IN THE MATTER OF THE INQUIRIES ACT 2014

AND IN THE MATTER OF A BOARD OF INQUIRY INTO THE COVID-19 HOTEL QUARANTINE PROGRAM

SUBMISSIONS OF YOUR NURSING AGENCY (VICTORIA) PTY LTD

1. There should be no adverse findings against Your Nursing Agency (Victoria) Pty Ltd (**YNA**).

YNA Involvement in Hotel Quarantine Program

2. YNA had no involvement in the planning, design or establishment of the Hotel Quarantine Program.

3. It was one of several providers of nursing staff to the Hotel Quarantine Program.[1]

4. YNA first learned that the Department of Health and Human Services (**DHHS**) was seeking nursing staff for quarantine hotel sites when it received a telephone call from a DHHS representative at 12.05pm on Saturday, 28 March 2020. The foreshadowed involvement of YNA at that time was limited in scope; namely, the supply of one triage registered nurse (for each 8 hour shift) to Crown Casino. DHHS requested that nursing staff be allocated "as soon as possible" given the first flight of returned travellers was scheduled to arrive the following morning.[2] On the morning of Sunday, 29 March 2020, DHHS sought confirmation that YNA would provide a single Emergency Department trained, triage nurse per shift (with potential backup) at Crown Promenade and Crown Metropol Hotels from that day until Sunday, 5 April 2020. The duration was stated to be "for now" but referred to an assumption that the arrangement would continue until 26 April 2020.[3]

5. YNA was engaged pursuant to the pre-existing written contract between YNA and Health Purchasing Victoria to facilitate the provision of nursing staff to the Hotel Quarantine

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1 Exhibit 85 at [50]-[51]: from 16 April 2020, Registered Nurses were rostered from Alfred Health to assist with welfare checks, and from 8 May 2020, a nursing agency called "Swingshift" provided all mental health nurses to the Hotel Quarantine Program.

2 Exhibit 85 at [22].

3 Exhibit 86 [YNA.0001.0001.0078].

Program.[4] Given the imminent arrival of the flights, YNA sought to co-operate in order to assist the returned travellers.

6. There was uncontested evidence that, in response to queries raised by YNA's Operations Manager prior to the supply of any nursing staff, DHHS assured YNA that:[5]

   (a) DHHS was in charge of each of the relevant hotels and would oversee the clinical governance at each hotel;
   (b) DHHS was responsible for establishing the processes and procedures in each hotel, including the infection control procedures in operation at each site and the provision of PPE to all YNA staff;
   (c) DHHS would appoint a Team Leader for each shift who would be in charge of each hotel during that shift;
   (d) the Team Leader would be the point of contact for each hotel, and YNA staff should contact him or her on arrival, and throughout their shift if they had any issues;
   (e) DHHS staff would provide YNA staff with an initial site orientation.

7. This advice remained unchanged until July 2020, when Alfred Health commenced overseeing the clinical governance of quarantine hotels.[6]

8. The position of nursing staff was somewhat different to the position of other contractors on-site. Unlike other contractors on-site, nurses already had extensive professional training and experience in infection prevention and control measures, including the correct application of PPE. Further, the contractors involved in the provision of hotels, security, food and cleaning were engaged pursuant to contracts that been negotiated with and/or administered by the Department of Jobs, Precincts and Regions (**DJPR**), and such contracts contained clauses that purported to place responsibility on those contractors for training, PPE and/or cleaning services. This gave rise to contested evidence during the hearing as to which government department was responsible for overseeing those contractors. However, that controversy did not impact upon the

4 Exhibit 85 at [17] and [28]-[31].
5 Exhibit 85 at [34] and [35].
6 Exhibit 187 [DHS.0001.0001.0713]. Exhibit 90 at [8.1]-[8.3] reveals that DHHS similarly informed "Swingshift" Nursing Agency that infection control was being managed by DHHS, that all PPE for nurses was being provided by DHHS, and nurses would be provided with a full induction on their role, use of PPE and operating procedures. Prior to the establishment of the "health hotels", Alfred Health's understanding was also that the DHHS Team Leader was in charge of operations on-site and this included responsibility for the oversight of infection prevention [Exhibit 99 at [25] and T1021.37-T1022.6 and T1029.1-9].

position of nurses at the quarantine hotels. It was not disputed that nurses had been engaged by DHHS, that DHHS was responsible for health and wellbeing services within the Hotel Quarantine Program and that on-site nurses reported to DHHS personnel.[7] Indeed, Ms Kym Peake, Secretary of DHHS, gave evidence that "the aspects of public health and wellbeing services were the responsibility of the Department of Health and Human Services"[8] and it was her impression that "there was a clear understanding that team leaders who were from DHHS understood that their role and responsibility related to the health and wellbeing services".[9]

9. From 29 March 2020, the number and classifications of nurses provided by YNA to the Hotel Quarantine Program varied in accordance with DHHS' requests to YNA from time to time.[10] That is to say, the specific number of nursing staff allocated to each shift, the duration and hours of each shift, the classification of the nurses, the tasks that nurses were to perform and their physical location at the hotel site were all matters within the remit of DHHS.[11] The evidence is that DHHS requests were "countless" and varied on a daily, and sometimes hourly, basis in accordance with needs at the various hotels.[12] In so far as some witnesses queried, in their evidence, whether it would have been more appropriate for health professionals to have accompanied returned travellers on "fresh air breaks",[13] YNA was not consulted about such matters or asked to provide nurses for that purpose; the role and tasks allocated to nursing staff was determined by DHHS.

10. Nurse Jen gave evidence of her concerns in relation to the provision of mental health nurses. However, Nurse Jen had just commenced employment with YNA and conceded "I was new to the place so wasn't too familiar with how that sort of process worked. I'm also not a mental health nurse, myself, so was unfamiliar with how YNA was handling

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7 Exhibit 85 at [34]-[35] and [80]-[82], Exhibit 186 at [63.2] and [165.2] and Exhibit 211 at [19]. See also the Operation Soteria Operations Plans [in Exhibit 145], pursuant to which DHHS had responsibility for health and wellbeing matters during the quarantine period. For example, Operation Soteria Operations Plan version 2 [DOJ.501.001.9224_R] at clause 2.3 (which provided that the provision of welfare and healthcare was the responsibility of the DHHS Commander COVID-19 Accommodation) and clause 2.4 (the establishment of medical and nursing support at the accommodation was the responsibility of DHHS Health Co-ordination (EOC), the provision of regular welfare calls to passengers and support to meet identified needs, including psychosocial, mental health and family violence was the responsibility of DHHS Welfare (EOC)).

8 T1899.35-36. See also Exhibit 211 at [19].

9 T1901.33. See also Exhibit 80 at [97].

10 Exhibit 85 at [60] and Exhibit 86. For example, DHHS requested paediatric nurses to assist minors [YNA.0001.0001.0117 in Exhibit 86].

11 Exhibit 85 at [39], [43]-[49], [55], [61]-[64], [69]-[73], Exhibit 86 and Exhibit 135 at [20].

12 Exhibit 85 at [60]-[61] and [69]-[73].

13 See, for example, T235.30, T241.14 and Exhibit 173 at [6.2].

the situation."[14] There was evidence that nurses supplied by YNA (including the supply of mental health experienced enrolled nurses) had been approved by DHHS, including DHHS's Chief Mental Health Nurse.[15]

11. The evidence suggests that, at least in the early stages of the Hotel Quarantine Program, there were difficulties with the establishment and/or implementation of systems "on the ground". However, when faced with these challenges, nurses attempted to fix gaps and ameliorate difficulties. For example, in some instances a nurse, rather than the DHHS representative, provided a site orientation to nurses and explained the processes, including "what to expect and how things worked".[16] Nurse Jen's evidence revealed that she understood her role and that if she encountered any issues she understood that these were to be escalated to DHHS.[17] There was evidence that Michael Tait, a nurse who attended the Crown complex on the first day of the Hotel Quarantine Program, was also given the contact details of a DHHS representative prior to attending the site, that he met with that person, attended a meeting with DHHS representatives and a medical practitioner on arrival and was given instructions on what to do by DHHS.[18]

12. Although agency nurses often work at unfamiliar locations, they have the professional training, clinical skills, and experience to perform their tasks. By analogy, although a firefighter does not know the type or details of a specific fire before arriving at a location, he or she has the professional skills and experience to safely perform their role.

13. Some nurses were asked to perform tasks in addition to their normal scope of practice, and in respect of which neither they nor YNA had been informed prior to the nurse attending the site. For example, Michael Tait gave evidence that as well as taking care of returned travellers, he was required to create "all the nurse processes" including a documentation system for returned travellers.[19] Similarly, Nurse Jen gave evidence about problems with access to and storage of medical records for returned travellers.[20] She described having to develop an excel spreadsheet on a DHHS computer to keep track of returned travellers until such time as an improved computerised system was

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14 T140.12-13.
15 Exhibit 87.
16 T131.18 and T131.35.
17 Exhibit 9 at [33]-[34], T131.40-45, T132.5, T132.20-24, T136.6 and that when she was concerned about finding some "ripped up" clinical notes she telephoned YNA's Manager, whom the evidence suggests was supportive [Exhibit 9 at [108], T.138.33-T139.20].
18 T166.14, T166.26, T166.38-39, T167.1, T170 and Exhibit 14 at [16]-[19].
19 T170.21-T171.2 and Exhibit 14 [18]-[19].
20 T137.33-T139.32.

developed.[21] Nurses demonstrated their flexibility and professionalism by performing these tasks to try to fill gaps in the system. YNA raised issues identified by nurses with DHHS for DHHS's resolution.

14. DHHS was responsible for the provision of PPE, hand sanitiser stations and all equipment to nurses to enable nurses to perform their tasks on-site.[22] It appears that initially some nurses experienced difficulties with access to certain medical equipment and PPE.[23] However, as soon as YNA became aware of these matters, it raised them with DHHS for resolution[24] and, to YNA's knowledge, these issues were quickly resolved.[25] Nurse Jen considered that there was a "sufficient amount" of PPE, which was "adequate in nature" for the nursing staff.[26] Whilst there was evidence that nurses sought N95 masks in order to be as safe as possible when undertaking swabbing,[27] as an organisation YNA understood that, at that time, not even nurses in hospitals were required to use N95 masks.[28] DHHS' policy provided that N95 masks were only required when performing aerosol generating procedures on guests inside their room.[29] Notwithstanding, Michael Tait gave evidence that he was provided with N95 masks on day eight of the Hotel Quarantine Program[30] and Nurse Jen referred to both N95 and surgical masks being available for nurses.[31]

15. Michael Tait gave evidence that the "nurse-returned traveller ratio" fluctuated at Crown Metropol Hotel and, at times, he considered the ratio to be insufficient.[32] It is submitted

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21 T138.33 to T139.15.
22 Exhibit 85 at [83]-[86], [95]-[97] and Exhibit 135 at [20], [32], [77] and Exhibit 130 at [53].
23 Exhibit 85 at [98]-[99], T171.10-T172.24 and Exhibit 14 at [22].
24 Exhibit 85 at [113]: the Excel Spreadsheet referred to therein is at YNA.0001.0001.0249 in Exhibit 108. As set out in Exhibit 108 [YNA.0001.0001.0250] and in Exhibit 85 at [72], an electronic medical records system was subsequently implemented by DHHS.
25 T133.30-34 and Exhibit 85 at [91]-[93] and [98]-[99].
26 T133.30-34.
27 Exhibit 135 at [32], T1169.5-T1173.5 and Exhibit 136 [DHS.5000.0027.5106 to 5110].
28 Professor Euan Wallace gave evidence [T1170-T1173] that whilst Safer Care Victoria had asked DHHS' Public Health Team why nurses could not be provided with N95 masks, he accepted DHHS' response – namely, that it was not in accordance with State and national guidelines at the time, it would compromise access to a national stockpile if it were needed, and "what messages does it send to our nurses in ED and ICU and so on" who were being told that they didn't need a N95 mask. See also Exhibit 135 at [32].
29 Exhibit 223: see column entitled "Health Care Worker PPE Required" in the final row of the chart on YNA.001.0001.0121. The chart notes that naso-pharyngeal swabbing is not classified as an aerosol generating procedure.
30 T171.27 and Exhibit 14 at [37].
31 Exhibit 9 at [41].
32 Exhibit 14 at [55] and T174.21. Mr Tait said in the very beginning there were only two nurses, but conceded "it may have been higher" [T174.22]. After 29 March 2020, the number of YNA staff rostered at Crown Metropol Hotel increased: see Exhibit 223 [YNA.0001.0001.0081].

that this is one aspect in which the comparison with a hospital setting is inapposite.[33] In a hospital setting, each patient is in need of constant medical care, whereas this was not the case at Crown Metropol.[34] There was evidence that only approximately 1% of returned travellers were infected with COVID-19.[35] If, for example, the Crown Metropol, at full capacity, had in the order of 400 returned travellers, this would equate to approximately four COVID-19 positive returned travellers in total. In other words, taking a conservative estimate of 3-4 nurses per shift,[36] it would result in almost a 1:1 ratio, which is a substantially ratio higher compared with a hospital setting. Whilst some returned travellers had other and varying health needs, not all returned travellers at Crown Metropol were in ill health or required any medical care.[37] It can also be assumed that returned travellers were meeting their other health needs without the need for hospitalisation before entering the Hotel Quarantine Program.[38]

16. There were differing views on the nurse-returned traveller ratio. Nurse Jen, for example, gave evidence that the "nurse-returned traveller ratio" was sufficient.[39] In respect of the Park Royal and Holiday Inn, where she had worked, Nurse Jen agreed that there were enough nursing staff to do the work.[40] Other witnesses observed that, on occasions, there were too many nurses.[41] As noted above, the number of nurses to be allocated to each shift was a matter determined by DHHS in accordance with its assessment of local needs, which regularly fluctuated based on the guest cohort.

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33 There are other differences including the fact that, unlike a hospital, a quarantine hotel is not a controlled environment and returned travellers are not there of their own free will. In a hospital setting, patients generally answer questions asked of them by health professionals about their health and symptoms. By contrast, Ms Liliana Ratcliff, a returned traveller, gave evidence that throughout her quarantine period she repeatedly refused to answer questions asked of her by nurses about her health and/or symptoms, even after receiving a telephone call from a more senior nurse requesting that she do so [T255.32 to T256-5]. The latter also illustrated some of the difficulties that nurses faced in trying to perform their tasks. There are other important differences, including that in a hospital setting, save for the Emergency Department, medical procedures and surgery are generally planned well in advance and health professionals know in advance (and have relevant details of) the patient's health condition(s), which was not the case in the Hotel Quarantine Program.

34 Crown Metropol was not a designated COVID-19 positive hotel.

35 T1271.27-30 and Exhibit 130 at [41(f)].

36 See Exhibit 223 [YNA.0001.0001.0079-0081], which sets out Enrolled Nurses and Registered Nurses per shift at Crown Metropol.

37 Other staff conducted the daily welfare calls including nurses from Alfred Health.

38 See Exhibit 130 at [41(c)], where Ms Pam Williams said most guests did not require attendance by nurses.

39 T132.27-T133.29. She said there were between 20 to 300 (at full capacity) returned travellers at the Park Royal at any one time, and 3 or 4 general nurses and 1 mental health nurse per shift.

40 T133.1-29.

41 Exhibit 205 at [45(d)]. See further Exhibit 85 at [71].

17. YNA had no involvement in the development of the systems, policies or procedures at the hotel sites, including in relation to the model of care. Nurses were inserted into the established framework and required to work in accordance with the systems, procedures and policies that were established by DHHS.[42] These included matters such as how and when welfare checks, tests and screening of returned travellers were to be performed,[43] in-room checks for returned travellers,[44] the IT systems, data collection and medical records,[45] the process for obtaining temporary leave or exemptions[46] as well as the pro-forma documentation required for nursing tasks, such as forms and questionnaires.[47]

18. Two reviews undertaken by Safer Care Victoria found that some of the systems, procedures, policies and documentation that were initially in place at quarantine hotels were deficient.[48] However, this was the system into which nurses were deployed rather than one that they or YNA had designed.

19. When nurses had concerns, including about processes, they raised them. There was evidence of each concern that was raised and/or complaint made to YNA during the course of the Hotel Quarantine Program. Each concern or complaint was elevated by YNA to DHHS for its consideration and resolution.[49] This included a number of issues that were identified in the Safer Care Victoria final reports, such as access to medical records and the need to improve processes and procedures including processes for undertaking welfare checks.[50]

20. Despite these challenges, nurses did their best within the established systems and framework to fulfil their tasks and assist returned travellers. Nurses' preparedness to co-

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42 Exhibit 135 at [45]-[72] and [77]-[78].
43 For example, Exhibit 135 at [45]-[68].
44 Exhibit 135 at [68]-[69].
45 For example, Exhibit 135 at [68] and Exhibit 85 at [72].
46 Exhibit 122 at [98]-[109] and Exhibit 135 at [75(a)] and [75(c)].
47 T1169.10-47, T11769-T1173.5 and Exhibit 136.
48 Exhibit 116 and Exhibit 117. The first review was undertaken on 10-11 April 2020 and released on 10 June 2020 and the second review was undertaken on 13 April 2020 and released on 17 June 2020. See also Dr Rob Gordon's evidence in relation to the sufficiency of measures implemented to overcome the psychosocial impacts of quarantine [Exhibit 176 and Transcript 18 September 2020]. As noted above, the systems, processes, policies and staff profile on-site, for the health and welfare of returned travellers, were determined by and the responsibility of DHHS.
49 Exhibit 85 at [113]: the Excel Spreadsheet referred to therein is YNA.0001.0001.0249 in Exhibit 108.
50 Exhibit 108 [YNA.0001.0001.0249].

operate, comply with requests made of them by DHHS and adapt to evolving systems and processes is commendable.[51]

21. Indeed, there was evidence of the genuine care and compassion shown by nurses to returned travellers, including nurses advocating for the needs of returned travellers.[52] Mr Hugh de Kretser, for example, gave evidence that "nurses were very sympathetic about the lack of fresh air and exercise breaks, and my impression was that they were doing what they could to advocate for that to be provided"[53] and "[a]s I said in the statement, the nurses seemed to be genuinely concerned for people's welfare and doing what they could to look after people's welfare",[54] "advocating for people's welfare within the structures of the detention program".[55] He felt comfortable in raising any issues that he had while in quarantine with the nurses.[56]

22. Dr Gordon also observed, the fact returned travellers were generally compliant was not only a cultural issue but also "indicative of the way in which they were managed, and the kind of relationships they formed with the people they dealt with that developed that confidence".[57] This necessarily included nurses who conducted daily welfare checks, health checks and attended to health care needs of returned travellers.

Alfred Health Model

23. Ms Simone Alexander, Chief Operating Officer of Alfred Health, gave evidence in relation to a clinical model, introduced at the Brady Hotel from 17 June 2020 and "rolled out" thereafter to other quarantine hotels.[58] The clinical model includes the provision of a Clinical Nurse Leader (or an equivalent position) on-site at each hotel,[59] Alfred Health being in charge of clinical governance at each site, including implementation and

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51 Exhibit 162 at [60]: there was a high level of co-operation between all healthcare and welfare providers, all needed to work with a high level of adaptability and a high degree of collegiality, which was evident when they worked.

52 For example, T142.37-T143.29 in relation to Nurse Jen raising concerns about a guest whom she concerned was considering suicide or had threatened suicide, T143.30-T144.40 about a guest with endometriosis who lacked a kettle or microwave, generally at T144.45-T146.10, and Michael Tait at T176.40-T177.15 and T178.10-25 about dietary needs and attempts to get an exemption for a woman who had escaped domestic violence with a young child and new born baby. See also Exhibit 205 at [60(a)] about nurses raising serious welfare concerns about a female guest whose partner was not allowing her to speak with Alfred Health nursing staff.

53 T191.4-7.

54 T192.45 to T193.5.

55 T204.1-10.

56 T204.10-14.

57 T1742.1-5.

58 Exhibit 99 and Exhibit 100.

59 Exhibit 99 at [30]-[31] and [45(a)], T1027.20-45, T1029.40-47 and T1030.5-27.

oversight of infection control measures consistent with a hospital setting, contact tracing, provision of PPE, infection prevention and control training for all staff, and review and auditing of infection control measures.[60]

24. There are obvious benefits to such a model, including having a Clinical Lead on-site as the primary contact for infection prevention control issues. YNA nurses had identified the need for a Clinical Nurse Manager at hotel sites on or about 6 April 2020 and YNA had raised the issue with DHHS.[61] Ms Alexander agreed with the proposition that, to her knowledge, "[p]resumably there would have been nothing to prevent [Alfred Health] from responding" if it been approached in relation to setting up a "health hotel model" prior to 26 May 2020.[62] However, arguably that was an observation made with the benefit of hindsight. The environment in late March 2020, and in the initial stages of the Hotel Quarantine Program, was one of rapidly increasing infection rates and an almost palpable fear that Melbourne's health services would be unable to cope.[63] There was also hospital transmission of COVID-19 and hospital outbreaks in Melbourne (including, but not exclusively, at Alfred Health) in the lead up to May 2020.[64] The knowledge about COVID-19 has developed significantly since earlier this year, and even the Chief Health Officer's advice (for example, in relation to the wearing of masks in public) has changed markedly since that time. It is important not to assess the environment and level of knowledge that existed in March, through an August, September or October lens.

25. Evidence suggested that, at the time the Hotel Quarantine Program commenced and in its initial stage, there were concerns that health services would be overwhelmed by a significant influx of COVID-19 patients. For example, Dr van Diemen was asked about whether the Hotel Quarantine Program warranted being undertaken by "more health-qualified people", to which she responded:

> "….So in response to the outbreak at Rydges, one of the things we discussed was how we could consider using people who perhaps normally worked in health settings to do things like some of the security observing of passengers or the delivery of meals or other things who were more used to doing the

60 Ms Alexander gave evidence that prior to 17 June 2020, there was no one on-site who was in charge of infection prevention and control other than the DHHS team leader [T1029.1-10, T1029.32-39 and Exhibit 99 at [25]]. Unfortunately, notwithstanding the measures introduced since 17 June 2020, there have been recent outbreaks of COVID-19 amongst some workers at health hotels.

61 Exhibit 108 [YNA.0001.0001.0249].

62 T1053.40 to T1054.4.

63 See, for example, T1542.7-20, T1542.30-35 and T1543.33-39.

64 See also Exhibit 99 at [76(a)].

> infection prevention and control requirements in a health setting. And again, I would agree with Dr Sutton that all of this is in retrospect and, even given more time to consider it at the time of inception, we may not have recommended that at the time, and it may not, I suspect would not, have been practical at the time, given our health services were preparing for an enormous influx of patients as we had seen around the world".[65]

Dr van Diemen further stated:

> "[W]e were not in a regular scenario and we were very, very aware of what we were seeing happen in many other jurisdictions and very aware of the epidemiological curve that we were seeing in Victoria and in Australia, and that we were quite literally weeks away from our systems being completely overwhelmed with thousands of cases."[66]

26. Similar observations were made by Ms Andrea Spiteri, who said, in the context of discussing the engagement of Alfred Health:

> "One of the things that I would like to point out at this time, though, is that when the program initially started….It was also at a time where health services themselves were gearing up for a potential influx of patients that might need intensive care. So, at that time it was a very different environment, when the program started, to where we were a couple of months later, with the lifting of restrictions in Victoria, with the easing of the potential pressure on health services, and their ability to potentially support into that environment. But there were up to 17 hotels at any one time, so that was something that we needed to work through with health services in terms of the capacity to be able to provide that sort of level of service to all hotels." [67]

27. Ms Peake also relevantly noted:

> "The second part of the mission was around making sure there was sufficient health system capacity to deal with what we anticipated at that point would be a very significant influx of COVID patients to Victorian health services, including

65 T1532.45 to T1533.6.
66 T1542.26-35.
67 T1602.33-43.

needing to significantly expand intensive care capacity or critical care capacity for COVID patients, and ensure there were sufficient critical supplies for health services".[68]

28. The concern about the anticipated significant influx of COVID-19 positive patients, and consequential pressure on the health services, in the initial phase of the Hotel Quarantine Program may explain in part why the clinical model that was established on 17 June 2020 was not introduced in the initial phase of the Hotel Quarantine Program.

29. In any event, and as noted above, YNA had no involvement in the planning or design of the model of care, systems, processes or policies in the Hotel Quarantine Program. Nursing staff did their best, within the established framework, to perform their tasks and provide care to returned travellers.

Information, Training and Guidance

30. YNA nurses had been trained in, and received continuous information and guidance from YNA, in relation to COVID-19 and how to work in a safe manner.[69]

31. Infection prevention and control, the use of PPE and hand hygiene are part of a nurse's professional training, experience and everyday practice. The evidence was that YNA nurses have to demonstrate that they have completed the necessary competencies and continuing professional development when they renew their annual AHPRA registration.[70]

32. In and from early 2020, YNA provided training, information and guidance to its employees in relation to COVID-19. In January 2020, YNA commenced working on a Covid-19 Training Module, which formed part of YNA's Learning Management System. YNA was proactive in that it commenced developing a Covid-19 specific Training Module for staff well before the Australian Government had released its on-line training course. The Covid-19 Training Module was launched on or about 24 March 2020 and YNA directed all staff to complete it.[71] The YNA Covid-19 Training Module set out information and instructions in relation to PPE, types of PPE including surgical masks and P2/N95

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68 T1912.35-40.
69 See also Exhibit 1 at [61].
70 Exhibit 85 at [75]-[76].
71 Exhibit 85 at [77] and Exhibit 108 (including extracts from the Covid-19 Training Module at YNA.0001.0001.0139 and following, and directions to staff to complete the Covid-19 Training Module in the Covid-19 Staff Updates and the other communications set out in therein).

respirators and the activities for which each should be worn, gloves/goggles and face shields, the sequence for "donning and doffing", cough technique, hand hygiene, transmission (droplet, airborne and fomite) precautions, social distancing, cleaning of equipment, environmental cleaning, links to further educational on-line material, contact telephone details for the National Coronavirus Information and Triage Line and what staff must do if they experience symptoms.

33. From at least 18 March 2020, YNA also directed its staff to complete the Australian Government's Infection Control Training Module: "How to protect yourself and the people you are caring for from infection with Covid-19". This government approved, on-line resource contained information about COVID-19, signs and symptoms and infection control precautions.[72] Staff were provided with the most recent version, as updated by the Australian Government from time to time. Nurse Jen, who completed this course, observed that the version she had completed differed slightly from the version that had been tendered through Professor Grayson,[73] but considered the training to be "really useful"[74] and adequate.[75]

34. From January 2020 onwards, YNA also provided "Coronavirus Covid19 Staff Updates" to each staff member.[76] These Staff Updates were continuous and dynamic. That is to say, they contained updated information as knowledge of the coronavirus evolved, and provided constant reinforcement to staff about infection prevention and control.[77]

35. The Coronavirus19 Staff Updates contained information, including about:
    - symptoms of COVID-19;
    - how the virus can be spread;
    - social distancing, hand hygiene (including the sequencing of hand washing) and other infection control measures;
    - maintaining clean and contaminated zones;
    - adherence to waste disposal and cleaning requirements;

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72 Exhibit 108 (see emails to staff and Covid-19 Staff Updates in relation to the Australian Government on-line course) and Exhibit 87 at [YNA.0001.0002.0080].
73 Exhibit 3, T129.25-45 and Exhibit 11.
74 Exhibit 9 at [12].
75 T136.10.
76 Exhibit 108. See also Exhibit 85 at [78], [122]-[123] and Exhibit 86 at [YNA.0001.0001.0237 to 0248].
77 For example, Exhibit 108 reveals that YNA provided Coronavirus Update information to its staff on 2 March, 6 March, 11 March, 16 March, 18 March, 19 March, 23 March, 24 March, 25 March, 26 March and 30 March 2020.

- what staff must do if they have been in close contact with a confirmed case or have symptoms;
- testing for health care workers and isolation requirements;
- instructions on how to change from work wear into normal clothing and the washing of work wear;
- taking care of mental health and wellbeing.

36. The Coronavirus Covid19 Staff Updates provided useful links including to Australian Department of Health resources such as daily health alerts, isolation guidance information sheets, and the Australian Guidelines for the Prevention and Control of Infection in Healthcare. They also contained telephone numbers for the National Coronavirus Health Information Line and DHHS as well as relevant State links and World Health Organisation resources. YNA also provided a copy of the Australian Department of Health information guide, titled "Novel Coronavirus – Information for Health Care and Residential Care Workers," to all staff.[78]

37. There was also uncontested evidence that YNA Allocation Staff spoke with each YNA staff member assigned to the Hotel Quarantine Program before their first hotel shift to ensure they understood the nature of the role that DHHS had requested, the environment and the need to work in a safe manner.[79]

38. DHHS did not provide infection control or PPE training to YNA nurses.[80] Ms Pam Williams, Commander, Operation Soteria, gave evidence DHHS "was responsible for providing training to its contracted staff on site," noting "the Department's contracted nursing and medical staff could be assumed to have familiarity with the correct use of PPE."[81] There was evidence DHHS established red and green zones, displayed posters at hotel sites,[82] and published policies directed to PPE and infection prevention and control. Ms Merrin Bamert, Commander, Operation Soteria, gave evidence that DHHS Team Leaders were expected "to conduct a shift handover briefing for Department staff

78 Distributed to staff on 3 February 2020: see Exhibit 108 [YNA.0001.0002.0056 to 0060].
79 Exhibit 85 at [79].
80 Exhibit 85 at [74]. Ms Alexander also gave evidence that DHHS did not train Alfred Health nurses but that nurses were required to maintain specific training including infection prevention control [T1021.10-30].
81 Exhibit 130 at [56].
82 Exhibit 85 at [64] and [88], Exhibit 223 [YNA.0001.0001.0120 to 0123], Exhibit 45 at [25(a)] and T592.25-40.

(including AOs and nursing staff) and the Dnata team leader if possible, covering PPE, instructions, OHS considerations and physical distancing."[83]

39. In closing submissions, Counsel Assisting noted that on 11 April 2020 DHHS decided all staff at Rydges Hotel should undertake a short tutorial in relation to PPE. In that context, Counsel Assisting observed that the beneficial effect of conducting the briefing was shortly lost to the Rydges site, given the subcontracted security team was stood down shortly thereafter and it appears that not all nursing staff remained working at that site for 14 days. Some nurses worked at different locations in the course of the Hotel Quarantine Program. It must be remembered that YNA was initially asked to provide a limited number and classification of nurses from 29 March to 5 April, with an assumption that the engagement might extend until 26 April 2020. Thereafter, the needs at each hotel continued to vary and the engagement remained of an uncertain duration. Given the uncertain duration of the engagement and unpredictable and specific needs at each hotel,[84] YNA could not offer permanent work at a single site. YNA had raised the issue of nurses working at other locations with DHHS at the outset of the engagement. In response to an enquiry by YNA in early April 2020, DHHS advised YNA that nurses who were assigned to work at quarantine hotels were permitted to work elsewhere.[85] Indeed, on occasions, DHHS specifically requested the provision of nursing staff with experience from working at other quarantine hotels.[86] However, for the period that Novotel South Wharf Hotel was designated COVID-19 positive hotel, DHHS directed nursing staff not work elsewhere and YNA complied with that request.[87] It is not uncommon for health professionals, including nurses, to work across more than one health service and/or site.[88] Even if all nurses were not present at the PPE briefing at Rydges on 11 April 2020, as health professionals, they can all be assumed to have the requisite knowledge and skills in relation to the appropriate use of PPE and infection control measures

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83 Exhibit 135 at [26].

84 Directions and requests from DHHS varied on a daily and sometimes hourly basis [Exhibit 85 at [60]]. For example, Exhibit 86 [YNA.0001.0001.0117] in which there is a request for a paediatric nurse to attend a hotel site as soon as possible until 10pm, and that DHHS "will be in touch if further arrangements need to be made ongoing".

85 Exhibit 86 [YNA.0001.0001.0111-0112 and YNA.001.0001.0001.0114-0116].

86 Exhibit 85 at [52]-[53] and Exhibit 86 [YNA.0001.0001.0114 and YNA.0001.0001.0116].

87 Exhibit 85 at [54].

88 See also Exhibit 99 at [75], [76(c)], [76(d)] and [77]-[78]: some Alfred Health nurses were also employed by nursing agencies and/or other employers and, in that capacity, had worked at other health services and hotel sites. Ms Alexander said that, in more recent times, there had been an increased awareness about movement of staff between sites so that since 12 July 2020 staff working in the Hotel Quarantine Program had been rostered to work at one specific site. She acknowledged, however, that Alfred Health could not prevent staff from completing shifts with other employers if they chose to do so.

because of their continuous professional training and experience, including the extensive training by YNA referred to above.

40. There was evidence nurses complied with infection control and PPE measures and would prepare as if they were going into theatre for surgery.[89] Nurse Jen gave evidence, for example, of donning and doffing full PPE in correct sequence, adhering to protocols to ensure physical distancing between nurses and guests, and disposing of PPE and items in the yellow clinical waste bins that were available on each floor[90] because "you always treat it [PPE] as if it definitely is contaminated".[91] Witness "Security 16" referred to nurses wearing face masks, gloves and coverings over their clothes[92] and the "full PPE kit",[93] Mr de Kretser observed nurses "generally took their job seriously",[94] and the Behavioural Insights Unit from Department of Premier and Cabinet found that nurses were "well trained" in relation to PPE.[95] Importantly, Dr Sarah McGuinness, Senior Medical Advisor and former "Outbreaks Lead" in the Case Contact and Outbreak Management division of DDHS, gave evidence in relation to the COVID-19 outbreaks at Rydges Hotel and Stamford Plaza. In doing so, Dr McGuinness made no adverse comments in relation to the application of infection prevention and control measures (including use of PPE) by YNA nursing staff and did not attribute any act or omission by YNA nursing staff to the outbreaks at either Rydges or the Stamford Plaza Hotel.[96]

41. A few witnesses gave evidence in relation to non-compliance with infection control measures by mental health nurses. However, those nurses were not employed by YNA.[97]

42. Ms Liliana Ratcliff, a returned traveller, gave evidence of her concern that nurses, who swabbed her and her children at the Stamford Plaza, may not have complied with infection prevention measures, that she considered would be followed in a hospital.[98] Ms Ratcliff said that "my expectation was that they would change their personal

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89 Exhibit 85 at [90].
90 Exhibit 9 at [43]-[44] and T134.15-44.
91 T.134.15-44 and T135.10-17.
92 Exhibit 31 at [40].
93 Exhibit 31 at [71].
94 Exhibit 16 at [9].
95 Exhibit 186 at [251.2] and Exhibit 187 [DHS.0001.0001.0713].
96 Exhibit 106 at [47]-[52] and [73]-[80].
97 Exhibit 125 at [121a] and the annexure referred to therein, which identifies the relevant nursing agency. See also Exhibit 201 at [39] – YNA did not provide mental health nurses at that time. That is to say, the mental health nurse was employed by another nursing agency.
98 But see also T251.45: Ms Ratcliff observed that "definitely nursing staff always wore gloves".

protective equipment for each patient, or at least in between hotel rooms".[99] Ms Ratcliff's statement that nurses "went from door to door to do swabs, wore the same gowns, same gloves, the same mask"[100] was merely an assumption based upon the fact that she could not see what nurses did either before or after they left the doorway of her hotel room. In other words, as to whether nurses changed their gloves before or after they attended her doorway, Ms Ratcliff could only say that she "never observed",[101] she "didn't see" spare gloves or a bin[102] but had merely "inferred"[103] nurses must not have changed their PPE before or after going from room to room.

43. Nurse Jen described the process undertaken by nurses at hotels when they were required to attend on a guest, including the fact that nurses would wear PPE, they would stand back from the doorway rather than enter the room,[104] that each floor of the hotel had a yellow clinical waste bin and, after seeing the guest, nurses would remove their gowns and gloves, in the requisite sequence, and deposit their PPE in the yellow clinical waste bin[105] because "you always treat it [PPE] as if it definitely is contaminated".[106] The fact Ms Ratcliff could not see what happened either before or after nurses attended her doorway does not mean the same process, described by Nurse Jen, and reinforced in nurses' significant infection control training, was not followed. With respect, Ms Ratcliff's inability to see nurses' activities and equipment beyond her room is not a cogent basis for the drawing of such an inference.

44. The inference is also inconsistent with other, extensive evidence about the seriousness with which nurses generally approached infection control at the hotel sites. For example, the fact nurses were "nervous" about using surgical masks and wanted P2/N95 masks for swabbing.[107] It is also inconsistent with the assessment of the Infection Prevention Consultant from Infection Prevention Australia, who undertook a review of the

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99 Exhibit 20 at [41]. Ms Pam Williams gave evidence [Exhibit 130 at [41(c)] that the protocol at hotels was that the nursing staff performing the swabbing were to wear PPE, and perform the procedure at the door to the guest's room, so as to reduce infection risk; "the nurse performing the swabbing procedure was required to doff PPE after each room, and the whole team changed PPE when they changed floors".

100 T253.L20.

101 T253.31.

102 T253.32 to 33.

103 T253.34.

104 T134.15-44. In discussing the protocol for nurses and doctors attending on guests, Ms Pam Williams stated that most interactions could be at the guest's door, but sometimes this was not always possible: Exhibit 130 at [41(c)].

105 T134.20-40.

106 T.134.15-44 and T135.10-17. See also Exhibit 88 at [30]: Dr Stuart Garrow stated that the infection control practices of the doctors and nurses were those adapted from hospitals and general practice.

107 Exhibit 135 at [32] and [41] and Exhibit 136 at [DHS.5000.0027.5106 to 5110].

quarantine hotels and on 5 May 2020 noted, "the health care team's compliance with PPE and HH [hand hygiene] has been excellent",[108] and the finding of the Behavioural Insights Unit from Department of Premier and Cabinet that nurses were "well trained" in relation to PPE.[109] Their concern to ensure safety was also demonstrated by the fact nurses raised concerns about the incorrect application of PPE and infection control measures by other staff at hotel sites.[110]

45. In a work environment, agency nurses need to trust those around them. Given their professional training, nurses are acutely aware of the serious risk, to themselves and to others, if some members of their team are not adhering to infection prevention and control requirements and they will complain. YNA received no complaints in relation to non-compliance, by YNA nurses, with infection control measures.[111]

46. Nurses gave training and refreshers about PPE and infection control precautions to other on-site personnel. On occasions, contractors requested that nurses provide ad hoc "refreshers", whilst at other times, nurses provided refreshers after observing the incorrect application of PPE or social distancing requirements by other personnel.[112] All training and advice by nurses was provided under the direction and/or with the approval of DHHS.[113] There was also evidence of nurses providing PPE to other personnel on-site when they ran-out,[114] providing inductions including showing a DHHS video in relation to hand hygiene and mask usage to staff when they commenced,[115] being present at security changeovers to brief staff on PPE and hygiene protocol,[116] attending daily briefings[117] and, under the direction and advice of DHHS and its infection control consultant, setting up red/green zones and PPE stations.[118] At times nurses made suggestions in relation to infection control measures, although the decision as to whether to adopt those suggestions fell within the remit of DHHS.[119] For example, the Manager of Rydges Hotel referred to nurses making a suggestion hotel staff undertake

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108 Exhibit 136 at [DHS.0001.0021.0020].
109 Exhibit 186 at [251.2] and Exhibit 187 [DHS.0001.0001.0713].
110 Exhibit 139, T1338.40-44, Exhibit 51 at [72(j)] and Exhibit 108 [YNA.0001.0001.0251].
111 Exhibit 108 [YNA.0001.0001.0249 to 0252].
112 For example, Exhibit 61 at [134], Exhibit 186 at [246.2] and Exhibit 201 at [50]. As to training see also Exhibit 45 at [36(b)], [45] and T576.31-46, T593.31-T594.26, Exhibit 44 at [8(c)], [34] and [41], Exhibit 84 at [28], Exhibit 80 at [30], Exhibit 75 at [26(c)].
113 T1337.12 to T1339.25.
114 Exhibit 67 at [115], See also Exhibit 45 at [62].
115 Exhibit 139, T1337.35 to T1339.25, Exhibit 58 at [23] and [42]. See also Exhibit 52 at [23] and [42(a)].
116 Exhibit 69 at [126]-[127].
117 Exhibit 45 at [27] and [36].
118 Exhibit 45 at [25(a)].
119 See for example, T594.23-26.

a hand hygiene course,[120] nurses requested the use of temperature checks for hotel staff[121] and Nurse Jen gave evidence of suggesting to a DHHS representative that nurses provide PPE training to contractors and/or that other contractors could undertake on-line training.[122]

47. Nurses efforts, in willingly providing such training and assistance to other personnel, underscores their serious attitude towards infection prevention and control including PPE, the recognition of the risks associated with COVID-19, and that they did their best to co-operate and ensure the safety of all persons at the hotel sites.

48. The many hundreds of YNA staff deployed worked approximately 17,500 shifts in the Hotel Quarantine Program.[123] Notwithstanding the significant number of staff who provided services in the Hotel Quarantine Program, only three YNA staff members have been infected with COVID-19, two of whom were nurses. Two of those staff have advised YNA the source of their infection was not one of the hotels hosting the Program and the source of the third staff member's infection is unknown.[124] This supports the fact that, by reason of their professional training and experience, nurses were acutely aware of transmission risks and adhered to infection prevention and control measures.

49. None of infections that emanated from the Hotel Quarantine Program, and were reported on by Dr Sarah McGuinness, were linked to YNA staff.[125]

Conclusion

50. No adverse findings should be made against YNA.

51. Nurses were injected into a system, which neither they nor YNA had designed or established. It is evident that there were shortcomings in the initial phase of the Hotel Quarantine Program. However, in that context, it is also relevant to consider that the Hotel Quarantine Program was established within a timeframe of 36 hours and the magnitude of the Program.

52. Nurses went "above and beyond" in their efforts to care for returned travellers, and fill gaps in and adapt to an evolving system. Nurses are professionally trained in infection

120 Exhibit 45 at [36(e)] and [46].
121 Exhibit 45 at [36(d)].
122 Exhibit 9 at [51].
123 Exhibit 223 [YNA.0001.0001.0079 to 0110] and Exhibit 85 at [125].
124 Exhibit 85 at [116]-[117].
125 Exhibit 106.

prevention and control measures, including the correct application of PPE. Their acute understanding of infection control, and concern for the safety of others on-site, was evidenced by nurses' requests for N95 masks, the fact they elevated their concerns about the incorrect application of infection control measures by others and their willingness to provide training and "refreshers" to other contractors on-site. Their compliance with PPE and hand hygiene was described by Infection Prevention Australia as "excellent".

53. YNA nurses worked approximately 17,500 shifts throughout the Hotel Quarantine Program. The fact that none of YNA's staff acquired COVID-19 through their work at quarantine hotels, and none of the outbreaks that emanated from the Hotel Quarantine Program were linked to YNA staff, is a testament to their conscientiousness and adherence to infection prevention and control measures.

DATED: 5 October 2020

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