

**IN THE MATTER OF  
PART 3 OF THE  
INQUIRIES ACT 2014**

**AND**

**A BOARD OF INQUIRY ESTABLISHED TO EXAMINE ASPECTS  
OF THE COVID-19 HOTEL QUARANTINE PROGRAM**

**SUBMISSIONS ON BEHALF OF RYDGES HOTELS LTD**

**Introduction**

1. These submissions are made on behalf of Rydges Hotels Ltd. It operated and managed the hotel known as Rydges on Swanston on behalf of and as agent for the owner of the site, Charlor Pty Ltd.<sup>1</sup>
2. Throughout these submissions the term “Rydges” is used interchangeably, depending on the context, to refer to both the corporate identity of the operator and manager of Rydges on Swanston and the physical premises of the hotel, Rydges on Swanston.
3. In these submissions, Rydges responds only to the specific and express terms of the key findings<sup>2</sup> counsel assisting invited the Chair to make. Given the strict provisions of s76 of the *Inquiries Act* 2014, it is clear that, were the Chair to propose to make findings in any way different to those proposed by counsel assisting (and that would affect Rydges interests in a material way), the procedural fairness process established under s76 would need to be engaged with. That would include any different findings the Chair is minded to make based on submissions made by other parties that the Board receives.

**Onus and standard of proof**

4. Due to the investigative, as opposed to adversarial, nature of the Board’s inquiry, there is no onus of proof upon any party.<sup>3</sup>

---

<sup>1</sup> HQ0045\_RP, Witness Statement of Rosswyn Menezes, paragraph 6.

<sup>2</sup> See T2190:21-23

<sup>3</sup> See, e.g., *Bushell v Repatriation Commission* (1992) 175 CLR 408, 425 (Brennan J)

5. The standard of proof that applies to the Board is the civil standard,<sup>4</sup> being reasonable satisfaction on the balance of probabilities. However, counsel assisting submit that the failure of the program is, apparently solely, responsible for 768 deaths and 18,418 infections.<sup>5</sup> That submission could not be more serious. It inevitably means that the principles in *Briginshaw v Briginshaw* (1938) 60 CLR 336 are engaged, and the Chair is required to reach a very high level of satisfaction before proceeding to make any such finding sought by counsel assisting.

## Background

6. The owner of the Rydges site, together with a number of other Victorian hotels, provided premises to the State for the purpose of the Hotel Quarantine Program (**program**). The owner did so under contracts entered into between it and the State - initially, with the Department of Jobs, Precincts and Regions. Whilst Rydges Hotels Ltd was not a party to the contracts, it managed the site on behalf of the owner, and provided various basic services.
7. As the contracts, their performance and the relevant dealings between the hotel owner and the State reveal, Rydges provided no more than premises, food, cleaning of the reception area (which was not used by quarantine guests) and basic other services. Following the reopening of Rydges in June 2020, the cleaning of common/reception areas was undertaken by the State and/or its contractors.
8. The site's owner was providing one of the premises at which the State operated its quarantine program. Whilst the site owner had a number of basic functions within the program, it did not design, oversee, nor operate the program. The site owner was

---

<sup>4</sup> See, e.g., the Royal Commission into Trade Union Governance and Corruption, Final Report (2015) Vol 1, 52-3; Royal Commission into the Building and Construction Industry, Final Report (2003) Vol 2, Ch 5, 48-49. See also First Report of the Parliamentary Judges Commission of Inquiry (Queensland) (1989), the report of McGregor J of the Royal Commission into Matters in Relation to Electoral Redistribution in Queensland (Commonwealth of Australia, 1977), and the report of the Hon W J Carter QC of the Royal Commission into an Attempt to Bribe a Member of the House of Assembly (Tasmania) (1991).

<sup>5</sup> T2234: *In light of the epidemiological, genomic sequencing, positive case data and mortality rates, the failure by the Hotel Quarantine Program to contain this virus is, as at today's date, responsible for the deaths of 768 people and the infection of some 18,418 others.*

reliant on the State for direction as to how the State wished it to perform a number of contractual obligations, for example, cleaning of rooms.<sup>6</sup>

9. Further, as will be detailed later in these submissions, from the commencement of the performance of the initial agreement, and despite the terms of the contracts, the State arranged its own agents to conduct deep cleaning of rooms following the departure of quarantine guests, whether or not those guests were COVID-19 positive.

### Timing and identity of those infected at Rydges

10. As a preliminary matter, Rydges seeks to address the Board concerning the timing of virus transmission which occurred at Rydges in late May 2020, together with the identity of those who contracted the virus.
11. The chronology circulated by counsel assisting includes the following entry for 25 May 2020:

No	Date	Event	Source	Cases per day
43	25 May 2020	Three members of staff at the Rydges on Swanston become symptomatic and are subsequently diagnosed with COVID-19.	DHS.9999.0001.0001 at [86],[88]	5

12. The term “members of staff at Rydges” is clearly incorrect. It is not supported by the evidence. The ordinary reader of this phrase would understand it to mean that the three persons concerned were all members of Rydges’ staff. The evidence is clear

<sup>6</sup> See, for example, the first iteration of the contract between DJPR and the owner of the hotel premises, which included clause 2.1(d) in the following terms (underlining added):

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

that this was not the case. It is respectfully submitted that this phrase should not be replicated in the Board's report.

13. As the Board is aware, genomic<sup>7</sup> and epidemiological evidence confirms that a particular genomic strain of the virus was passed from a family of four returned travellers to a number of security guards, a nurse and one hotel employee some time in late May 2020. The genomic evidence also confirms that this genomic strain of the virus entered the broader community, to the point that it represents the majority of infections which have occurred in Victoria since June 2020.
14. The Board did not explore the many other points in time that the family of four may have passed on the genomic strain to others, both before and after their stay at Rydges. The evidence confirms that the family of four contracted the virus prior to their stay at Rydges. They largely became symptomatic while quarantined at the Crowne Promenade Hotel.<sup>8</sup> They were moved to Rydges following positive test results of 2 of their group, the other 2 positive test results quickly followed.
15. The evidence confirms that there is no way of determining whether one of the security guards, the hotel employee or the nurse (each of whom had been present at Rydges):
  - 15.1. first contracted COVID-19 from the family of returned travellers;<sup>9</sup> or
  - 15.2. passed COVID-19 on to any other person in the broader community.<sup>10</sup>
16. It is submitted that, given counsel assisting's erroneous use of the phrase "*Three members of staff at the Rydges on Swanston*", the public nature of this inquiry, and the significant human and economic effect of the virus entering the population following

---

<sup>7</sup> HQ10104\_RP, Outbreak Management Plan [DHS.0001.0036.0145] at page 10.

<sup>8</sup> HQ10104\_RP, Outbreak Management Plan [DHS.0001.0036.0145] at page 10.

<sup>9</sup> Evidence of Dr Alpren, T122:13

<sup>10</sup> Evidence of Dr Alpren, T122:19

the outbreak, the Board's report should make a positive finding as to the foregoing evidence.

17. Further, it is submitted that the Board should also recognise and contrast the evidence regarding the hotel employee with the evidence of security guard "G16", both of whom became symptomatic at roughly the same time, namely:

17.1. as to the hotel employee, in the days prior to becoming symptomatic, they underwent regular, routine temperature checks as part of their employment. All results were within the normal range.<sup>11</sup> They first experienced symptoms while away from work, and not rostered on that day.<sup>12</sup> They immediately advised their employer.<sup>13</sup> They did not return to work.<sup>14</sup> They immediately entered voluntary quarantine.<sup>15</sup> There is no evidence that the hotel employee undertook any risky conduct or passed the virus on to any other employee. Indeed, no other Rydges employees contracted the virus, nor did any member of the employee's family;

17.2. as to the security guard, G16, he was working at Rydges and became symptomatic at roughly the same time as the hotel employee.<sup>16</sup> He became symptomatic while at work. He did not tell anyone.<sup>17</sup> Once tested, he was told to self-isolate – a direction he ignored.<sup>18</sup> Indeed, he worked for an online food delivery service while symptomatic, after being tested and prior to receiving his test results.<sup>19</sup> After a period of downtime, but clearly while still symptomatic,<sup>20</sup> he made further food deliveries.<sup>21</sup> He then worked in a

---

<sup>11</sup> HQ0045\_RP, Witness Statement of Rosswyn Menezes, paragraph 41.

<sup>12</sup> HQ0045\_RP, Witness Statement of Rosswyn Menezes, paragraph 41.

<sup>13</sup> HQ0045\_RP, Witness Statement of Rosswyn Menezes, paragraph 41.

<sup>14</sup> HQ0045\_RP, Witness Statement of Rosswyn Menezes, paragraph 41.

<sup>15</sup> HQ10104\_RP, Outbreak Management Plan [DHS.0001.0036.0145] at page 15.

<sup>16</sup> Exhibit HQI0031\_RP Witness Statement of G16, paragraph 51-102.

<sup>17</sup> Exhibit HQI0031\_RP Witness Statement of G16, paragraph 83-85.

<sup>18</sup> Exhibit HQI0031\_RP Witness Statement of G16, paragraph 90-92.

<sup>19</sup> Exhibit HQI0031\_RP Witness Statement of G16, paragraph 92.

<sup>20</sup> Exhibit HQI0031\_RP Witness Statement of G16, paragraph 100.

<sup>21</sup> Exhibit HQI0031\_RP Witness Statement of G16, paragraph 99.

warehouse and this was in the same week that he received his second positive test result.<sup>22</sup>

18. Whilst the reasons for G16's dangerous conduct may be complex, it was indeed fundamentally dangerous conduct. The risks that G16's conduct posed to the Victorian community are extreme.
19. G16's dangerous conduct stands in stark contrast to Rydges and its employee's conduct, which on any view was both cautious and responsible.

### Cleaning

20. Whilst the various iterations of the contracts between the State and the owner of the site contained a clause that the hotel would be responsible for cleaning and disinfecting of rooms at the end of each quarantined person's stay,<sup>23</sup> the evidence the Board received was that from the time the first cohort departed, the State, through DJPR, separately contracted with private contractor deep cleaners to perform this function.<sup>24</sup> Certainly the contractual obligation on the State to undertake specialised deep cleaning of rooms in which a confirmed case had stayed<sup>25</sup> was applied across all rooms from the beginning.

<sup>22</sup> Exhibit HQI0031\_RP Witness Statement of G16, paragraph 101-102.

<sup>23</sup> See, for example, clause 2.1(d) of the first iteration of the agreement between DJPR and Charlor, at Exhibit HQ10046\_RP – Attachments to Witness Statement of Rosswyn Menezes, RYD.0001.0010.0003, which provided:

2. *Supplier's Obligations*

2.1 *The Supplier must:*

...

(d) *subject to clause 2.1(e), ensure that each Room is thoroughly cleaned and disinfected at a minimum:*

(i) *prior to the commencement of each Department's Nominee's stay; and*

(ii) *as soon as practicable following the conclusion of each Department Nominee's stay,*

*to a standard consistent with the most recent recommended public health standards in respect of COVID-19;*

<sup>24</sup> Exhibit HQ10046\_RP – Attachments to Witness Statement of Rosswyn Menezes, RYD.0001.0010.0791, 30 April 2020 email from Rosswyn Menezes to [Redacted] of DHHS, confirming deep cleans to be conducted by IKON following the departure of the first cohort.

<sup>25</sup> HQ10046\_RP – Attachments to Witness Statement of Rosswyn Menezes, RYD.0001.0010.0003, clause 2.1(e)

21. Further, the Board heard evidence from a quarantine guest, Mr de Kretser, to the effect that upon arrival at Rydges, he found aspects of his adjoining rooms to be unclean.<sup>26</sup> As pointed out by counsel assisting, the hotel had been subject to at least one inspection by the Department's infection prevention personnel prior to Mr de Kretser's arrival.<sup>27</sup>
22. Mr Girgis, of IKON, confirmed that IKON, on behalf of DJPR, had conducted a deep clean of the adjoining rooms Mr de Kretser and his family stayed in prior to their stay.<sup>28</sup> Mr Girgis confirmed that after guests left rooms, the deep cleaning service IKON provided included wiping down all surfaces, disinfectant misting, removal of all rubbish, removal of all cutlery, moving small items of furniture in order to disinfect surfaces.<sup>29</sup> In answer to a question as to whether IKON employees would move a bed on casters to fog disinfectant underneath and behind it, he replied "*I'm not sure to be honest, I can't answer that one*".<sup>30</sup>
23. Counsel assisting submit that there is "vacuum of evidence"<sup>31</sup> concerning the state of that guest's rooms. However, no guest used the rooms after IKON deep cleaned them and the issues identified included cleanliness issues that would, on any view, need to have been cleaned by IKON.<sup>32</sup>
24. Certainly, no criticism can or should be made of Rydges in this regard given:
  - 24.1. at the relevant time, the hotel was essentially under State control;

---

<sup>26</sup> HQI0016\_P Witness Statement of Hugh de Kretser at paragraph 29.

<sup>27</sup> T2250:5

<sup>28</sup> Evidence of Michael Girgis, T1253:14-27

<sup>29</sup> Evidence of Michael Girgis, T1246

<sup>30</sup> Evidence of Michael Girgis, T1247 (note, the answer is clear in the audio visual, but is not reflected in the transcript).

<sup>31</sup> T2250:20

<sup>32</sup> For example, as counsel assisting identify in their submissions, food crumbs on floors and dust on surfaces – T2250:10.

- 24.2. post-guest cleaning and disinfecting (including removal of rubbish and moving small items of furniture to disinfect behind them) were obligations which sat squarely with the State's contractor, IKON – Mr Girgis accepted this;<sup>33</sup>
- 24.3. Mr Girgis had no explanation as to why the rooms were in that state. He simply said the rooms were "...*definitely not to our standard. So that's not the standard we left the hotels in.*"<sup>34</sup> However it must be remembered that, Mr Girgis did not observe the rooms first-hand. No guest stayed in the rooms after IKON cleaned them prior to the arrival of Mr de Kretser. At the very least, dust, crumbs and the items found by Mr de Kretser would have been identified had a diligent deep clean been conducted by IKON;
- 24.4. the Department infection prevention control personnel inspected the hotel prior to reopening.

**Response to particular submitted open findings counsel assisting have invited the Board to make.**

25. The following paragraphs address the specific submitted open findings counsel assisting identified, which they invite the Board to make. Those specific open findings were articulated by senior counsel assisting at T2263-2269. In reliance on counsel assisting's confirmation that they only invite those findings to be made, the submissions at T2190-2262 are specifically not responded to. As addressed in paragraph 3, Rydges confirms that the process in s76 of the *Inquiries Act* 2014 would need to be engaged in were alternate findings affecting its interests to be contemplated.

---

<sup>33</sup> Evidence of Michael Girgis, T1246

<sup>34</sup> Evidence of Michael Girgis, T1254:20-22



26. The submitted open findings articulated by counsel assisting at T2263-2269 are in some regards unclear, particularly as to their precise content and breadth. For example, it is unclear:
- 26.1. the number of submitted open findings;
  - 26.2. whether on each occasion *all* of the words following “*the findings we invite you to make*” and “*the findings we urge are*” comprise the content of the submitted open findings; and
  - 26.3. where each submitted open finding begins and ends.
27. In the absence of a clear written document setting out precisely the number and terms of submitted open findings, an attempt has been made below to identify, understand and respond to what appear to be the submitted open findings. If there is any misunderstanding as to what the submitted open findings are, the process in s76 of the *Inquiries Act 2014* would need to be engaged in regarding what the actual submitted open findings are.

**Submitted finding 1 - the Program carried its own infection risks, for which the State assumed responsibility**

28. Rydges accepts this finding.

**Submitted finding 2 – prior to 27 March 2020, the Victorian Government and its Departments had no plan for large-scale quarantine**

29. Rydges accepts this finding.

**Submitted finding 3 - the Program was properly understood as part of the State's response to the public health emergency and properly allocated to the**

**Department of Health and Human Services as control agency in accordance with the State Emergency Response Plan**

30. Rydges accepts this finding.

**Submitted finding 4 - the conclusion that private security would be the first tier of enforcement in the Hotel Quarantine Program was not made before the State Control Centre meeting; no one person made that decision; it can be best understood as a creeping assumption or default consensus**

31. This submitted finding is plainly not supported by the evidence.

32. Mr Ashton's initial text message to Mr Kershaw (AFP) at 1:12pm on the afternoon of 27 March 2020 confirms that he did not want Victoria Police to provide security services within the hotel quarantine program.<sup>35</sup>

33. Mr Ashton's next text message to Mr Eccles (DPC) at 1:16pm on 27 March 2020 inquires of the Department of Premier and Cabinet whether it is correct that it was at that time proposed that police would guard detainees.<sup>36</sup>

34. Mr Ashton's next text message to Mr Kershaw (AFP) at 1:22pm on 27 March 2020 confirmed that by then Mr Ashton understood that private security would be used, rather than police.<sup>37</sup>

35. Mr Ashton's text message to Mr Kershaw (AFP) at 1:32pm on 27 March 2020 confirmed that he understood by then that the use of private security was "...the deal

<sup>35</sup> 1:12pm 27 March 2020 text message from Mr Ashton to Mr Kershaw (AFP): "Mate. Question. Why wouldn't AFP guard people At The Hotel??" VPOL.0005.0001.0244, referred to at T1663:11 and paragraph 5.2 of the witness statement of Mr Graham Ashton [VPOL.027.0001.0030\_R].

<sup>36</sup> 1:16pm 27 March 2020 text message from Mr Ashton to Mr Eccles (DPC): "Chris I am getting word from Canberra for a plan whereby arrivals from overseas are to be subjected to enforced isolation from tomorrow. The suggestion is Victorian arrivals are conveyed to a hotel Somewhere where they are guarded by police for 14 days. Are you aware of anything in this regard?? Graham". VPOL.0005.0001.0140, referred to at T1663:11 and paragraph 5.5 of the witness statement of Mr Graham Ashton [VPOL.027.0001.0030\_R].

<sup>37</sup> 1:22pm 27 March 2020 text message from Mr Ashton's to Mr Kershaw (AFP) at "Mate my advise [sic] is that ADF will do Passenger transfer and private security will be used". VPOL.0005.0001.0244, referred to at T1700:11 and paragraph 5.2 of the witness statement of Mr Graham Ashton [VPOL.027.0001.0030\_R].

*set up by our DPC...*" On the evidence, he can only have arrived at that understanding between 1:16pm and 1:22pm.

36. The evidence demonstrates, quite plainly, that someone told Mr Ashton between 1:16pm and 1:22pm that the use of private security had been decided by the Department of Premier and Cabinet. That is unambiguously confirmed in his contemporaneous text message.
37. Two hours later, at 3:15pm, the Premier announced that private security would be used. The Premier, like Mr Ashton, knew at that that stage that the decision to use private security had been made.
38. Mr Ashton's evidence was that he had (himself, not the Board) looked at his own billing records,<sup>38</sup> that he only had a record of outgoing calls (not incoming calls), that he did not recall receiving a phone call from Mr Eccles.<sup>39</sup> He was asked from where he received the information regarding "*the deal set up*" by DPC. His evidence was:

*No, I can't guarantee --- I can't remember where I got that advice from. I followed the text I sent to Chris Eccles and there was a six-minute period in which I received information which is along the lines that I have outlined in that text. So I don't know for sure where I got that information from and the records --- because I do not have incoming records primarily, I don't know where I got that from.*<sup>40</sup>

39. Mr Eccles' evidence was that he had (again, himself, not the Board) looked at his own billing records,<sup>41</sup> that the records did not reveal contact with Mr Ashton, that he was not

---

<sup>38</sup> T1661

<sup>39</sup> T1662:45

<sup>40</sup> T1663:40

<sup>41</sup> T1805:37-47, in answer to a question from counsel for Victoria Police.

sure how complete his phone records were, and that it was possible that he may have had someone else contact Mr Ashton on his behalf.<sup>42</sup>

40. Without interrogating the network provider's records of all incoming and outgoing landline and mobile telephone calls of Mr Ashton, Mr Eccles and those working with them in that short period of time on the afternoon of 27 March 2020, the Chair could not possibly conclude there was simply a "creeping assumption". Mr Ashton's contemporaneous text message, which should be preferred to his lack of recollection in the witness box, indicates that the decision in fact from within DPC. A "creeping assumption" takes time to form – it does not form in 6 minutes. Further, rather than denying it, Mr Eccles accepted that he may have had someone from DPC call Mr Ashton.
41. It does not appear that the relevant phone call records have been the subject of a Notice to Produce. If there was any legal impediment to issuing such a Notice to Produce, it has not been identified by counsel assisting. If any impediment existed, there is no indication that the relevant individuals were requested to consent to the Board being provided with access to those records. Nor does there appear to have been a request by the Board that the relevant bodies holding the information provide it to the Board voluntarily and in the absence of a Notice to Produce – an approach utilised by other bodies established under the *Inquiries Act 2014*.<sup>43</sup>
42. If the incoming and outgoing telephone records are not to be the subject of a Notice to Produce (which the Board can still issue), or have not otherwise been sought or obtained by the Board (which the Board can still request), the only safe finding - which

---

<sup>42</sup> T1806:6-11

<sup>43</sup> For example, the *Royal Commission into the Management of Police Informants* dealings with Commonwealth bodies – see, by way of example, <https://www.rcmpi.vic.gov.au/sites/default/files/2020-05/Exhibit%20RC0793b%20Letter%20from%20Australian%20Federal%20Police%20lawyers%20to%20Commission%2C%2022%20November%202019%2C%20tendered%2027%20November%202019.pdf>

accords with contemporaneous records - is that someone within the DPC decided that private security would be used.

43. A “creeping assumption” finds no support whatsoever in the evidence. A positive decision from within the Department of Premier and Cabinet is directly supported by the contemporaneous evidence.

**Submitted finding 5 - infection prevention and control:**

- (a) **There was not a sufficient focus on why self-quarantine it was necessary; that is, to prevent the transmission of COVID-19;**
- (b) **The contracts with hotels and security companies should not have placed responsibility for PPE and infection control education on those contractors...the presence of those contractual arrangements did not remove the State's responsibility to ensure that the Hotel Quarantine Program operated as an effective infection prevention and control mechanism;**
- (c) **Within DHHS, as the control agency, insufficient regard was given to health-related matters, including infection prevention and control.**
- (d) **All people working at hotels should have been given in-person training about infection prevention and control and the use of personal protective equipment;**
- (e) **People working at quarantine hotels should have been required to demonstrate knowledge of how to use PPE.**
- (f) **There should have been supervision and monitoring to ensure adherence to IPC and PPE requirements.**

44. As to (a), Rydges does not seek to respond to the submission that there was not a sufficient focus on why self-quarantine was necessary; that is, to prevent the transmission of COVID-19. That is a matter for the State to respond to.
45. As to (b), where the State sought to place contractual liability for PPC and IPC, was a matter for the State. There is no suggestion that the hotels sought or negotiated the relevant contractual provisions.
46. However, relevantly, the Board can be satisfied that:
- 46.1. as set out in paragraph 20, from the time the first quarantine guests departed Rydges, rooms were deep cleaned by the State's expert contractor, not by Rydges staff;
  - 46.2. it was the State's responsibility to ensure effective IPC (as counsel assisting submit); and
  - 46.3. contractually, the standards applicable to the use of IPC and PPE were to be set by the State, with which the hotel operators were obliged to comply.<sup>44</sup>
47. As to (c), Rydges does not seek to respond to the submission that within DHHS, as the control agency, insufficient regard was given to health-related matters, including infection prevention and control. That is a matter for the State to respond to.
48. As to (d), any requirement that those working at hotels be given in-person IPC and PPE training could only have been mandated and delivered or arranged by the State, which was responsible for the program. However, based on the evidence, the Board can find that:

---

<sup>44</sup> See, for example, clause 2.1(h) in HQ10046\_RP – Attachments to Witness Statement of Rosswyn Menezes, RYD.0001.0010.0003

- 48.1. prior to any quarantine guests arriving, DHHS told hotel staff to assume that all guests were COVID-19 positive<sup>45</sup> and the State provided various directions concerning IPC and PPE;<sup>46</sup>
- 48.2. Rydges had itself independently established robust procedures concerning IPC and PPE.<sup>47</sup>
49. As to (e), any such “requirement” would need to have been mandated by the State, which was operating the program. Even so, there is no direct evidence which could satisfy the Chair to the requisite standard that Rydges employees themselves (as opposed to other contractors of the State) did not have appropriate knowledge of how to use PPE – such evidence was not led and has not been identified in counsel assisting’s submissions.
50. As to (f), any “supervision and monitoring” would need to have been established and conducted or arranged by the State, which was operating the program. Even so, there is no direct evidence which could satisfy the Chair to the requisite standard that Rydges employees themselves (as opposed to other contractors of the State) did not adhere to IPC and PPE requirements and so would have required “supervision and monitoring” – such evidence was not led and has not been identified in counsel assisting’s submissions.

**Submitted finding 6 – cohorting positive cases in a single location required particular attention to IPC; insufficient regard to this was paid when Rydges was identified as a ‘hot hotel’**

51. The decision to cohort positive cases in a single location was a matter for the State. From the first iteration of the contract,<sup>48</sup> the State had full discretion as to which

---

<sup>45</sup> HQ0045\_RP, Witness Statement of Rosswyn Menezes, paragraph 22 and exhibit RYD.0001.0012.0090

<sup>46</sup> HQ0045\_RP, Witness Statement of Rosswyn Menezes, paragraph 36

<sup>47</sup> HQ0045\_RP, Witness Statement of Rosswyn Menezes, paragraph 22(a), (b) and (c).

<sup>48</sup> HQI0046\_RP – Attachments to the Witness Statement of Rosswyn Menezes at RYD.0001.0010.0003.

returned travellers it would place at Rydges. Any particular attention which was to be paid to IPC given that cohorting was a matter for the State.

52. Even so, there is no direct evidence which could satisfy the Chair to the requisite standard that Rydges employees themselves (as opposed to other contractors of the State) did not pay sufficient attention to IPC – such evidence was not led and has not been identified in counsel assisting's submissions. Indeed, the uncontested evidence regarding Rydges was to the contrary. Rydges was pro-active in alerting the State to the dangerous practises of other State contractors working at the site.<sup>49</sup>

**Submitted finding 7 – in respect of the Rydges Hotel, it is more likely than not that the outbreaks occurred as a result of environmental contamination rather than person-to-person contact. Poor training and education of frontline staff and the delays in cleaning the common areas of the Rydges Hotel and in quarantining all staff were further failures which contributed to the further proliferation of the virus into the community.**

53. In so far as this submitted finding seeks to draw a distinction between Rydges and Stamford,<sup>50</sup> the much lower infection number of Rydges staff (1) and contractors at Rydges (approximately 6), as compared to the far more significant numbers of frontline worker infections at Stamford, demonstrates that the virus spread was more contained within Rydges than was the case at Stamford.
54. In relation to question as to how contamination at Rydges occurred, the only conclusion which could be comfortably drawn – or, certainly could be drawn given the applicable evidential standard – is that it is simply not known, and could never be known, whether the contamination from the guests to the security guard, nurse and/or staff member was directly person-to-person or environmental.

---

<sup>49</sup> HQ0045\_RP, Witness Statement of Rosswyn Menezes, paragraph 68.

<sup>50</sup> As might be said to be the case at T2267:15-20



55. Dr McGuinness's evidence was that:

*"Ultimately, the Deputy Public Health Commanders and I were unable to draw a firm conclusion about the transmission events that precipitated the outbreak. In my opinion, the possibility that the outbreak was precipitated by person-to-person transmission is less likely than the outbreak being precipitated by an environmental source."<sup>51</sup>*

56. The Chair needs to be comfortably satisfied, to the *Briginshaw* standard, of findings the Chair determines to make. Counsel assisting submit that the chair should find that "... it is more likely than not that the outbreaks occurred as a result of environmental contamination rather than person-to-person contact".<sup>52</sup> With respect, given the actual evidence (no "firm conclusion", but one "possibility" being "less likely" than another) and the applicable standard, such a finding would be non-sensical – it is unknown what standard Dr McGuinness was applying to her conclusion and the Board is simply being invited to adopt it. The basis of the opinion is unclear and seems to be only based on timing of infection. There does not appear to have been any examination of CCTV, records of access to premises, interrogation of contact between people or diligent or scientific examination of cleaning practices.

57. No one, not even Dr McGuinness, knows with any degree of certainty whether the outbreak occurred as a result of environmental contamination or person-to-person conduct.

58. A finding in this regard would be unsafe as it would self-evidently not be supported by the evidence. It would fail for the reasons warned against in *Briginshaw*, namely, "... 'reasonable satisfaction' should not be produced by inexact proofs, indefinite

---

<sup>51</sup> HQI0106\_RP – Witness Statement of Dr Sarah McGuinness at paragraph 64.

<sup>52</sup> T2267

*testimony, or indirect inferences.*"<sup>53</sup>

**Submitted finding 8 - percentages of outbreaks attributable to Rydges and Stamford.**

59. Rydges is not in a position to contest this finding. Given the inquisitorial and investigatory nature of the Board's task, it was not a matter for a party to interrogate. Further, even if a party wished to interrogate it, it is a matter for detailed lay and expert evidence which, could not have been examined and tested in the time available.
60. However, in relation to the outbreak being tied only to Rydges, the "family of four" contracted the virus well prior to arrival at Rydges. There were many points at which they would have come into contact with others, both before and after their time at Rydges. They arrived by plane. They went through customs. They were transported to Crowne Promenade. They stayed at Crowne Promenade for some time. They were tested while at Crowne Promenade. They were transported to Rydges. They left Rydges upon its closure. Their full quarantine period was not served at Rydges. It is unknown where they went afterwards. None of these issues were explored before the Board.

**Submitted finding 9 - The Hotel Quarantine Program in Victoria failed to achieve its primary objective. The program that was intended to contain the disease was instead a seeding ground for the spread of COVID-19 into the broader community. Infection prevention and control measures were ad hoc and inadequate, not only at the Rydges Hotel in Carlton but across the entire Hotel Quarantine Program, until the establishment of the health hotel model with the standing up of the Brady Hotel in mid-June.**

---

<sup>53</sup> at 361-3.

**Several salient features of the structure of the Hotel Quarantine Program increased or at least did not sufficiently guard against the risk of transmission of COVID-19 from the Hotel Quarantine Program. These are features that applied generally but more specifically were evidenced at Rydges and Stamford in particular. The features are: mischaracterisation of the program as mainly a logistical and compliance operation; failure to engage and embed public health experts in the operational aspects of the program; inadequate testing of detainees; and deficiencies in cleaning processes and performance.**

61. Whether the program failed to achieve its primary objective is a matter for the State to respond to.
62. As to whether infection prevention and control measures were ad hoc and inadequate, specifically at the Rydges, it is unclear what evidence counsel assisting are referring to. This makes the submission difficult to respond to. On the assumption that counsel assisting are referring to the contents of the Outbreak Management Plan,<sup>54</sup> the “Environmental Investigation” within that document contains both assumptions and clear errors. One significant error is the conclusion that cleaning products used were “*unlikely to be effective against SARS-CoV-2*”. The author names two cleaning products. One of those products is specifically confirmed by the Therapeutic Goods Administration to be a “*disinfectant for use against COVID-19 in the ARTG for legal supply in Australia*”.<sup>55</sup> It remains entirely unclear who is said to have been using which product and for what purpose. It is also unclear whether one or both products are said to have been used.
63. Further, in circumstances where the Chair cannot safely make a finding concerning environmental, as opposed to person-to-person transmission, it cannot be concluded

---

<sup>54</sup> HQI0104\_RP

<sup>55</sup> [tga.gov.au/disinfectants-use-against-covid-19-artg-legal-supply-australia](https://www.tga.gov.au/disinfectants-use-against-covid-19-artg-legal-supply-australia)

that, even if there was a deficiency in IPC measures from hotel staff or anyone within the hotel, whether such deficiency actually led to any transmission.

64. As to whether “mischaracterisation of the program as mainly a logistical and compliance operation” increased or at least did not sufficiently guard against the risk of transmission of COVID-19, that is a matter for the State to respond to.
65. As to whether a “failure to engage and embed public health experts in the operational aspects of the program” increased or at least did not sufficiently guard against the risk of transmission of COVID-19, that is matter for the State to respond to.
66. As to whether there was, in fact, “inadequate testing of detainees” and, if so, whether that increased or at least did not sufficiently guard against the risk of transmission of COVID-19, that is matter for the State to respond to.
67. As to whether there were “deficiencies in cleaning processes and performance” - if indeed that submission, in part, seeks to include Rydges and its staff - and, if so, whether that increased or at least did not sufficiently guard against the risk of transmission of COVID-19, Rydges refers to its submissions at paragraphs 62 and 63 above.
68. Further, while the Outbreak Management Plan details “*Outside of the hotel, there has been onward household transmission to partners and housemates*”<sup>56</sup> it is of note that there is no such evidence concerning the hotel employee who contracted the virus. Indeed, there is no such evidence, because it did not occur. The employee, upon experiencing symptoms, immediately advised their employer. They immediately underwent a test. They immediately went into quarantine. They did not pass the virus on to any member of their family or any co-worker. Therefore, the hotel staff member should be explicitly excluded from any such finding.

---

<sup>56</sup> HQ10104\_RP, Outbreak Management Plan [DHS.0001.0036.0145] at page 13.

**Submitted finding 10 - the program did not always operate so as to meet the needs of those who were detained, in particular those who had specific needs or vulnerabilities which were not adequately met.**

69. The hotel owner's contractual obligations relevant to this submitted finding were to provide premises at which the program was operated and to provide food to the quarantine guests. There is no evidence that Rydges failed to cater for these needs. As to whether there were "deficiencies in cleaning processes and performance" - if indeed that submission, even in part, seeks to include Rydges and its staff - and, if so, whether that increased or at least did not sufficiently guard against the risk of transmission of COVID-19, Rydges refers to its submissions at paragraphs 62 and 63 above.

**Submitted finding 11 - mandatory home quarantine or a hybrid model involving initial reception into a hotel for risk assessment and triage, was a better alternative than hotel quarantine.**

70. This is matter for the State to respond to.

**Submitted finding 12 - significant issues should have been brought to the respective Ministers' attention.**

71. This is matter for the State to respond to.

5 October 2020

Andrew Woods  
Counsel for Rydges Hotels Ltd

Gilbert + Tobin  
Solicitors for Rydges Hotels Ltd