MSS subcontractor staff were to be paid in accordance with the relevant industrial agreement.[128] This was an understanding which Mr Gupta and Mr Attalah both expressed awareness of and compliance with and was consistent with the POC.[129]

77 Subject to the requirements of the Services Subcontracts with respect to sub-subcontracting, MSS did not place restrictions on how its subcontractors could recruit and roster staff for the Program. There was no requirement to do so in the POC.[130] Mr Krikelis was not aware of such a limitation having been imposed by the DJPR or the DHHS upon MSS.[131] Indeed, from the evidence no such limitation was imposed. Mr Gupta, Mr Attalah and Mr Chakik, each gave evidence of how they went about recruiting staff, which ranged from permanent and casual staff on their databases, and external

[122] Adams T826:13-47-T827:1-14, Gupta, Attalah T731, T732:1-41. See also Exhibit 52 Statement of Mina Attalah (URM.0001.0001.0204) at 008-009, Exhibit 53 Statement of Ishu Gupta (WIT.0001.00015.0001) at [34], Exhibit 58 Statement of Abdul Hamid Eddie Chakik (WIT.0001.0011.0001) at 0005.
[123] Gupta, Attalah T759:16-27.
[124] See Exhibit 67 Statement of Sam Krikelis (MSSS.0002.0014.0001) at [95].
[125] Exhibit 65 Statement of Jamie Grant Lachlan Adams (MSSS.0001.0014.0002) at [28], Exhibit 66 Annexures to Statement of Jamie Grant Lachlan Adams at MSSS.0001.0001.0004 at 0039.
[126] See Exhibit 53 Statement of Ishu Gupta (WIT.0001.00015.0001) at [22], Exhibit 52 Statement of Mina Attalah (URM.0001.0001.0204) at 005, Exhibit 58 Statement of Abdul Hamid Eddie Chakik (WIT.0001.0011.0001) at 0004. See also Exhibit 65 Statement of Jamie Grant Lachlan Adams (MSSS.0001.0014.0002) at [111]-[115] and Exhibit 66 Annexures to Statement of Jamie Grant Lachlan Adams at MSS.0001.0013.0034. See also, Erasmus T241:19-36.
[127] Gupta, Attalah T747:20-31. See also discussion between the Board and Ms Robertson at T691:11-26.
[128] Adams T825:31-41. See also Exhibit 65 Statement of Jamie Grant Lachlan Adams (MSSS.0001.0014.0002) at [118], Exhibit 67 Statement of Sam Krikelis (MSSS.0002.0014.0001) at [83]-[86], Exhibit 68 Attachments to Statement of Sam Krikelis at MSSS.0001.0005.2953, MSSS.0001.0005.2955, MSSS.0001.0005.2958, MSSS.0001.0005.2965.
[129] Attalah, Gupta T750:36-46-T751:1-23. See also Exhibit 58 Statement of Abdul Hamid Eddie Chakik (WIT.0001.0011.0001) at 0005.
[130] Exhibit 65 Statement of Jamie Grant Lachlan Adams (MSSS.0001.0014.0002) at [80]; Exhibit 66 Annexures to Statement of Jamie Grant Lachlan Adams at MSSS.0001.0002.0050.
[131] Exhibit 67 Statement of Sam Krikelis (MSSS.0002.0014.0001) at [86].

recruitment by word of mouth, referrals or online sources. Notably, neither Mr Gupta nor Mr Attalah confirmed that they utilised WhatsApp for the recruitment of their staff.[132]

78 During early discussions with its subcontractors around 5 or 6 April 2020,[133] MSS outlined the general duties, as were known to it at that time, for security staff during the Program. These included checking in passengers, escorting them up to their rooms, where MSS (and its subcontractors) understood they would stay for 14 days.[134] As the Program evolved, these duties changed and expanded.

79 Each subcontractor firm engaged by MSS in the Program, executed its obligations under its respective subcontract agreements diligently and professionally, with a consistent understanding of what was expected of them by MSS.

The speed with which the Program was established and the implications upon MSS

80 Whilst both MSS and its subcontractors made every effort to meet the ever-changing demands and requirements of the Program and Government agencies - which they largely succeeded in doing - the incredibly fast implementation of the Program, with little to no foundational policy or procedure in place at commencement, a non-compulsory testing regime, the introduction of fresh air breaks and other external room activities, together with the pace with which important decisions were being made and communicated (assuming they were in fact actually communicated), and a distinct lack of oversight and clear governance within the Program - made its delivery doomed from the outset.

81 The number of persons and shifts which MSS was allocated changed frequently.[135] This occurred principally as a result of fluctuations in guest numbers within the hotels as guests arrived and then, after quarantine, left. Further, security duties changed over the course of the Program - for example, when MSS was directed to deliver meals to rooms, it increased the roster to allocate more escort guards to accommodate this. Finally, personnel needs changed as a result of a reassessment of security needs by the DJPR. MSS staff numbers, across all hotels, officially reduced on 21 June 2020.[136]

82 Due to last minute, often insufficiently detailed flight manifests,[137] MSS became aware of security staffing requirements at hotels, sometimes with notice of only a day or just a few hours'. Mobilising resources in such a short turnaround time was inherently difficult. It meant subcontractors were informed very late about rostering requirements. MSS subcontractors appreciated that MSS was reliant upon information it received from the DHHS in respect of flight manifests. This nonetheless

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[132] Gupta, Attalah, T711:32-41, T712:29-33, T712:41-47, T713:1-17, T713:42-47, T714:1-2. See also Exhibit 67 Statement of Sam Krikelis (MSSS.0002.0014.0001) at [76]-[82].
[133] Gupta, Attalah T710:25-47.
[134] Krikelis T818:37-39, Gupta, Attalah T721:21-47-T722:1-4. See also Exhibit 53 Statement of Ishu Gupta (WIT.0001.00015.0001) at [19], Exhibit 52 Statement of Mina Attalah (URM.0001.0001.0204) at 004-005, Exhibit 58 Statement of Abdul Hamid Eddie Chakik (WIT.0001.0011.0001) at 0003.
[135] Exhibit 67 Statement of Sam Krikelis (MSSS.0002.0014.0001) at [23], Phemister T1832:13-23.
[136] Exhibit 67 Statement of Sam Krikelis (MSSS.0002.0014.0001) at [35]-[40], Exhibit 68 Attachments to Statement of Sam Krikelis at MSSS.0001.0005.1457, MSSSS.0001.0005.1213.
[137] Cleaves T906:32-47-T907:1-12.

placed significant pressure on rostering and resourcing on all involved. Despite this, MSS fulfilled all its obligations in this regard.[138]

83 The evidence the Board received demonstrated an evolving practice of security being called upon during the Program, by the DJPR, the DHHS team leaders and AOs, as well as hotel staff and contract nurses, to perform duties well beyond, their contracted security-related duties. In his evidence, Mr Krikelis explained that MSS staff undertook additional tasks including checking in guest luggage, setting up family rooms, delivering meals, searching bags, and escorting guests on exercise walks and cigarette breaks.[139] Notably, the extension of security-related tasks, the exposure to other personnel – for instance nurses moving room-to-room, guests and the broader hotel environment, significantly increased the risk of transmission of COVID-19 to MSS staff and others.

84 The Board also heard and received evidence from MSS subcontractors as to their experience of these changes. Each of Mr Gupta, Mr Attalah and Mr Chakik referred to the duties they observed their staff undertake during the Program, which extended markedly beyond those originally contemplated by, and explained to, MSS.[140] Mr Gupta gave evidence about how duties "evolved drastically" but that they "just followed instructions".[141]

TOPIC 3: The information, guidance, training and equipment provided to MSS, whether such guidance or training was followed, and such equipment properly used (see Term of Reference 4)

85 Counsel Assisting submitted that there was no proper early and appropriate training and supervision for security with regard to infection control, either as a result of a failure of contractual management by the DJPR or because of a failure of provision of services by the DHHS.[142] MSS concurs with this submission.

86 Counsel Assisting went further and suggested that it was open to the Board to find that poor training and education of frontline staff were additional failures which contributed to the further proliferation of the virus into the community. In our submission, from the outset security staff at the frontline of the Program worked in a high-risk environment. It is clear that the plainly ad hoc training and supervision by the DHHS in respect of PPE usage and infection prevention and control, was insufficient and inadequate.[143] In the circumstances which prevailed, no findings should be made against MSS in respect of the steps it took to ensure its staff and subcontractors were adequately and consistently trained. More than that, throughout the Program, and particularly following the outbreak at the Stamford, their efforts in successfully containing the transmission of the virus are to be commended.

[138] Gupta, Attalah T717, T718:1-7, T719:34-46-T720:1-10. See also Adams T813:24-36.
[139] Krikelis T818:37-47-T819:1-7. See also Exhibit 67 Statement of Sam Krikelis (MSSS.0002.0014.0001) at [32], [38]. As to exercise walks, see also Cleaves T:911:9-22, Tully T941:34-44, Unterfrauner T612:10-28.
[140] Exhibit 58 Statement of Abdul Hamid Eddie Chakik (WIT.0001.0011.0001) at 0004, Exhibit 53 Statement of Ishu Gupta (WIT.0001.00015.0001) at [19]-[20], Exhibit 52 Statement of Mina Attalah (URM.0001.0001.0204) at 004.
[141] Gupta T721:36-47-T722:1-13.
[142] Counsel Assisting, Mr Ihle, T2256:20-26.
[143] Counsel Assisting, Mr Ihle, T2239:1-4.

87 Ms Simone Alexander, COO of Alfred Health opined in her evidence that best practice dictated that aspects of quarantining relevant to infection control - including establishing the requirements for infection control and providing training to all onsite staff - should ideally be managed by a clinical service provider. Ms Alexander explained that such a practice would ensure consistency in relation to training and infection control requirements onsite, and a clear line of responsibility for identifying and rectifying infection control risks.[144] This was not something which occurred during the course of the Program.

88 From the outset of the Program, MSS understood from Ms Currie, and expected, that each hotel would be staffed by the DHHS and medical staff who would, at all times, provide direction to MSS personnel regarding infection control protocols and requirements.[145] Mr Adams had been told that the only training MSS personnel were required to undertake was the Commonwealth Government COVID-19 online training and that the DHHS would be present onsite and would provide personnel with an induction.[146] Although MSS required personnel to undertake the Commonwealth Government COVID-19 online training module, there was no onsite induction provided by the DHHS and, to the extent that the DHHS had personnel onsite, infection control measures were largely reactive, ad hoc and inconsistent, to the extent they existed at all. There were no face-to-face training sessions in relation to the PPE guidelines or infection control measures provided to MSS personnel by the DHHS - contrary to what Mr Adams had understood would occur - before 24 and 26 June 2020, after the outbreaks had occurred at the Rydges and the Stamford Hotels.[147]

89 As the Program progressed, the experience of MSS was such that, whilst there was an expectation that the DHHS would be a source of training and expert medical advice on matters of infection control and use of PPE, the infection control training actually afforded by the DHHS (to the limited extent to which it was provided), was, as Mr Krikelis observed, “ad hoc” rather than something “more structured”.[148] It was certainly not frequent or specialised, as might have been expected or preferred given the expertise of the control agency. Nor was it usually conducted in a formal setting. It was often – as appears from the evidence given in the course of the Inquiry – not even correct. Indeed, contrary to the evidence of Ms Peake for the DHHS, as to the occurrence of daily briefings provided by the DHHS,[149] there is no direct evidence before the Board of personnel providing structured or ongoing training onsite at the hotels, and indeed it was not the experience of MSS that DHHS team leaders or

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[144] See Exhibit 99 Witness Statement of Simone Alexander (ALFH.0001.0001.0001) at 0019, [69]. See also Exhibit 88 Witness Statement of Dr Stuart Garrow (WIT.0001.0031.0001) at 0009-0010 and Exhibit 96 Witness Statement of Dr Nathan Pinskier (WIT.0001.0047.0001) at 0006 [49].
[145] Adams T821:1-8. Exhibit 65 Statement of Jamie Grant Lachlan Adams (MSSS.0001.0014.0002) at [101].
[146] Currie T471:10-36. See also Exhibit 37 Attachments to Witness statement of Katrina Currie at DJP.101.002.1076-1077.
[147] See Exhibit 60 Attachments to Witness Statement of Principal Policy Officer at DJP.103.007.3576-3577. See also Exhibit 65, Statement of Jamie Grant Lachlan Adams (MSSS.0001.0014.0002) at [136]-[139], [146], Exhibit 67 Statement of Sam Krikelis (MSSS.0002.0014.0001) at [107], Exhibit 68 Attachments to Statement of Sam Krikelis at MSSS.0001.0005.1707 and MSSS.0001.0005.1632.
[148] Krikelis T821:10-15.
[149] Peake T2020:6-47-T2021:1-36.

otherwise, provided daily briefings to security personnel, including in relation to matters such as PPE use and infection control, during the Program.[150]

90 In his evidence, Mr Krikelis observed, that to his knowledge, no co-ordinated face-to-face training program was provided by the DHHS, the DJPR or any other government department to MSS staff; however, he was informed by site supervisors that some informal training and instruction was given by the DHHS personnel onsite.[151] It remains unclear from the evidence whether such training emanated in fact from the DHHS or agency nurses and, if it occurred, exactly when it took place.[152] These observations were echoed by MSS subcontractors, who agreed that if there were any questions around PPE, these were directed back to MSS.

91 Additionally, the information provided to both MSS and its sub-contractors by the persons who provided PPE guidance, varied from time to time.[153] Further, as set out above and discussed in more detail below, there was no formal advice about how 'physical distancing' was intended to be implemented.

92 In response to concerns MSS raised about a lack of formal training by the DHHS, the Department arranged for an infectious diseases' specialist to deliver face-to-face interactive training to MSS guards; however, this only occurred at the Stamford hotel on 24 June 2020 and at the Park Royal on 26 June 2020.[154] Other than these training sessions, and an incidental demonstration by a nurse at the Stamford hotel (again it may have been an agency nurse rather than a DHHS employee),[155] as to wearing a mask, the evidence of Mr Gupta and Mr Attalah was that no training was provided to their staff by the DHHS, the DJPR or any other Government department.[156]

93 Notably, there is no evidence before the Board that at the inception of the Program, any consideration was given to the vulnerability of security guards, the density of their private living arrangements or indeed any other cultural, educational, linguistic or socio-economic factors. The evidence given by the Premier indicates that the government had available to it an issues paper prepared in 2018 titled 'Victoria's Private Security Industry Issues Paper'.[157] By reason of that issues paper, the Government was clearly aware well before the COVID-19 pandemic, that security guards, as a cohort, were

[150] Exhibit 52 Statement of Mina Attalah (URM.0001.0001.0204) at 005, Exhibit 53 Statement of Ishu Gupta (WIT.0001.00015.0001) at [23].
[151] Exhibit 65, Statement of Jamie Grant Lachlan Adams (MSSS.0001.0014.0002) at [63]-[64].
[152] See Exhibit 52 Statement of Mina Attalah (URM.0001.0001.0204) at 005 [23].
[153] Gupta, Attalah T751:33-47-T752:1-22. Exhibit 52 Statement of Mina Attalah (URM.0001.0001.0204) at 005, Exhibit 53 Statement of Ishu Gupta (WIT.0001.00015.0001) at [23], Exhibit 58 Statement of Abdul Hamid Eddie Chakik (WIT.0001.0011.0001) at 0004. See further Exhibit 177 Witness Statement of Chris Eccles (DPC.0017.0001.0001) at 0013 [51](d)], Exhibit 178 Annexures to Statement of Chris Eccles at DPC.0012.0001.0463 and DPC.0008.0001.3213.
[154] Exhibit 65, Statement of Jamie Grant Lachlan Adams (MSSS.0001.0014.0002) at [146], Exhibit 67 Statement of Sam Krikelis (MSSS.0002.0014.0001) at [107], Exhibit 68 Attachments to Statement of Sam Krikelis at MSSS.0001.0005.1707 and MSSS.0001.0005.1632.
[155] See Exhibit 52 Statement of Mina Attalah (URM.0001.0001.0204) at 005 [23], see also Exhibit 139 Email from Stamford Plaza to DHHS.
[156] Exhibit 52 Statement of Mina Attalah (URM.0001.0001.0204) at 005, Exhibit 53 Statement of Ishu Gupta (WIT.0001.00015.0001) at [23]. See also Exhibit 139 Email from Stamford Plaza to DHHS.
[157] Premier Andrews T2145:20-47-T2147:1 -14; see "Victoria's Private Security Industry" issues paper for consultation Police Policy and Strategy (HQI.0001.0027.0001) at 0023, 0025, 0030, 0034.

vulnerable in a range of respects. Those vulnerabilities meant that the risks posed by a Program lacking a proper structure were necessarily increased.

94 It is apparent also from the evidence of the CHO Professor Sutton,[158] and the COVID-19 Division Deputy Public Health Commander - Case Contact and Outbreak Management, Dr Clare Looker,[159] that they considered that these vulnerabilities were clearly relevant to the operation of a successful program, albeit not contemplated or addressed by those within the DJPR when considering the involvement of private security. In the event these were matters which were of critical importance from an infection control perspective, as has been suggested in evidence before the Board, they were not matters which were raised with MSS when resourcing and selecting security personnel.[160]

95 While MSS, understanding the inherent need to protect its staff and the community and the importance of infection control, did take steps to provide its personnel with as much training as it possibly could, it did so from the starting point that:

(a) In Mr Adams' initial discussions with Ms Currie, it was made clear that MSS was to ensure they had a supply of PPE as part of the rollout of the Program.[161] From the outset, MSS flagged to each of Ms Currie (and the DJPR Principal Policy Officer) that it may have difficulties sourcing sufficient PPE.[162] As matters transpired, MSS was able to source sufficient PPE, with the assistance of supply from the DHHS.[163] The experience of the MSS subcontractors engaged in the Program was certainly that there was an ample supply at all times, at all hotels in which they operated[164] even if, at times, the DHHS through the policies and procedures it put in place, did not promote use of such PPE;

(b) Nothing was said to Mr Adams by Ms Currie during initial conversations, as to how MSS was to <u>use</u> PPE, nor was anything said to the effect that MSS was required to <u>train</u> its staff in a particular way about such use;[165]

(c) Ms Currie, as the representative of either the DJPR, and also the DHHS, had confirmed to Mr Adams, and Mr Adams understood, that completion of the COVID-19 Government online training module[166] was adequate training and the only formal training prerequisite to be completed prior to private security commencing in the Program; [167] and

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[158] See Exhibit 159 Series of Emails from 19-21 June 2020 Document ID 5000.0034.6968, Sutton T1496-T1498:1-2.
[159] McGuinness T1103:32-35, T1104-T1105:1-12. See Exhibit 97 Witness Statement of Dr Clare Looker (WIT.0001.0048.0001) at 0021 [95].
[160] See also Pakula T1934:24-47-T1935:1-7, Peake T2000:45-47-T2001:1-32.
[161] Currie T448:4-11.
[162] Adams T828:11-16.
[163] Adams T828:45-47-T829:1-20. See also Exhibit 65, Statement of Jamie Grant Lachlan Adams (MSSS.0001.0014.0002) at [131]-[132], Exhibit 67 Statement of Sam Krikelis (MSSS.0002.0014.0001) at [100]-[103] and [108]-[119], Exhibit 68 Attachments to Statement of Sam Krikelis at MSSS.0001.0013.0055. See also as to Government supply of PPE, May T968-T969:1-19.
[164] Gupta, Attalah T728:3-14, T728:41-47-T729:1-7.
[165] Currie T470:13-47, T471:1-36.
[166] Exhibit 3, Slides.
[167] Currie T447:29-47. See also Exhibit 65, Statement of Jamie Grant Lachlan Adams (MSSS.0001.0014.0002) at [120]-[122]. See further Phemister T1851:7-30.

(d) The DHHS would be present onsite and would provide infection control advice and MSS personnel with an induction[168] (which in fact never eventuated), but in any event any COVID-19 positive guests would not be brought to the hotel and those who were positive would be immediately transported to a health facility. [169]

96 In that context, MSS undertook that all of its staff, and subcontractors, would complete the Government training module. MSS personnel consequently completed the Commonwealth government COVID-19 online training module and as matters transpired, the personnel obtained Certificates to evidence completion of the course.[170] Mr Gupta and Mr Attalah, each confirmed their respective companies also adhered to, and completed, the training and obtained Certificates accordingly.[171] In evidence before the Inquiry, Professor Grayson explained that the COVID-19 Government online training module was “for the general public rather than someone who is going to come into direct contact, or indeed, be responsible for managing COVID patients”. Professor Grayson concluded that the module was confused in its target audience, having regard to the level at which it pitched information and the detail with which the information was provided.[172] In short, the precise training the security guards were directed to undertake by the DJPR staff was inadequate. Beyond that though, Minister Mikakos in her evidence suggested that the DHHS’ “understanding of this virus changed over time and therefore the advice around these issues broadly changed over time.” She knew that the DHHS’ “understanding of the virus has led to changes around PPE usage in our health services”, yet she couldn’t comment on the Program and said she was not aware of that detail.[173] The evidence discloses that to the extent there were changes in understanding, the information and guidance provided to those working at the frontline of the Program – such as MSS personnel – was either absent or, if provided, was wrong.

97 In all of the circumstances, MSS, in endeavouring to ensure the safety of its own workers, provided its staff and subcontractors with the following substantive COVID-19 information and training, *before* they commenced with the Program:

(a) COVID-19 information updates, regarding safety and prevention measures and links to government websites about COVID-19, which were circulated on the MSS Employee Portal on a weekly basis, from as early at 31 January 2020.[174]

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[168] Currie T471:10-36. See also Exhibit 37 Attachments to Witness statement of Katrina Currie at DJP.101.002.1076-1077.
[169] Adams T816:8-21, T840:36-42. See further, Exhibit 65, Statement of Jamie Grant Lachlan Adams (MSSS.0001.0014.0002) at [51].
[170] Exhibit 65, Statement of Jamie Grant Lachlan Adams (MSSS.0001.0014.0002) at [100], Exhibit 66 Annexures to Statement of Jamie Grant Lachlan Adams at MSSS.0001.0010.0017, MSSS.0001.0003.1002. See also Exhibit 67 Statement of Sam Krikelis (MSSS.0002.0014.0001) at [67]-[68].
[171] Gupta, Attalah T747:20-31. See also discussion with Madame Chair and Ms Robertson, Counsel for MSS, at T691:11-26.
[172] Grayson T47: 1-16.
[173] Mikakos T2093:17-27.
[174] Exhibit 65, Statement of Jamie Grant Lachlan Adams (MSSS.0001.0014.0002) at [97], see examples of such updates at Exhibit 66 Annexures to Statement of Jamie Grant Lachlan Adams at MSSS.0001.0013.0008 MSSS.0001.0013.0009, MSSS.0001.0013.0010, MSSS.0001.0013.0011, MSSS.0001.0013.0012, MSSS.0001.0013.0013, MSSS.0001.0013.0014, MSSS.0001.0013.0015, MSSS.0001.0013.0016, MSSS.0001.0013.0017, MSSS.0001.0013.0018, MSSS.0001.0013.0019, MSSS.0001.0013.0020, MSSS.0001.0013.0021, MSSS.0001.0013.0022, MSSS.0001.0013.0023, MSSS.0001.0013.0024, MSSS.0001.0013.0025, MSSS.0001.0013.0026 and MSSS.0001.0013.0027.

(b) Information sent by email by Mr Adams, to all Victorian employees about hygiene as well as updated COVID-19 information, as early as 16 March 2020 and continuing throughout the duration of the Program.[175]

(c) an internal training module, specifically targeted to its subcontractor's personnel, entitled *"Infection Prevention and Control"* which was available on the MSS subcontractor portal, and circulated to all subcontracting partners on 30 March 2020.[176] In particular, the module provided substantial explanation as to the nature of COVID-19, working safely in an infectious environment, hand hygiene, PPE, social distancing and self-isolation. It contained links to related Government websites containing information about COVID-19 and infection prevention measures. Mr Gupta and Mr Attalah, in giving evidence, were each taken to the module. They each agreed that they received it and were aware of its contents and the MSS requirement that it be undertaken by all subcontracting personnel.[177]

98 Once onsite, and consistent with its obligations under the POC,[178] MSS took steps to ensure that:

(a) It undertook daily onsite briefings with staff and routinely provided the advice it had received from the DHHS around PPE and its use throughout the Program (noting that the first advice – PPE guidance dated 5 May 2020 - was only received by MSS in late May 2020 and was then changed when the 8 June 2020 PPE guidance was issued on 11 June 2020).[179] MSS subcontractors also confirmed their understanding and experience of these briefings, and made every effort to ensure their staff attended briefings, and followed any advice provided.[180] When MSS received the 8 June 2020 PPE guidance, MSS arranged to train and brief its staff.[181] It is notable that no steps in that regard were undertaken by the DHHS notwithstanding, according to Minister Mikakos' evidence, that after she became aware of the Rydges' outbreak she asked her Department to put in place a number of changes and supported bringing in Alfred Health.[182] It remains implausible why if Minister Mikakos and the Department, were making suggestions for the involvement of health practitioners in the Program, there was no training about the updated PPE guidelines provided to security personnel by the DHHS following the Rydges outbreak, and <u>before</u> the Stamford outbreak.

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[175] Exhibit 65, Statement of Jamie Grant Lachlan Adams (MSSS.0001.0014.0002) at [98], see examples of such emails at Exhibit 66 Annexures to Statement of Jamie Grant Lachlan Adams at MSSS.0001.0013.0031 to MSSS.0001.0013.0032.
[176] Exhibit 67 Statement of Sam Krikelis (MSSS.0002.0014.0001) at [69], Exhibit 68 Attachments to Statement of Sam Krikelis at MSSS.0001.0003.0857 at 0001-0002. See also Exhibit 65, Statement of Jamie Grant Lachlan Adams (MSSS.0001.0014.0002) at [123], Exhibit 66 Annexures to Statement of Jamie Grant Lachlan Adams at MSSS.0001.0013.0029 at 0001-0015.
[177] Gupta, Attalah T747:33-47, T748-T750:111.
[178] At Schedule 3 of the POC, see Exhibit 65, Statement of Jamie Grant Lachlan Adams (MSSS.0001.0014.0002) at [80], Exhibit 66 Annexures to Statement of Jamie Grant Lachlan Adams at MSSS.0001.0002.0050_0065.
[179] Adams T819:37-41. See also, Exhibit 65 Statement of Jamie Grant Lachlan Adams (MSSS.0001.0014.0002) at [125] and [134], Exhibit 66 Annexures to Statement of Jamie Grant Lachlan Adams at MSSS.0001.0004.0310 at 0006, Exhibit 67 Statement of Sam Krikelis (MSSS.0002.0014.0001) at [70] and [106].
[180] Gupta T758:14-18. Gupta, Attalah T723:11-21, T750:13-34, T752:16-28. See also Exhibit 58 Statement of Abdul Hamid Eddie Chakik (WIT.0001.0011.0001) at 0004.
[181] Exhibit 65, Statement of Jamie Grant Lachlan Adams (MSSS.0001.0014.0002) at [126(a)], Exhibit 66 Annexures to Statement of Jamie Grant Lachlan Adams at MSSS.0001.0003.1609, MSSS.0001.0005.1432, MSSS.0001.0005.1433, MSSS.0001.0005.1427.
[182] Mikakos T2097:24-35.

(b) MSS staff were kept up to date with, and trained about the content of any prevailing information, guidance or practice issued by the Government agencies throughout the Program, noting that at the commencement of the Program there was no other available formal or face-to-face training available from any Government agency in respect of COVID-19, and MSS could not train about matters about which it was provided no information (a further example of which is the fact that there was no written physical distancing policy ever provided to MSS which detailed how its guards were required to act in the specific circumstances which confronted them within the hotel environments); and

(c) The work its staff undertook was carried out within the prism of infection control awareness, which extended to being acutely cognisant of the infectious environment in which its staff were operating, and how such infection was transmitted.

99 Insofar as any instances of non-compliance occurred by security guards employed by, or within the cohort of personnel working for subcontractors engaged by MSS, these were features of human error and not a feature of a lack of training on the part of MSS about COVID-19, its virility and the paramount importance of infection control in the hotel environment during the Program. Crucially, if and when instances of non-compliance arose, they were immediately investigated and the MSS practice was to promptly and permanently dismiss such staff - a practice which speaks to the seriousness with which MSS took its role, the safety of its staff and all personnel operating within the Program.

100 Mr Adams observed that, by virtue of the fact that there were no issues escalated to him personally by the DJPR, he believed that was an indication that the DJPR and/or the stakeholders involved during the Program, were satisfied with the response by MSS throughout the Program.[183] These observations were not contested by the DJPR or indeed any other party during the Inquiry. Having regard to the magnitude and length of the Program, with MSS having deployed some 900 security officers to work across the Program, 24 hours a day,[184] to the extent that any matters were raised with MSS during the Program, they were discrete, small in number, resolved efficiently and proactively.[185] To the extent that any issues were identified in evidence before the Board, we submit that nothing flows from them, and there is no evidence of any systemic failing on the part of MSS during the Program.

TOPIC 4: The policies, protocols and procedures applied by Government agencies (see Term of Reference 5)

101 In line with Counsel Assisting's submissions, private security bore the primary responsibility of implementing various policies, and providing guidance, in relation to health, welfare and infection

[183] Adams T832:31-35.
[184] Adams T832:20.
[185] See Exhibit 67 Statement of Sam Krikelis (MSSS.0002.0014.0001) at [124]-[127], Adams T832:22-28, T832:31-35. See also, Gupta T739:29-47-T740:1-29, T758:1-19, Attalah T738:3-16, T735:20-26, T758:21-44, Erasmus T235:26-40, T241:1-17, T242:47, T243:1-4, T243:42-47, Ferrigno T539:35-47, T540:1-18, T542-T543:1-6, T831:39-47-T832:1-3, Krikelis T823:32-40, T831:39-47-T832:1-3, Unterfrauner T617:1-11, May T978:39-47-T979:1-34.

prevention and control throughout the Program. This structure, which segregated those with specific health expertise, from the operation of infection prevention and control policies, created a diffusion of responsibility and a dilution in understanding.[186] It left those working within the Program to decipher and implement complex, specialised medical-based policies and procedures. MSS did the best it could within the parameters of its knowledge.

102 Throughout the Program, Government agencies, particularly the DHHS and the DJPR, created a minimal number of policies, protocols and procedures which were to apply onsite at hotels. In this respect, the experience of MSS during the Program could be summarised in this way:

(a) Applicable formal written policies, protocols and procedures provided to MSS were limited in number.

(b) Policies, protocols and procedures changed frequently, and appeared to be reactive to infection control experiences onsite rather than pre-emptive.

(c) New and otherwise updated documents were issued to security staff on an ad hoc basis, were expected to have immediate implementation onsite and were subject to review at any time. When new documents or guidance were issued, those documents were often not disseminated to private security until well after they were created – for instance the first PPE policy endorsed on 5 May 2020 by the DHHS was not disseminated to MSS until 29 May 2020.[187] Additionally, they were largely not explained or implemented through any hands-on specialised infection control training onsite through the DHHS. Rather, there seems to have been an expectation by the DHHS that they would be privately interpreted, and coalesced with any existing procedures at the time, by MSS and the security staff working onsite.[188]

(d) Oral instructions and guidance were provided to private security by a range of bodies and individuals within the Program. These were often inconsistent with the documents and guidance issued by Government agencies.

(e) There were instances of such documents conflicting with either the prevailing POC or indeed, the infection control measures understood to be 'best practice' at any one time. Moreover, guidance provided by Government agencies, at times conflicted with guidance issued by the hotels to their staff, or practices engaged in, by the DHHS nurses; resulting in security staff being perceived to have acted inappropriately in circumstances where fairly, they may not have.

New and reviewed policies during the Program - the Government perspective

[186] Counsel Assisting, Mr Ihle, T2245:7-15. See also Counsel Assisting, Mr Ihle referencing the evidence of Ms Simone Alexander at T2259:10-17.
[187] Exhibit 67 Statement of Sam Krikelis (MSSS.0002.0014.0001) at [65], Exhibit 68 Attachments to Statement of Sam Krikelis at MSSS.0001.0005.1029.
[188] See for example Exhibit 201 Statement of DHHS Learning Consultant (DHS.9999.0021.0001) at 0006 [23(c)], particularly at DHS.5000.0151.2702.

103 In his evidence, Mr Noel Cleaves, Manager, Environmental Health Regulation and Compliance in the DHHS, explained the way in which he appreciated written procedures and policy were being changed throughout the Program. He agreed that it was an iterative process, whereby the DHHS would develop procedures and policies and then as situations changed, such policies and procedures would be refined or updated, or new procedures would be drafted for quite specific situations. As and when the Department perceived a need in a particular area, it would try to draft such an instruction and seek comment from various bodies, and then at some stage that would be endorsed, and distributed as a final endorsed document.[189]

104 With respect to PPE guidance in particular, in evidence Mr Cleaves said that:[190]

(a) his experience was that "guidelines changed, but generally very subtly";

(b) whilst gloves "became much more optional", "hand hygiene became a strong push";

(c) you were expected to wear masks predominantly, "but that there were some moments when that may have been less clear"; and

(d) "the recommendation on whether you wore disposable gowns and gloves and goggles was a little bit variable".

105 Whilst those may have been valid observations by Mr Cleaves, they demonstrate the uncertainty and variability inherent in subtle changes and potentially inconsistent information. The vague and varying policies were of limited use in a practical sense to security staff who were trying diligently to implement the Program onsite at hotels.

106 One such policy which it appears was being drafted very early on in the Program, was the policy contained in a document entitled "COVID-19 – DHHS Physical Distancing and Public Health Compliance and Enforcement Plan" dated 4 April 2020 - 17:00.[191] Professor Sutton, CHO, said in his witness statement that he reviewed that draft document[192] and it was, it seems, available as a draft, to some departmental staff.[193] This was a document which was within DHHS control. Commissioner Crisp had tasked Mr Helps with its creation.[194] However, there is no evidence that this particular document was ever formalised, disseminated or circulated down to personnel onsite, including to security personnel. Indeed, at no time before or during the course of the Program, was MSS provided with this document, or any guidance or information of the kind it contained - particularly with respect

[189] Cleaves T901:37-47-T902:1-16.
[190] Cleaves T913:24-47-T914:1-7.
[191] See Exhibit 76 Annexures to Statement of Noel Cleaves, "COVID-19 - DHHS Physical Distancing and Public Health Compliance and Enforcement Plan" at DHS.0001.0001.0729. See further, earlier draft of the Plan at Exhibit 131 Attachments to Witness Statement of Pam Williams at DHS.0001.0008.0674-0728. Subsequently, it would seem the Exercise and Fresh Air Implementation Plan (v 1) dated 15 April 2020 was developed, see Exhibit 131 Attachments to Witness Statement of Pam Williams at DHS.5000.0003.2831-2841.
[192] See Exhibit 153 Witness Statement of Professor Brett Sutton (DHS.9999.0002.0001) at 0044.
[193] Each of Mr Noel Cleaves and Mr Murray Smith were in possession of it and describe the document in their statements. See Exhibit 75 Witness Statement of Noel Cleaves (DHS.9999.0005.0030) at 0034, Exhibit 122 Witness Statement of Murray Smith (DHS.9999.0007.0001) at 0013.
[194] Exhibit 144 First Witness Statement of Andrew Crisp (DOJ.600.002.0008) at 0027 [52(b)].

to physical distancing. The importance of this omission cannot be understated. MSS operated in a variety of hotels and under a variety of conditions. Each hotel was different. Many hotels had narrow hallways and lifts[195] where it was not always possible to maintain a 1.5m distance. MSS was expected to train its staff about physical distancing but the lengthy DHHS policy document which dealt extensively with such matters, was never provided to it. Consequently the real risk that MSS personnel faced was never communicated to MSS by the DHHS. Nor did DHHS communicate the guidance around how physical distancing should be maintained in the variety of circumstances which confronted MSS personnel.

107 Relevantly, this document contained knowledge and information which was necessarily available to the DHHS at or around 4 April 2020, when this document originated. By reason of this document, it was known to the DHHS at least as early as 4 April 2020, and certainly well before the Rydges or Stamford outbreaks, that:

(a) disposable gloves were to be used always[196] where a person had symptoms and one could not always maintain 1.5 metres distance;

(b) where a person needed to be in a confined space, such as a lift, or a narrow hallway, with a known COVID-19 case, they needed to wear PPE which included eye protection and gloves; and

(c) fomite (and aerosol) transmission of COVID-19 was possible.

108 This was, it is submitted, relevant, indeed vital, information which ought to have been provided to MSS to enable it to train its staff to meet the real risk its personnel faced. That risk was one of transmission of COVID-19 as a result of the presence of COVID-19 positive guests in the hotels, in circumstances where inappropriate arrangements were being made by the DHHS to require COVID-19 positive guests to be placed in separate rooms, or to remain in their rooms during the entire quarantine period; where the DHHS did not ensure adequate and appropriate PPE use by guests; where there was a lack of control of fomite transmission including amongst DHHS staff;[197] where no adequate risk assessment had been undertaken by the DHHS; and where advice and guidance to private security was confused, conflicting and at times non-existent.

109 Despite the importance of such information, there is no evidence to suggest the policy was endorsed, nor the information contained within it provided to MSS. It was certainly not put to either Mr Adams or Mr Krikelis in evidence that it was provided to MSS and no positive evidence was led by the DHHS that this document, or a document containing information of like effect, was provided to MSS by the DHHS or the DJPR.

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[195] Exhibit 1 Witness Statement of Professor Grayson (GRAY.0001.0001.0001) at 0012 [54]; Grayson T66:34-43.
[196] Exhibit 131 Attachments to Witness Statement of Pam Williams at DHS.0001.0008.0674-0728 and annexures thereto including Appendix 9 at 0792. See also See Exhibit 76 Annexures to Statement of Noel Cleaves, "COVID-19 - DHHS Physical Distancing and Public Health Compliance and Enforcement Plan" at DHS.0001.0001.0729.
[197] McGuinness T1110:22-40.

110 In her evidence, Minister Mikakos conceded that she was not made aware of fomite transmission as a source of transmission of COVID-19 until after the Rydges and Stamford outbreaks.[198] This evidence sits in stark contrast to her Department's document which makes clear that from at least 4 April 2020, and probably earlier, the DHHS (although unfortunately, not the Minister) was well aware of the risk of fomite transmission of COVID-19 and the risks associated with inappropriate PPE use; particularly in respect of guests who were either symptomatic or COVID-19 positive. Such information should have informed first, cleaning procedures associated with infectious common areas which personnel onsite were likely to come into contact with (halls and lifts are two examples), and second, the communication protocols around symptomatic guests and the related infection control procedures and PPE use to be expected therein.

111 It was apparent from Mr Cleaves' evidence and related evidence that the process of creation and review of policies and procedures was reactive, iterative and often inconsistent. Whilst updated guidance was potentially aimed at achieving greater consistency across a wide range of hotels, it did not succeed in achieving this goal during the course of the Program.

New and reviewed policies during the Program - the MSS perspective

PPE changes

112 At the commencement of the involvement of MSS in the Program at hotels on 6 April 2020 and despite assurances given by Ms Currie, there was no DHHS training or induction provided to MSS personnel by DHHS.

113 As the Program progressed, and well after commencement, MSS was provided with two PPE-specific guideline documents. The first was the PPE guidelines dated 5 May 2020 (received by MSS on 29 May 2020) [199] and the second was the PPE guidelines dated 8 June 2020 (received by MSS on 11 June 2020). [200] The PPE guidelines were created by the DHHS, but circulated by the DJPR in accordance with the contractual arrangements in place. The 5 May 2020 guidelines were the first written communication about PPE guidance received by MSS over 7 weeks after commencement of its services in the Program.[201]

114 Upon receipt, MSS immediately disseminated these guidelines amongst all its staff and subcontractors, and ensured they were visible in all MSS staff rooms and break-out rooms.[202] MSS

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[198] Mikakos T2093:17-47-T2094:1-27.
[199] Exhibit 67 Statement of Sam Krikelis (MSSS.0002.0014.0001) at [65], Exhibit 68 Attachments to Statement of Sam Krikelis at MSSS.0001.0005.1029.
[200] Exhibit 67 Statement of Sam Krikelis (MSSS.0002.0014.0001) at [65], Exhibit 68 Attachments to Statement of Sam Krikelis at MSSS.0001.0005.0253.
[201] See also Exhibit 97 Witness Statement of Dr Clare Looker (WIT.0001.0048.0008) at 0003 [2], 0007 [36]. It remains unclear why the materials Ms Looker outlines at [36] "materials (video and written) on proper hygiene and use of PPE" had not been formulated and distributed, well before the end of May, after the Rydges outbreak.
[202] Krikelis T821:17-33. See Exhibit 65, Statement of Jamie Grant Lachlan Adams (MSSS.0001.0014.0002) at [145], Exhibit 66 Annexures to Statement of Jamie Grant Lachlan Adams at MSSS.0001.0005.1715 at 0001-0004, Exhibit 67 Statement of Sam Krikelis (MSSS.0002.0014.0001) at [65], Exhibit 68 Attachments to Statement of Sam Krikelis at MSSS.0001.0005.1029, MSSS.0001.0005.1030, MSSS.0001.0005.0253, MSSS.0001.0005.0254.

subcontractors, in evidence through Mr Gupta and Mr Attalah, each agreed they received PPE guidelines from MSS, as and when they were updated by the DHHS.[203]

115 It was apparent from the evidence of Mr Gupta and Mr Attalah, that PPE training and guidance was also provided on an incidental basis during the Program from other bodies in the hotel, including hotel staff, nursing staff and AOs.[204] Mr Attalah agreed with the proposition that this practice of guidance and advice being provided from different bodies within the Program, would have been a source of confusion amongst his staff. [205]

116 In his evidence Mr Adams explained that the change in advice received along the way, particularly through the 8 June 2020 guideline, represented a significant deviation from what he perceived to be the norm, a primary example of which was the requirement for MSS staff not to wear disposable gloves while they were on duty.

117 Notably, in his evidence before the Board, Professor Michael Grayson, explicitly said that if direct physical contact was likely or possible, gloves should be worn, in addition to other forms of PPE. Professor Grayson opined that this was particularly important for duties such as escorting guests from their rooms to open air spaces for recreation breaks (since direct physical contact was possible).[206]

118 At many of the hotels there was evidence of multiple family groups with young children.[207] The DHHS was aware that the role of children in transmission was unclear,[208] but that there were higher person to person contact rates.[209] Further, there was evidence of confirmed cases sharing rooms with other family members.[210] At one point Ms Williams recalled having 600 children and young people under 18 years of age in hotel quarantine.[211] In those circumstances the possibility of physical contact was inevitably higher and the consequent transmission risk heightened. Together with small lifts[212] and narrow hallways[213] at the hotels, the risk to those working at the hotels including private security guards was high. The advice about PPE should have been clearer and timelier.

119 When asked specifically about the 8 June 2020 guidelines and their implications for staff in relation to PPE and infection control measures, Professor Grayson concluded that the recommendations contained therein were inappropriate, particularly because the focus on PPE is not limited only to the 1.5m rule; PPE is needed anyway. This was because there is a level of unpredictability of that 1.5m

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[203] Gupta, Attalah T752:16-28.
[204] Gupta T729: 15-46-T730:1-4, Attalah T752:37-46. See also Exhibit 52 Statement of Mina Attalah (URM.0001.0001.0204) at 005.
[205] Attalah T752:37-46.
[206] Exhibit 1 Witness Statement of Professor Grayson (GRAY.0001.0001.0001) at 0019.
[207] Exhibit 80 First Witness Statement of Rachaele May dated 28 August 2020 (DJP.050.002.0001) at 0028; Exhibit 38 Witness Statement of Gonul Serbest (DJP.050.009.0001) at 0017, see also Returned Traveller No 1 T152:32-42; Tait T175:25-33; De Kretzer T188:14-17; Nagi T857:12-23; Williams T1270:28-T1271:4; Bamert T1305:18-26.
[208] Exhibit 76 Annexures to statement of Noel Cleaves, “COVID-19 - DHHS Physical Distancing and Public Health Compliance and Enforcement Plan” at DHS.0001.0001.0729, at 0768.
[209] Exhibit 76 Annexures to statement of Noel Cleaves, “COVID-19 - DHHS Physical Distancing and Public Health Compliance and Enforcement Plan” at DHS.0001.0001.0729, at 0770.
[210] Crouch, Exhibit DHS.9999.0003.0001, page 9.
[211] Williams T1270:28-1271:4.
[212] Ratcliff T251.12-18.
[213] Ratcliff T251:11.

suddenly becoming less in various scenarios (ie. lifts).[214] This is precisely the risk that the DHHS failed to appreciate and the risk – so it is suggested – which led to the outbreaks.

120 It is clear that insofar as the 8 June 2020 guidelines were concerned, and the DHHS advice during the Program - at least from 8 June onwards - the tenor of Professor Grayson's expert medical opinion was not shared nor advised. It remains unclear, on what medical opinion, if any, the DHHS protocols about PPE came to be drafted and circulated as directives.[215] Indeed, Dr Julian Rait, President of the Australian Medical Association, gave evidence and observed that the Government, and particularly the DHHS, "did not seek input from experts, and so unsurprisingly, when they encountered issues in the ensuing weeks and months, they were not well prepared. It appears that they dealt with issues individually, haphazardly and reactively".[216]

121 The lack of expert input was made plain as a result of the evidence of the Infection Control Consultant.[217] That evidence described the Infection Control Consultant providing initial advice about PPE selection and use to the DHHS between January and March 2020 as well as cleaning and disinfection.[218] However, the Infection Control Consultant stated that she had no formal role in hotel quarantine.[219] She further stated that she was involved in developing documents that were used in the Program but, she was not involved in the implementation of the procedures, and so could not comment on their effectiveness.[220]

122 Having been issued the PPE guidelines, with no training or explanation provided by DHHS, MSS sought further advice. It was put to Mr Krikelis in cross-examination by the DHHS that Mr Krikelis was not suggesting that there wasn't other advice provided and that he was just highlighting that advice. Mr Krikelis agreed with that proposition.[221] The DHHS did provide some other advice. However, given the first guideline – the 5 May 2020 guideline – was not received until 29 May 2020, such advice would not have been timely. Even knowing that the Rydges outbreak had occurred, the DHHS still did nothing to organise structured face-to-face training for personnel working onsite or for MSS to ensure that those working at the frontline of the program understood the infection control requirements of the new guidelines. The real question, however, is whether such advice in respect of which MSS was expected to comply, was even appropriate. It is meaningless, after the fact, to suggest that 'general guidance' or 'advice' was provided without providing the specifics of such advice. The pertinent point is that the first written advice MSS received about PPE was the PPE guidelines (dated 5 May 2020) first sent through from the DJPR on 29 May 2020.[222] That fact was not challenged. In circumstances

[214] Grayson T69:34-47, T70:1-38.
[215] See Febey T434:25-41. See also Exhibit 92 Witness statement of Dr Julian Rait (WIT.0001.0038.0001).
[216] Exhibit 92 Witness statement of Dr Julian Rait (WIT.0001.0038.0001) at 0005.
[217] Exhibit 203 Statement of Infection Control Consultant (DHS.9999.0020.0001).
[218] Exhibit 203 Statement of Infection Control Consultant (DHS.9999.0020.0001) at 0004 [17].
[219] Exhibit 203 Statement of Infection Control Consultant (DHS.9999.0020.0001) at 0006 [26].
[220] Exhibit 203 Statement of Infection Control Consultant (DHS.9999.0020.0001) at 0006 [28].
[221] Krikelis T838:11-34.
[222] Krikelis T838:11-34.

where neither the DJPR nor the DHHS has produced evidence to the contrary, Mr Krikelis' evidence is to be preferred.

123 The PPE advice - in contrast to Professor Grayson's evidence[223] and the earlier advice available to the DHHS[224] - made available to MSS confirmed that the use of gloves as opposed to deferring to good hand hygiene practices, was to be avoided.

124 The experience of receiving guidelines which sought to dramatically change onsite practice with immediate effect, without any formal explanation or training by the DHHS either at all or until sometime later - created confusion and misunderstanding for guards, where it should have created certainty and clarity for those tasked with effecting infection control measures.[225] Moreover, relying on Professor Grayson's uncontested evidence, there is a real question as to the suitability of the PPE guidance that was indeed provided to all hotels and security staff and whether the adoption of such advice, rather than preventing the spread of COVID-19, indeed promulgated the spread of infection.

Other infection-control policy and procedure changes

125 The following key policy and procedure changes were implemented throughout the course of the Program and applied to MSS staff as and when they were issued. The changes, which arose from both the DHHS and the DJPR, impacted upon all manner of services provided by MSS including its day-to-day duties, infection control measures, staffing and resourcing.

(a) *1 April 2020: DJPR* - No manhandling policy issued, which confirmed that for health issues DHHS was to be notified, and for security issues Victoria Police was to be notified.[226]

(b) *9 April 2020: DHHS* - advice received of a 'Health and Welfare Policy' having been endorsed by the CHO; instructions as to its implementation were issued via email only, without any Plan document having been circulated at this time, or at any time since.[227] The effect of this email circulation however, was that the DHHS required an additional three security staff to be rostered for each shift between 8am-8pm to facilitate a range of health and exercise provisions. The email also requested that AOs would work with security onsite to put these procedures into place immediately the following day.

(c) *9 April 2020: DHHS* - Food safety and delivery direction. The DHHS Deputy Chief Health Officer (Environment) provided a direction that anyone that DHHS deemed as high risk was to be granted

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[223] Exhibit 1 Witness Statement of Professor Grayson (GRAY.0001.0001.0001) at 0019.
[224] Exhibit 76 Annexures to statement of Noel Cleaves,"Physical Distancing and Public Health Compliance and Enforcement Plan" at DHS.0001.0001.0729.
[225] Adams T830:28-47-T831:1-12. See also Exhibit 65 Statement of Jamie Grant Lachlan Adams (MSSS.0001.0014.0002) at [133]-[139].
[226] Exhibit 59 Witness Statement of Principal Policy Officer (DJP.050.0004.0001) at 0009, Exhibit 60 Annexures to Statement of Principal Policy Officer at DJP.110.002.9126 at 9134.
[227] See Exhibit 60 Annexures to Statement of Principal Policy Officer at DJP.110.003.3058-3059, see also Exhibit 65 Statement of Jamie Grant Lachlan Adams (MSSS.0001.0014.0002) at [105], Exhibit 66 Annexures to Statement of Jamie Grant Lachlan Adams at MSSS.0001.0005.0592.

access to food deliveries (Uber Eats, etc) to meet their requirements. Security staff were to assist in food deliveries of that nature.[228]

(d) *13 April 2020: DJPR* - changes in number of escort guards required for shifts at Park Royal.[229]

(e) *15 April 2020: DHHS* - Exercise and Fresh Air plan implemented (circulated on 18 April 2020).[230]

(i) This plan had the effect of requiring security, who were to assist with fresh air walks, to wear a mask (provided by DHHS),[231] to touch all surfaces as necessary (for instance to press lift buttons and door handles), to keep a 1.5m distance (including in circumstances where this was not always possible), ensure there were no more than 3 people in a lift, and ensure that appropriate hand hygiene was utilised. Gloves were not recommended. The nature of the plan was to allow exercise once a week per guest, children twice a week, all of which was to be approved by an AO. Guests were recommended to wear masks and gloves when exercising, particularly as accompanied by security in lifts.[232]

(ii) In giving evidence about fresh air breaks, Ms May described a meeting of 16 April 2020, designed to canvass the role of security officers at hotels, and particularly the questions of fresh air breaks and checking of luggage.[233] In relation to fresh air walks, Ms May explained that the plan was developed and circulated some days after this meeting and was specific to each hotel, as each hotel was physically different insofar as where the most suitable location would be for fresh air breaks to be undertaken. She understood that fresh air breaks were not to occur before the plan was implemented. Despite this, in her first week (12 April 2020) there were reports that some fresh air breaks were occurring at hotels where an implementation plan had not yet been developed. This was raised with the DHHS at the time and those breaks were ceased unless the AO and nurse determined that there was some particularly significant mental health need for a particular guest at the hotel at that time.[234]

(f) *24 May 2020: DJPR* - directive on Prohibited Items issued.[235] This had the effect of security guards being required to assist with removing alcohol, drugs and other prohibited items from guest deliveries in full view of CCTV camera.[236]

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[228] Exhibit 59 Witness Statement of Principal Policy Officer (DJP.050.004.0001) at 0008, Exhibit 60 Annexures to Statement of Principal Policy Officer at DJP.110.003.3057. As to contractual obligations, see also Exhibit 66 Attachments to Witness Statement of Jamie Adams at MSSS.0001.0002.0050_0063).
[229] Exhibit 67 Statement of Sam Krikelis (MSSS.0002.0014.0001) at [31]-[32].
[230] See Exhibit 131 Attachments to Witness Statement of Pam Williams at DHS.5000.0003.2831, see also Exhibit 60 Annexures to Statement of Principal Policy Officer at DJP.110.003.9072-9073 as to receipt of the Plan.
[231] See also Exhibit 67 Statement of Sam Krikelis (MSSS.0002.0014.0001) at [115].
[232] See also Cleaves T909:16-47-T910, T911:1-7 as to how the policy came to be and the decision concerning exercise walks made by an AO. As to contractual obligations, see also Exhibit 66 Attachments to Witness Statement of Jamie Adams at MSSS.0001.0002.0050_0063).
[233] May T963:41-46-T965:1-27.
[234] May T964:3-21.
[235] Exhibit 67 Statement of Sam Krikelis (MSSS.0002.0014.0001) at [56], Exhibit 68 Attachments to Statement of Sam Krikelis at MSSS.0001.0003.1616.
[236] See also May T964:16-42, Krikelis T819:1-8.

(g) *23 June 2020: DHHS* - temperature checks at hotels commenced.[237]

(h) *23 June 2020: DHHS* - luggage handling policy changed.[238] These changes had the effect of guards being required to roll up their sleeves to their elbow when handling luggage, removing suit jackets, sanitising up to their elbows, and washing hands after each contact with luggage.

126 The Board also heard and received[239] specific evidence from Ms Rachaele May, Executive Director, Emergency Coordination and Resilience at the DJPR, in relation to how and when cleaning policies were changed, and the implications of those changes upon practices for hotels and contractors, and thereby MSS.

127 For context as to this evidence, it is also relevant to note Ms Williams' evidence as to why the policies came to be changed. Ms Williams opined that as the Program progressed, the understanding of fomite transmission developed and fomite transmission was recognised as a potentially bigger issue than had previously been thought. In this context, Ms Williams explained that the processes for cleaning were tightened up, and particularly following the outbreaks, near the end of the Program, a much more rigorous requirement for the cleaning of the common areas was implemented.[240] In short, the cleaning processes prior to the outbreaks were inadequate and put frontline staff at risk.

128 In her evidence, Ms May explained the following:

(a) The DJPR took responsibility for securing commercial cleaning contractors.[241]

(b) There were two forms of cleaning - one which might be called the standard hotel cleaning and that responsibility remained with the hotel, and one which might be called commercial cleaning and that contractual responsibility lay with the DJPR. [242]

(c) On or about 20 March 2020, the DHHS issued cleaning protocols entitled "Cleaning and disinfecting to reduce COVID-19 transmission - Tips for non-health care settings 20 March 2020".[243] Ms May said that it was confirmed to her, by the DHHS that this was the cleaning standard in accordance with which the commercial cleaning should be undertaken. Notably, in his evidence, Mr Menon, Executive Director Aviation Strategy and Services with the DJPR, described a leaflet which was available from 24 March 2020, created by the Hotels Association and the Commonwealth Department of Health, which dealt specifically with cleaning procedures. He understood hotels had access to this document as of 24 March 2020 for the purposes of meeting their contractual obligations.[244]

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[237] Gupta, Attalah T730:33-37, T758:44-47-T759:1-14.
[238] See Exhibit 53 Statement of Ishu Gupta (WIT.0001.00015.0001) at [19](c) and 25(a). See also Gupta T758:8-12.
[239] See in particular Exhibit 82 Statement of Rachaele Elizabeth May dated 28 August 2020 (DJP.050.0002.0032).
[240] Williams T1282:1-16.
[241] May T970:17-20.
[242] May T970:26-41. See also Exhibit 186 Witness Statement of Kym Lee-Anne Peake (DHS.9999.0009.0001) at 0049 [251.3].
[243] May T971:2-47-T972:1-13. See Exhibit 83 Annexures to Statement of Rachaele Elizabeth May dated 28 August 2020 at DJP.103.007.7332-7335.
[244] Menon T639:38-47-T640:1-9.

(d) The DJPR engaged 3 contractors for commercial cleaning, one of whom, IKON, was providing commercial cleaning services from 13 April 2020. The contracts contained broad stipulation to provide cleaning in line with the most recent cleaning advice from the DHHS, so as to capture any changes. [245]

(e) Following the outbreak at the Rydges Hotel, the DHHS asked the DJPR to arrange for 'deep cleaning' of common areas of the Rydges Hotel and some twice-daily touch point cleaning of common areas. This was not a service that had previously been provided by the DJPR at any of the hotels; the cleaning of common areas according to Ms May was the responsibility of hotels in their contract. To achieve this, at the end of May, the DJPR contracted two further companies to undertake such 'deep cleaning'.[246] There was no evidence that notwithstanding this deep cleaning had occurred at Rydges, that it was also undertaken at other hotels.

(f) A new cleaning protocol was established by the DHHS and issued on 16 June 2020 and re-issued on 28 June 2020 with further amendments.[247] However, by then the Rydges and Stamford hotel outbreaks had already regrettably occurred.

129 It was quite apparent from Ms May's evidence that whilst the DJPR contracted commercial cleaning of COVID-19 positive rooms, they did not contract deep cleaning of common areas or high-touch points until the implementation of the 16 June 2020 protocol. This left wide open, the possibility of fomite transmission throughout common areas of hotels. Deep cleaning, as a concept, was reactive at best.

130 Dr Crouch, in his evidence explained that at least since the end of May, following the Rydges outbreak, fomite transmission, that is lingering environmental contamination through surfaces around a quarantine hotel, was not something he reflected on as being particularly significant as a source of transmission.[248] Dr Crouch agreed with the proposition that common areas in which infected persons may be passing through, needed to be subject to pathogen cleaning, that is the use of appropriate disinfectant that would kill the virus.[249] This was of course not the case, for a significant portion of the Program.

131 When considering the Government's objective of effectively managing and containing the spread of COVID-19 through the Program - a failure to undertake deep cleaning of common areas for a prolonged period of time in the context of the duration of the Program - was entirely inadequate, improper, and itself potentially contributed to the spread of infection.

[245] May T920:38-46-T921:1-17.
[246] May T972:15-47-T973:1-2.
[247] May T973:4-32, T974:9-17, T975:11-21. See also Menon T644:6-38, May T978:20-37.
[248] Crouch T1068: 40-47.
[249] Crouch T1071:32-47-T1072:1.

132 Bearing in mind the DHHS had information within the department as to fomite transmission as a possible form of transmission, from at least as early as 4 April 2020,[250] the evidence given by Ms Williams as to the DHHS decision to implement a change in cleaning protocols in mid-June was woefully inadequate.

Onsite experience of changing policies - hotels

133 The hotel environment in which MSS operated and in particular, how the hotels were cleaned and managed, was directly related to the safety precautions which MSS staff employed, and the risks to which they were exposed. It was apparent from the evidence of hotel managers that ad hoc changes in policy and procedure were common, not always successful, and often introduced quite late in the Program. There was no evidence for example, to suggest that any of the quarantine hotels had deep cleaning of common areas prior to the change in policy on 16 June 2020.

134 The Board heard evidence from Mr Mandyam, Mr Ferrigno and Mr Unterfrauner, about changes in cleaning and temperature checking policies and procedures at their respective hotels: Travelodge, Four Points Sheraton and Stamford Plaza. MSS staff operated in each of these hotels.

135 In particular, they each described the following experiences:

(a) *Cleaning:*

i. Mr Mandyam explained that the policy at his hotel - the Travelodge - was clear: no one was going to be entering the rooms in the period of 14 days. To that end, his hotel was responsible for cleaning of rooms, and otherwise outsourced cleaning of guest rooms following departure. However, in terms of positive guests, Travelodge relied upon the DJPR for deep cleaning of rooms where guests had tested positive.[251]

ii. Mr Ferrigno explained that there was a change in his hotel – the Four Points by Sheraton - such that the cleaning of rooms of guests that were asymptomatic would be performed by the hotel contractor. However, where a guest was confirmed COVID-19 positive, the DJPR contractor was arranged to clean the guest's room. Further into the Program, Mr Ferrigno explained that the Government contracting arrangement shifted from the DJPR to the DHHS, who partnered with Alfred Health, who contracted Spotless cleaning.[252]

iii. Mr Unterfrauner also spoke to a change in exit policy cleaning in his hotel - the Stamford - in late June, which introduced a deep cleaning regime of rooms where guests had returned

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[250] See Exhibit 76 Attachments to Statement of Noel Cleaves at DHS.0001.0001.0762-0763. Subsequently, it would seem the Exercise and Fresh Air Implementation Plan (v 1) dated 15 April 2020 was developed, see Exhibit 131 Attachments to Witness Statement of Pam Williams at DHS.5000.0003.2831-2841. See further, earlier draft of "COVID-19 – DHHS Physical Distancing and Public Health Compliance and Enforcement Plan" at Exhibit 131 Attachments to Witness Statement of Pam Williams at DHS.0001.0008.0674-0728.
[251] Mandyam T520:39-47, T521:1-3.
[252] Ferrigno T521:17-47, T522:1-28.

COVID-19 positive results. He explained commercial cleaning had occurred beforehand, however with a different subcontractor.[253]

(b) *Temperature checking:* Each of Mr Unterfrauner and Mr Ferrigno described a change in temperature checking practices introduced to their hotels in late June, towards the end of the Program.[254]

TOPIC 5: Communications between Government agencies, hotel operators and MSS relating to COVID-19 testing, symptomatic guests and positive results (see Term of Reference 2)

136 The evidence before the Board, demonstrates shortcomings on the part of Government agencies throughout the Program with respect to record keeping, information sharing, and communication.[255] This had particularly serious ramifications for MSS and their sub-contractors' staff who were required, in the course of their day-to-day duties, to interact with guests who, unbeknown to them, may have been symptomatic, awaiting test results, had refused testing or had tested COVID-19 positive.

137 COVID-19 is a highly infectious virus, which requires careful control and management. Effective management of the infection risk requires a proper information sharing process. The lack of co-ordinated information sharing by the DHHS was a glaring omission, the effect of which was that those working at the frontline - such as private security firms - had no knowledge about the substantial day-to-day risks their personnel faced.

138 Such risks were known to the DHHS and other Government agencies and ought to have been addressed by them at the outset when designing the Program. Minister Mikakos, although aware of different interstate programs from media reports,[256] even when giving evidence, had not inquired of other states as to the details of their hotel quarantine programs.[257] Although she had some recognition that fresh air breaks[258] and police presence[259] were not features of interstate programs, generally she had no personal knowledge about "granular operational matters" and PPE,[260] and other differences between the Program in Victoria and interstate programs. But she should have. She was the individual with overall responsibility for the Department[261] which in turn, as control agency and the Department with responsibility for health and well-being, was responsible for the Program[262] and ultimately the health and safety of the Victorian community. In those circumstances it was incumbent upon her to understand the foundational structures of the Program, over which her Department had accountability.

[253] Unterfrauner T611:6-31.
[254] Ferrigno T513:37-47, T514:8-19, Unterfrauner T620:40-47, T621:1-12.
[255] Counsel Assisting, Mr Ihle, T2254:10-25.
[256] Mikakos T2098:6-10.
[257] Mikakos Exhibit 211 Witness Statement of the Hon. Jenny Mikakos MP (MIK.0144.0001.0001) at 0010 [50], Mikakos T2089:38-44.
[258] Mikakos T2092:25-33.
[259] Mikakos T2090:7-23, T2092:34-38.
[260] Mikakos T2093:5-10.
[261] Mikakos T2096:29-43.
[262] Mikakos T2069:35-T2070:42.

139 The Program was not just a program with the central aim of ensuring the health and well-being of those in hotel quarantine, or about protecting their human rights. It was a program which had the protection of the community more broadly against the risk posed by COVID-19 at its core. This included protecting those working at the frontline - persons known to the government to represent a vulnerable cohort.

140 Ms Peake ought to have understood these matters and communicated the “granular detail” of the Program to the Minister. This was her role. As Minister Mikakos observed, COVID-19 is a “global health emergency that is unprecedented in our lifetimes”.[263] COVID-19, and any programs directed at containing the spread of COVID-19, are matters of significant importance for both the DHHS and the Minister.

141 The Board heard substantial medical evidence about the way in which COVID-19 is to be understood, the importance of infection control measures, the manner of communication concerning testing and results, and importantly the management of COVID-19 positive guests.

142 COVID-19 is an incredibly infectious virus, transmitted through respiratory secretions, which then come into contact with others. Professor Grayson, explained in evidence that the usual entry point for COVID-19 is through mucosa, most notably through the lungs, the mouth, and eyes.[264] There are clear respiratory symptoms that are the dominant feature, including cough, shortness of breath, fever.[265] The logic behind 1.5m physical distancing, is to prevent transmission where droplets fall to the ground close to where they are expelled from infected individuals, usually within a metre.[266]

143 To this end, Dr Sarah McGuinness also explained that transmission can occur through fomite transmission, through inanimate objects such as surfaces and door handles, and lift buttons.[267]

144 Other forms of transmission (including through aerosols), were understood by the DHHS to be a form of possible transmission of COVID-19, at least as early as 4 April 2020.[268]

145 The Board also heard evidence from Dr Charles Alpren, a lead in the Intelligence Section of the COVID-19 Public Health Incident Management Team. Dr Alpren explained that an individual can be infectious, that is, able to spread the disease to others, from about 2 days before they develop symptoms.[269] Dr Alpren explained that with COVID-19, the average incubation period is about 5.5

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[263] Exhibit 211 Witness Statement of the Hon. Jenny Mikakos MP (MIK.0144.0001.0001).
[264] Grayson T33:42-47, T34:1-4.
[265] Grayson T34:8-15.
[266] Grayson T39:8-10, T39:35-38.
[267] McGuinness T1110:6-10.
[268] See Exhibit 76 Attachments to Statement of Noel Cleaves at DHS.0001.0001.0729 and following - “COVID-19 – DHHS Physical Distancing and Public Health Compliance and Enforcement Plan. See further, earlier draft of the Plan at Exhibit 131 Attachments to Witness Statement of Pam Williams at DHS.0001.0008.0674-0728. Subsequently, it would seem the Exercise and Fresh Air Implementation Plan (v 1) dated 15 April 2020 was developed, see Exhibit 131 Attachments to Witness Statement of Pam Williams at DHS.5000.0003.2831-2841.
[269] Alpren T100:4-27.

days, with a range of two to 14 days,[270] and that 10 days after developing symptoms, it is considered that an individual will no longer be infectious.[271]

146 Reflecting on the concept of hotel quarantine, the infectiousness of the virus means, as Professor Grayson explained, that the purpose of the Program was about keeping patients or individuals who are either infected or potentially infected physically separated from others, so as to prevent them acquiring infection.[272] In this medical context, Professor Grayson relevantly explained the whole structure in a quarantine facility is founded upon the assumption that a person is infected until proven otherwise. In that respect, Professor Grayson opined that anyone who has *symptoms or suggestive symptoms* should be channelled into an area where they can be safely investigated.[273]

147 Given the virility of the COVID-19 virus, effective management and control of the virus was vital. It required that appropriate risk assessments be undertaken[274] and necessitated ensuring individuals who were either infected or potentially infected, being physically separated from others to prevent further spread of the infection.

148 The DHHS, in particular nursing staff, were it would seem, the only personnel at hotels with information concerning which guests were symptomatic, had undergone a test but were awaiting results, had refused a test, or had indeed returned positive results.

149 Mr Cleaves gave evidence that in the early days of his AO role, spreadsheets and paper were used for record keeping. This led to the creation of a 'Compliance App' which recorded details about a guest. There was also an 'app' for medical purposes which recorded the details of whether someone had exhibited symptoms, whether someone had been tested and, eventually, the swab result. For security reasons, he said this information did not transfer to the Compliance App; they were quite distinct and separate.[275]

150 He explained that AOs depended upon nurses for information about a guests' COVID-19 positive status or about guests who were relocated to a 'Red Floor'. That information was not readily available to AOs.[276] Only the people who needed to know the medical information were informed. Once a person was diagnosed with COVID-19, that result triggered nurses to pass medical information on to the AOs, but not sooner. Information about guests' COVID-19 symptoms, status and testing, or whether a guest had refused a test, would otherwise be held in a silo. [277]

151 Crucially, until such time as a positive result was returned, all manner of interactions occurred with guests, with no further precautions or isolation measures in place. AOs "arranged" exercise walks or fresh air breaks and identified the individuals who could go on such walks. The AOs relied on the

[270] Alpren T99:39-44.
[271] Grayson T36:22-23.
[272] Grayson T42:36-41.
[273] Grayson T45:43-47.
[274] Mikakos T2104:7-47-T2105:1-41, Peake T2018:45-47-T2019:1-39, T2021:46-47-T2024:1-30.
[275] Cleaves T907:14-27.
[276] Cleaves T907:29-46.
[277] Cleaves T908:1-20.

information provided to them by the DHHS nurses, but nurses were at no time, required to divulge information about guests who had been confirmed COVID-19 positive. There is no direct evidence before the Board to suggest the nurses prevented such guests from going on walks. The possibility of guests who were awaiting results being escorted for exercise walks, was a possibility which Mr Cleaves readily accepted.[278] Further, testing was not mandatory during the Program, and first occurred on day 3, allowing for a window of exposure to all personnel at hotels who had day-to-day responsibility for such guests.[279]

152 Ms Febey and Ms May each gave evidence to the extent of their knowledge about these matters. Ms Febey explained that in the early implementation of the Program, it was agreed that information about COVID-19 positive cases would be conveyed by the Deputy State Controller - Health to the relevant parties in a coordinated way. However, she was unable to say whether that occurred as the Program progressed.[280] Ms May said that the DJPR was unaware of which guests were being tested or awaiting results. In those circumstances, she agreed that those matters were certainly not something the DJPR could have then relayed to security contractors.[281] It followed of course, that if the DJPR was unaware of such information, MSS staff were also unaware, and were unable to take precautionary steps to ensure their staff weren't coming into contact with a COVID-19 positive guest.

153 The evidence overwhelmingly reveals that information concerning symptomatic guests or those awaiting testing, was not shared with any personnel at hotels who had day-to-day responsibility for such guests, until such time as a positive COVID-19 result was confirmed. The 'frontline' workers in the Program, and their safety, were forgotten. As we now know though, some guests were COVID-19 positive at the time they left the hotels indicating that they had clearly been COVID-19 positive at the hotels (including one guest at the Stamford who passed the virus on to the person who travelled with him in the car from the hotel).[282]

154 MSS and each of its subcontractors who gave evidence before the Board confirmed that they were unaware that there were COVID-19 positive cases confirmed in guests at the Stamford Plaza, or that some guests may have been symptomatic or awaiting a result, on more than one occasion when they came into contact with MSS guards – for instance during fresh air walks. Mr Adams explained that he came to understand that there were in fact people who were symptomatic for, or positive for, COVID-19 in the hotels where MSS staff were working "very late in the piece", around the time of the Stamford outbreak.[283] Mr Krikelis' evidence was that he too became aware of this issue once an MSS staff member contracted COVID-19 in mid-June.[284] Neither of them were aware that guests at the Stamford Plaza had been tested and/or had been confirmed as COVID-19 positive cases until the time of the

[278] Cleaves T901:36-40.
[279] Sutton T1463:4-37, T1464:6-22.
[280] Febey T420:24-38, T431:20-32.
[281] May T980:6-39.
[282] Sutton T1465:11-15.
[283] Adams T829:22-38.
[284] Krikelis T829:40-45.

outbreak in mid-June.[285] As Mr Adams explained in his evidence, he had been told at the outset that any guest who tested positive for COVID-19 would be removed to a health facility.[286] That did not always occur.

155 With the benefit of hindsight, Mr Adams opined that if he had indeed been aware that his staff, either directly employed or subcontracted by MSS, were working at a hotel where there were confirmed COVID-19 positive cases, MSS would have certainly engaged with the DJPR to understand how those risks could be mitigated and to try and limit the amount of contact, including indirect contact, his staff had with such guests.[287] Indeed, in circumstances where confirmed COVID-19 positive cases eventuated within MSS and its subcontracting staff, MSS and its subcontractors each undertook a series of immediate steps to mitigate any risks, in conjunction with advice from the DHHS.[288] For example, following the positive cases being confirmed, and in the course of MSS investigations into those matters, MSS came to understand that car-pooling was a possible source of transmission of COVID-19 amongst staff. The evidence given by Mr Adams and MSS subcontractors, Mr Attalah and Mr Gupta, was that the guards' car-pooling practice was not known to them before the first positive case was confirmed on or about 17 June 2020. MSS issued an immediate directive that car-pooling cease and was not to occur under any circumstances.[289] The receipt of this directive was confirmed by each of Mr Gupta and Mr Attalah.[290]

156 The stark gap in knowledge and information sharing experienced by MSS, also had consequences for MSS' subcontractors. In circumstances where MSS was not privy to information about positive, or potentially positive COVID-19 cases, the associated risks could not then be passed on to its subcontractors with whom it communicated regularly.[291] The evidence of each of Mr Gupta and Mr Attalah confirmed that they were unaware of COVID-19 positive cases in the Stamford Plaza before mid-June.[292] They accepted that if MSS did not have such information, it could not have been relayed to them.[293] They each agreed that absent such information, (i.e. until a positive COVID-19 case was identified and conveyed to them), their staff would have continued to perform their usual day-to-day duties, including interacting with guests, checking-in luggage in the foyer, escorting guests on exercise breaks, making deliveries to rooms, sharing lifts, and being present on the same floors as guests.[294]

[285] Adams, Krikelis T829:47-T830:1-4.
[286] Adams T816:8-21, T840:36-42.
[287] Adams T830:12-26.
[288] Adams T833:24-47-T834:1-5, Krikelis T833:6-22, Attalah T743:7-18, Gupta T741:40-47-T742-T743:1-5. See also Exhibit 65, Statement of Jamie Grant Lachlan Adams (MSSS.0001.0014.0002) at [148]-[151], Exhibit 66 Annexures to Statement of Jamie Grant Lachlan Adams at MSSS.0001.0004.2388, MSSS.0001.0005.1810, MSSS.0001.0005.2581, MSSS.0001.0004.2389, MSSS.0001.0004.2752, MSSS.0001.0010.0033, MSSS.0001.0010.0030. MSSS.0001.0005.0747, MSSS.0001.0005.0748 and MSSS.0001.0005.0749.
[289] Adams T834:34-47, Gupta, Attalah T756:31-43.
[290] Gupta, Attalah T757:7-14.
[291] Adams, Krikelis T832:37-47-T833:1-4.
[292] Gupta, Attalah T755:29-39.
[293] Gupta, Attalah T753:1-37, T725:10-15.
[294] Gupta, Attalah T754:1-17, T754:30-47-T755:1-12.

Their staff's day-to-day duties could also have included interactions with nurses, DHHS and DJPR representatives, hotel staff and potentially other security guards.[295]

157 In the foregoing circumstances, each of Mr Gupta and Mr Attalah agreed that it was certainly possible that, in circumstances where their staff were unaware of whether a particular guest was symptomatic or was awaiting results, those guests that they were interacting with could certainly have been infectious at the time their staff were interacting with them.[296] Mr Attalah in particular expressed a concern he had about guests being tested on day 3, despite security being requested to take guests out from day 1 for fresh air breaks. Mr Attalah's concern was founded upon a lack of knowledge around whether "those patrons were positive or not".[297]

158 In circumstances where medical information about the COVID-19 positive status, testing status or symptoms of a guest were not shared, all personnel in the hotels including MSS staff and subcontractors, went about their daily business in the usual way, continuing to interact with a range of staff and physical structures and surfaces at the hotels, with the very real risk of sustained exposure to COVID-19.

159 There is clear evidence that a 14-day incubation period, a commonly understood feature of the virus, might mean an individual does not present with symptoms, but is nevertheless infectious. It can be accepted that an infectious but asymptomatic presentation could not necessarily be mitigated against despite appropriate information sharing protocols. However, it cannot be accepted, that all staff, including those of MSS and its subcontractors - being cognisant of and using PPE and other infection control measures at all relevant times during the provision of their services - itself mitigated against the risk of their exposure to symptomatic guests, or those awaiting results. Such sustained exposure, should simply not have occurred at all. [298]

160 The risk posed was heightened because PPE advice which was meant to specifically address how personnel needed to treat the potential of coming into contact with symptomatic guests, including the use of gloves and eye equipment, was not comprehensive or clear. Nor was it advice which filtered down from the DHHS. Indeed, quite opposite advice than what should have been given in respect of glove use was disseminated in the PPE guidance dated 8 June 2020 and issued on 11 June 2020.

161 The Board also heard evidence from hotel managers and others[299] as to the extent of their knowledge and information in respect of COVID-19 testing and positive cases. Each of Mr Ferrigno and Mr Unterfrauner, of Four Points Sheraton and the Stamford Plaza respectively, confirmed they too were not advised of guests who were symptomatic or were awaiting tests results. Their information source extended only to guests who had returned COVID-19 positive results.[300]

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[295] Gupta, Attalah T754:19-28.
[296] Gupta, Attalah T755:14-25.
[297] Attalah T724:29-42. See also Grayson T55:41-47-T56:1-13.
[298] See Gupta, Attalah T770:20-47-T772:1-8.
[299] Ashford T273:20-47, T274-T275:1-8, T279:37-44.
[300] Ferrigno T539:1-33, Unterfrauner T607:11-41.

162 Further, the Program did not at any time establish protocols or procedures in respect of the physical structure of hotels, such that guests who had symptoms or were awaiting a test result (that is, were not yet confirmed COVID-19 positive), were channelled into an area where they could be safely investigated, without interaction with MSS staff and other hotel personnel. For example, there existed no 'Red Floor' at the Stamford hotel, such that guests who were symptomatic or awaiting test results, could have been isolated.[301] Such guests were given the option to self-isolate, but it was not compulsory and in some cases they did remain on floors with guests who were not COVID-19 positive.[302] Those floors were frequented not just by security staff, but also by nurses, departmental staff, hotel staff and others. There is evidence that nurses did not change PPE as they moved from room to room,[303] that hotel staff did not clean common areas, that rubbish was not removed efficiently, and that guests may have been taken out for fresh air walks without knowing their COVID-19 positive status.

163 When reflecting upon a quarantine environment, Ms Alexander of Alfred Health further opined that "[y]ou need to make sure that obviously people don't work in silos, because there needed to be a very team-based approach to this program, and, you know, lots of overlap in areas".[304]

164 The overarching conclusion which can be drawn from the evidence and foregoing circumstances is two-fold:

(a) first, the privacy of medical records and/or the priority need for exercise walks were deemed paramount to the potential spread of infection from guests to others, in the course of their day-to-day duties, the consequence of which allowed for a more rapid spread of infection; [305] and

(b) second, the privacy in medical records was given greater significance and import, than the utility, importance and absolute necessity of information sharing, in what was an otherwise highly infectious, indeed potentially deadly, viral environment.

165 A further important aspect of inadequate information sharing arose with respect to cleaning protocols. The delay in a deep cleaning protocol and procedure being formalised until mid-June, meant that MSS staff were necessarily working in hotel areas, beyond actual rooms; in the hotel foyer, on floors, in hallways and corridors, in lifts, in family rooms, in toilets and in other common areas. Such areas were accessible to and possibly frequented by guests who had potentially been symptomatic, were awaiting test results, had refused testing, and those who were ultimately classed COVID-19 positive. Common areas, in which security personnel worked (as well as nurses, DHHS and DJPR personnel and others), were quite possibly infectious, with fomite transmission having been regarded as a possible mode of transmission as early as 4 April 2020: information which the DHHS held. In these circumstances, MSS staff were exposed unnecessarily to a heightened risk of COVID-19, as between when MSS

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[301] See Exhibit 47 Witness Statement of Karl Unterfrauner (STAM.0001.0004.0009) at 0014 [14(c)], Unterfrauner T607:28-32.
[302] Exhibit 223 Bundle of Documents (tendered by the DHHS on 25.9.20) at WIT.0001.0031.0041 at 0047.
[303] Exhibit 20 Witness Statement of Liliana Ratcliff (WIT.0001.0005.0001) at 0005 [38] – 0006 [45].
[304] Alexander T1025:10-14.
[305] Exhibit 186 Witness Statement of Kym Lee-Anne Peake (DHS.9999.0009.0001) at 0060 [317].

commenced operations in these hotels in early April 2020, until such time as deep cleaning protocols were introduced on 16 June 2020.

Stamford Outbreak

166 Having regard to very significant issues and failures on the part of the DHHS and others, as outlined above in Topics 3, 4 and herein, the eventual Stamford outbreak should not have come as any surprise to those who were responsible for preventing it. Infection control training afforded by the DHHS (to the limited extent to which it was provided) to private security was wholly inadequate and ad hoc. Policies were confusing and not always disseminated in a timely way, and information sharing around COVID-19 cases was either delayed or non-existent.[306]

167 The means of prevention of the spread of COVID-19 was within the control and remit of the DHHS as control agency in the pandemic response. It is quite clear that the DHHS was not, as it should have been, properly cognizant of the factors which may have contributed to the transmission of COVID-19 to hotel staff. DHHS in late March and certainly by 4 April 2020, knew of the virility of COVID-19 and the many modes of transmission which it assumed. This information was not properly acted upon until *after* the outbreaks eventuated. The consequence of this was a complete failure by the DHHS to mitigate the risks posed by the virus to all those working in the hotels during the Program. The effect of these failures is particularly pronounced considering the Stamford outbreak, given only some weeks prior, the DHHS had investigated an outbreak at the Rydges Hotel. The lessons were simply not learnt, or at the very least, not implemented.

168 Dr Alpren gave evidence about confirmed cases of COVID-19 at the Stamford hotel, which confirmed the following information collected in relation to the eventual outbreak:

(a) On 1 June 2020, a returned overseas traveller commenced hotel quarantine, and on the same day became symptomatic. He was tested on 3 June and diagnosed with COVID-19 on 4 June 2020.[307]

(b) On 11 June 2020, a couple returned from overseas and commenced hotel quarantine. On the same day, one of them became symptomatic. On 12 June 2020, the other became symptomatic. Both were tested on 14 June 2020 and diagnosed with COVID-19 on 15 and 16 June 2020.[308]

(c) On 10 June 2020, a member of staff became symptomatic, and was diagnosed with COVID-19 on 14 June 2020.[309]

[306] Adams T829:22-38, Krikelis T829:40-45, Gupta, Attalah T755:29-39.
[307] See further Exhibit 8 Witness Statement of Charles Alpren (DHS.0000.0001.0001_R) at [95], Chronology at 47, 49.
[308] See further Exhibit 8 Witness Statement of Charles Alpren (DHS.0000.0001.0001_R) at [97], Chronology at 52.
[309] See further Exhibit 8 Witness Statement of Charles Alpren (DHS.0000.0001.0001_R) at [96], Chronology at 50.

(d) The outbreak consisted of two distinct chains of transmission indicated by two genomic clusters among the cases identified as epidemiologically linked to the outbreak; one cluster arose from the overseas returnee from 1 June and the other from the overseas returnees from 11 June.[310]

169 In her evidence, Dr McGuinness, having investigated the modes of transmission which were likely to have led to the Stamford outbreak, confirmed that the genomic data reflected the virus having been introduced to hotel staff through one or more overseas returned travellers. She concluded that transmission may have occurred directly (through person-to-person transmission) or via fomites.[311] Dr McGuinness concluded, insofar as the cases the subject of the Stamford outbreak are concerned, that there is no clear evidence which supports one mode of transmission of COVID-19 over another, and that both were possible.[312] Other than the epidemiological and genomic sequencing evidence which provides a very close (if not direct) link between hotel workers who became infected and those returned travellers who were the original source of the virus,[313] there is no direct evidence which conclusively illustrates the precise circumstances in which COVID-19 made its way from infected travellers to private security staff and beyond.

170 In considering the circumstances of the outbreak, the evidence does not afford a positive finding from a scientific perspective as to the cause of the outbreak. The evidence rises no higher than possibilities. The failures of the DHHS in alleviating the risks which made the Stamford hotel a seeding ground for COVID-19 transmission, well before the outbreak eventuated are nevertheless central; particularly in circumstances where the DHHS had the opportunity to take steps, in the wake of the Rydges outbreak, to prevent any further outbreaks occurring.

171 In the foregoing circumstances, we invite the Board to make no adverse findings against MSS with respect to the mode of transmission of COVID-19 at the Stamford Plaza hotel.

TOPIC 6: Any other matters (Term of Reference 6)

Alternative operational models for quarantine in other States

172 Reflecting upon the models adopted in other states, the Board has received some evidence about quarantining models and procedures adopted outside of Victoria.[314] The model adopted in Victoria did not sufficiently protect returned travellers and personnel operating within the Program day-to-day, from COVID-19, in the way interstate programs have.

[310] Alpren T104:34-47, T105:1-10, T105:28-34. See further Exhibit 8 Witness Statement of Charles Alpren (DHS.0000.0001.0001_R) at [105]-[106], Chronology at 72. See also, Exhibit 106 Witness Statement of Dr Sarah McGuinness (DHS.9999.0004.0001) at 0020 [72], see further Outbreak Management Report - Stamford Plaza Outbreak 19 July 2020 (DHS.0001.0036.0203), Chronology at 67.
[311] See Exhibit 106 Witness Statement of Dr Sarah McGuinness (DHS.9999.0004.0001) at 0025 [95].
[312] See Exhibit 106 Witness Statement of Dr Sarah McGuinness (DHS.9999.0004.0001) at 0025 [95].
[313] See Exhibit 106 Witness Statement of Dr Sarah McGuinness (DHS.9999.0004.0001) at 0020 [72], see further Outbreak Management Report - Stamford Plaza Outbreak 19 July 2020 (DHS.0001.0036.0203), Chronology at 67.
[314] See Bamert T1321:11-28, Coppick T877:3-23, Tully T938:39-47-T939:1-38, Ashton T1664:11-22, Eccles T1772:3-47-T1773:1-32, T878:16-35.

173 The differences in quarantine procedures between states are stark and as clearly indicated by the number of positive cases in relevant states, a key differentiator. By way of example, NSW and other states adopt a police-led model,[315] other states have medical departmental staff on site 24/7 for the purposes of providing infection control advice,[316] and NSW (and others) do not allow fresh air breaks.[317] Other state models have successfully avoided community transmission from hotel quarantine programs, in the way the Victorian Program failed to do. Whilst other state models may well be underpinned by different legislative frameworks,[318] they necessarily offered insights and opportunities for learning and improvement, which Victoria did not properly investigate.

174 Unfortunately and most concerningly, the way other models operated, was not within Minister Mikakos' knowledge, nor was she briefed about such matters by her Departmental Secretary, at the outset or indeed at any time during the Program.[319] An assessment of the way the Victorian Program was operating did not occur, at least through Minister Mikakos, until she became aware of the outbreaks.[320] In our submission, this represents a significant failing for a Minister of a Department, charged with overall Departmental responsibility for the State's response to the COVID-19 pandemic, in an unprecedented global health emergency, with accountability for the public's health and safety.[321] The DHHS was aware of the risks posed to those working within the Program and should have taken steps to properly address them. It is telling in this respect that the program now in place for health workers has recognised that those workers, and their health and safety, is just as important as those whose care is entrusted to them.[322]

175 It was incumbent upon Minister Mikakos to ensure that foundational structures for the Program worked well.[323] Neither the fact that the Minister was not consulted about, nor involved in, the operational model of the Victorian Program, nor that the Program was a multi-agency response,[324] nullify the ultimate failing of the DHHS in considering other available (and potentially safer and more stringent) quarantine models, in a far timelier manner. Minister Mikakos' conduct, as Minister of the Department classed as a control agency in the context of a deadly pandemic, fell well short of the standard of governance that the public could rightfully expect in all of the circumstances.

MSS reflections upon the Program and recommendations for future improvement

176 In all of the circumstances, when asked whether MSS would engage in a program like this again, Mr Adams said "the simple answer is yes, we would".[325] Each of Mr Gupta and Mr Attalah,

[315] Mikakos T2090:16-28.
[316] Mikakos T2090:30-47-T2091:1-30.
[317] Mikakos T2092:25-38.
[318] Mikakos T2096:3-10.
[319] Mikakos T2097:24-38, T2098:6-10.
[320] Mikakos T2101:5-47-T2105:1- 41.
[321] Mikakos T2096:29-45.
[322] See Exhibit 200 (HQI.0001.0030.0001) Document Titled "Protecting Our Healthcare Workers" dated 25 August 2020 at 0009.
[323] Mikakos T2096:19-27.
[324] Mikakos T2095:16-31, T2096:47-T2097:1-2.
[325] Adams T835:9.

representatives of MSS subcontractors, also both told the Board that they would definitely consider being involved in a program like this again.[326]

177 Mr Adams observed that the government was "one of the largest if not the largest clients for MSS and the organisation was asked to provide it with assistance". On reflection he said "that frankly goes to the core of what we do as an organisation. We did what we believe is the best job we could possibly have done under the circumstances".[327]

178 Mr Adams and Mr Krikelis each provided detailed reflections on the Program and very practical recommendations for its future development and improvement.[328] Of particular note, are the following recommendations which they proposed:

(a) A greater period in which to plan the operation. Typically, an operation of this scale could take three to four months to coordinate. Crucially, time should be afforded to precisely understanding the duties that would be required of MSS staff, in what context they would be performed, and the development of standard operating procedures, that could be approved by the customer and understood by staff, prior to commencement.

(b) A clear chain of command. In a program of this magnitude, a clearly established command and control regime is necessary to oversee the operation. For example, allocating one person with responsibility for each facility, who would then oversee all of the stakeholders, and be ultimately charged with making decisions.

(c) Unambiguous standards and guidelines provided to all staff onsite. With more time for careful planning, these matters are not developed along the way, but rather established from the outset.

(d) Structured shift-briefings twice daily, typically at shift handovers, between all persons in charge at a facility, including each of the key leads from each of the stakeholders' Departments or contracting entities present. These meetings would allow for consistent, structured and consolidated information output which could then be relayed back to work groups to ensure information is disseminated appropriately.

(e) Weekly or fortnightly senior management meetings, with key leads from each of the stakeholders' Departments or contracting entities present, to discuss any larger operational issues, complaints, and otherwise.

(f) Fortnightly meetings between hotel operators and key leads from each of the stakeholders' Departments or contracting entities present. This would allow an opportunity to discuss positive and negative operational structures, whereby facilities could learn from one another, through shared communication of their experiences.

[326] Gupta, Attalah T744:30-31, T745:22-27.
[327] Adams T835:9-14.
[328] See generally Adams, Krikelis T835:10-47-T837:1-19.

(g) A focus on medical expert training in infection control measures. Consistent and structured infectious disease training, face-to-face modules and continuous updated guidance.[329]

(h) A clear process for management of evacuation drills in a quarantine hotel, including how a drill might be conducted, who would assume control, how would social distancing be maintained and any other operational aspects.[330]

179 To MSS staff's credit and in recognition of their service and endeavour, the organisation received positive feedback at various stages of the Program. A DHHS team leader at Stamford Plaza, a hotel which later became home to one of two outbreaks in Victoria, and the site of a first positive case amongst MSS staff, commended MSS staff for their exceptional work some 6 weeks into commencement of services. In an email circulated on 11 May 2020, the team leader distinguished MSS staff, observing particularly that they had been "very respectful and professional which you don't always find in security guards", and described their "calming influence in diffusing some potentially explosive situations amongst the hotel guests". The team leader concluded that "they have been exceptional".[331]

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[329] See Exhibit 11 Witness Statement of Finn Romanes (DHS.9999.0013.0001) at 0019.
[330] Smith T1196:31-47-T1197:1-8.
[331] Exhibit 68 Attachments to Witness Statement of Sam Krikelis at MSSS.0001.0003.0395_0001.