COVID-19
Hotel Quarantine Inquiry

COVID-19 Hotel Quarantine Inquiry Interim Report and Recommendations

NOVEMBER 2020

COVID-19 HOTEL QUARANTINE INQUIRY

Interim Report and Recommendations

The Hon. Jennifer Coate AO
Board of Inquiry

ORDERED TO BE PUBLISHED

Victorian Government Printer
November 2020

PP No 169, Session 2018—2020

COVID-19 HOTEL QUARANTINE INQUIRY
INTERIM REPORT AND RECOMMENDATIONS

Published November 2020

ISBN 978-0-6450016-0-0
Suggested citation: COVID-19 Hotel Quarantine Inquiry, Interim Report and Recommendations, Parl paper no. 169 (2018-2020)

COVID-19
Hotel Quarantine Inquiry

6 November 2020

Her Excellency the Honourable Linda Dessau AC
Governor of Victoria
Government House
Melbourne VIC 3004

Your Excellency

In accordance with the Terms of Reference contained in the Order in Council made on 2 July 2020, and amended by the Order in Council made on 29 October 2020, I hereby present the Board of Inquiry into the COVID-19 Hotel Quarantine Program's (Inquiry) Interim Report.

This Interim Report identifies issues that have emerged from the Inquiry to date and makes recommendations for a Quarantine Program in Victoria as the State begins to consider re-opening to international arrivals.

This Interim Report will be followed by the Inquiry's Final Report, which will contain a full examination, findings and recommendations in respect of the decisions and actions taken in establishing and operating the Hotel Quarantine Program.

The Inquiry's Final Report is due to be delivered to you by 21 December 2020.

Yours sincerely

The Honourable Jennifer Coate AO
Chairperson
Board of Inquiry into the COVID-19 Hotel Quarantine Program

Contents

Foreword

The COVID-19 pandemic has had a profound impact on our world in 2020.

Here in Victoria, it has led to a sustained period of lockdown and restrictions, initially as a way to reduce the spread of the virus in the community, and then due to the 'second wave' of COVID-19 cases that was linked to the Hotel Quarantine Program.

The movement of this virus through Victoria has placed our State in sadly unique circumstances, in contrast with the rest of the nation.

It was this 'second wave' that led to the establishment of this Board of Inquiry, with the Terms of Reference as set out in Appendix C.

Since its establishment, this Inquiry has obtained a significant volume of documents and other evidence from relevant parties, including via the public hearings held from 17 August until 28 September 2020. The Inquiry heard evidence about the Program from medical and scientific experts, government officials, hotel staff, and returned travellers who experienced the Hotel Quarantine Program.

Following the conclusion of its hearings, the Inquiry began work to consolidate the information and evidence received in anticipation of delivering its Final Report by 6 November 2020.

Most regrettably, additional material has been provided to the Inquiry since that time. This additional, potentially significant material has resulted in the need to delay delivery of the Final Report while further enquiries are conducted. How and why this delay occurred will be addressed in the Final Report.

I am acutely aware of the importance of a timely re-opening of international points of entry to Victoria, and the necessity for appropriate quarantine arrangements to accompany such a re-opening. In light of this, and the Inquiry's desire to do all it can to assist in this important work of developing and implementing a robust quarantine system for our State as soon as possible, this Interim Report has been prepared and provides recommendations for a future Quarantine Program in Victoria.

Despite this disruption and delay to the Final Report, every effort will be made by the Inquiry to ensure that what happened in Victoria's Hotel Quarantine Program is fully and faithfully investigated and reported upon in accordance with the Inquiry's Terms of Reference.

By providing this Interim Report, I am making my best endeavours to achieve both aims.

I feel an enormous sense of responsibility for the work I have undertaken on behalf of the people of Victoria. I thank all Victorians for their patience and understanding as the Inquiry completes its important work.

In the meantime, I am comforted to be able to provide this Interim Report to assist in the development of a future Quarantine Program for our State.

The Honourable Jennifer Coate AO
Chairperson
Board of Inquiry into the COVID-19 Hotel Quarantine Program

Introduction

1. To provide some context to this Interim Report, several important dates and events are set out in this introduction. The full relevant background will be contained in the Final Report.
2. This year has been a difficult and unprecedented one as the COVID-19 pandemic has swept across the globe.
3. Many governments across the world have introduced measures to reduce the spread of the COVID-19 virus, particularly as the pandemic was seen to be escalating rapidly in the early months of 2020.

The World Health Organization declares a public health emergency on 30 January 2020

4. On 30 January 2020, the World Health Organization Director-General, Dr Tedros Adhanom Ghebreyesus, convened a meeting of the Emergency Committee on the novel coronavirus under the International Health Regulations (2005).
5. It was at this Emergency Committee meeting that Dr Tedros declared the COVID-19 outbreak constituted a public health emergency of international concern.[1]

The World Health Organization declares a pandemic on 11 March 2020

6. By 11 March 2020, Dr Tedros reported that the number of cases of COVID-19 outside China had increased 13-fold, compared with the number of cases two weeks earlier.[2] The number of affected countries had tripled – there were 118,319 cases in 114 countries including China, and 4,292 deaths had been recorded.[3]
7. Dr Tedros also noted that the number of cases, the number of deaths, and the number of affected countries were expected to climb higher. It was in this context that the World Health Organization declared COVID-19 a pandemic.[4]

The Australian response to COVID-19

8. On 20 January 2020, the Australian Health Protection Principal Committee (AHPPC), which comprises the Chief Medical Officer of Australia and all state and territory Chief Health Officers, met for the purposes of considering a national response to COVID-19.[5]
9. On 21 January 2020, then Chief Medical Officer for the Australian Government, Professor Brendan Murphy, in his capacity as Director of Human Biosecurity, made a written determination pursuant to s. 42 of the *Biosecurity Act 2015* (Cth) that COVID-19 (designated 'human coronavirus with pandemic potential') should be included as a 'listed human disease'.[6] This determination provided authority for the Federal Minister for Health to impose enhanced border screening measures for all travellers entering and departing Australia.[7]

10. Australia confirmed its first case of COVID-19 on 25 January 2020.[8]

11. The Australian Government subsequently raised the level of travel advice for Wuhan and Hubei Province to 'Level 4 – Do Not Travel' and introduced precautionary measures for travellers arriving in Australia from China, to detect unwell travellers, and to ensure all returning travellers were provided with information about COVID-19 and the steps to take should they develop symptoms.[9]

12. In addition, enhanced health advice was provided at every port of entry to Australia for all modes of travel (airline and sea).[10]

Escalating confirmed COVID-19 cases in Australia

13. By 1 February 2020, the number of confirmed COVID-19 cases in Australia had increased to 12.[11]

14. The Department of Foreign Affairs and Trade upgraded its travel advice for China to 'Do Not Travel'.[12] Restrictions were also placed on people travelling or returning to Australia from China:

> Foreign nationals (excluding permanent residents) who are in mainland China from today forward, will not be allowed to enter Australia for 14 days from the time they have left or transited through mainland China ...
>
> Any foreign nationals who do arrive in Australia notwithstanding the prohibition, and who choose not to immediately return to their port of origin, will be subject to mandatory quarantine.
>
> We will also be requiring Australian citizens, permanent residents and their families who do enter Australia and who have been in mainland China to self-isolate for 14 days from the time they left mainland China.[13]

15. A plan was also established to provide assisted departures for isolated and vulnerable Australians located in Wuhan and the Hubei Province in China, with individuals to quarantine for 14 days at Christmas Island.[14]

16. By 29 February 2020, there were 24 confirmed COVID-19 cases in Australia.[15]

Establishment of the National Cabinet: a governmental response to the pandemic

17. On 13 March 2020, in recognition of the unprecedented scale and potential consequences of the pandemic, a National Cabinet was established, following a meeting of the Council of Australian Governments (COAG).[16]

18. The Prime Minister stated that the National Cabinet was created to address and ensure consistency in Australia's response to the COVID-19 pandemic. Like COAG, it comprised the Prime Minister, Premiers and Chief Ministers of the states and territories.[17] It first met on 15 March 2020.[18]

Decisions made by National Cabinet

19. One of the first actions that the National Cabinet took to reduce the spread of COVID-19 in Australia was to implement the 'universal precautionary self-isolation requirement on all international arrivals', effective from 11.59 pm on 15 March 2020.[19] This required all returning travellers to quarantine at home for 14 days pursuant to state-based directions.[20]

20. By 27 March 2020, there were more than 3,000 confirmed COVID-19 cases in Australia and 13 deaths. The majority of cases were in New South Wales, Victoria and Queensland.[21] There was considerable concern that the majority of cases across the nation were coming in via international points of entry.

21. On 27 March 2020, the National Cabinet met and agreed to further restrict the movement of incoming travellers and increase compliance checks on travellers already self-isolating. Notably, the National Cabinet agreed that as soon as possible, but no later than 11.59 pm on 28 March 2020, all travellers arriving in Australia would be required to undertake mandatory 14-day self-isolation at 'designated facilities'.[22]

22. Hotels were given as an example of a designated facility, but the exact facilities to be designated and the implementation of the quarantine program was a matter for each state and territory government.

Victoria's Hotel Quarantine Program commences

23. It was in this context that Victoria's Hotel Quarantine Program was established over the weekend of 28 and 29 March 2020 and received its first returned travellers on Sunday 29 March 2020.

24. According to a recent analysis undertaken by the National Review of Hotel Quarantine, based on data provided by states and territories, a total of 21,821 returned travellers went through Victoria's Hotel Quarantine Program. Of these returned travellers, a total of 236 (1.1 per cent) tested positive for COVID-19 in quarantine.[23]

25. Despite the relatively low number of positive COVID-19 cases in the Hotel Quarantine Program, breaches of containment in the program in May and June led to the second wave of COVID-19 cases in Victoria,[24] with devastating social and economic consequences for the state.

26. Due to the established link between the second wave of COVID-19 cases and the outbreaks from the Hotel Quarantine Program, this Inquiry was established on 2 July 2020 to examine a range of matters related to the program, including:

    - decisions and actions of government agencies, hotel operators and private contractors
    - communication between government agencies, hotel operators and private contractors
    - contractual arrangements
    - information, guidance, training and equipment provided to personnel in hotels
    - policies, protocols and procedures.[25]

27. These are the matters that will be the substance of the Final Report.

28. In the wake of the second wave, international flights were diverted from Melbourne following a request to the Prime Minister from the Premier of Victoria on 30 June 2020.[26] The initial request was to divert international flights from Melbourne for two weeks.[27] International flights into Melbourne have not yet recommenced.[28]

29. It is in this context that this Interim Report is provided.

30. This Interim Report proposes recommendations for a future Quarantine Program that contains two models – a facility-based model and a home-based model.

31. This Interim Report contains 69 recommendations for consideration and action. Some of these recommendations are generally applicable across the Quarantine Program for international arrivals and some are specific to a facility-based model or a home-based model.

Endnotes

1 World Health Organization, 'Statement on the second meeting of the International Health Regulations (2005) Emergency Committee regarding the outbreak of novel coronavirus (2019-nCoV)' (Media Release, 30 January 2020) <https://www.who.int/news-room/detail/30-01-2020-statement-on-the-second-meeting-of-the-international-health-regulations-(2005)-emergency-committee-regarding-the-outbreak-of-novel-coronavirus-(2019-ncov)>; World Health Organization, 'Novel Coronavirus (2019-nCoV) Situation Report 11' (Situation Report, 31 January 2020) 1 <https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200131-sitrep-11-ncov.pdf?sfvrsn=de7c0f7_4>.

2 Dr Tedros Adhanom Ghebreyesus, 'WHO Director General's opening remarks at the media briefing on COVID-19' (Speech, World Health Organization, 11 March 2020) 1 <https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020>.

3 World Health Organization, 'Coronavirus disease 2019 (COVID-19) Situation Report 51' (Situation Report, 11 March 2020) 1 <https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200311-sitrep-51-covid-19.pdf?sfvrsn=1ba62e57_10>.

4 Dr Tedros Adhanom Ghebreyesus, 'WHO Director General's opening remarks at the media briefing on COVID-19' (Speech, World Health Organization, 11 March 2020) <https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020>.

5 Exhibit HQI0155_RP Annexures to witness statement of Prof. Brett Sutton, DHS.5000.0056.3664.

6 Biosecurity (Listed Human Diseases) Amendment Determination 2020 (Cth) sch 1.

7 *Biosecurity Act 2015* (Cth) ch 2, pt 2, div 2.

8 Federal Minister for Health, 'First Confirmed Case of Novel Coronavirus in Australia' (Media Release, 25 January 2020) <https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/first-confirmed-case-of-novel-coronavirus-in-australia>.

9 Federal Minister for Health, 'First Confirmed Case of Novel Coronavirus in Australia' (Media Release, 25 January 2020) <https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/first-confirmed-case-of-novel-coronavirus-in-australia>.

10 Ibid.

11 World Health Organization, 'Coronavirus disease 2019 (COVID-19) Situation Report 12' (Situation Report, 1 February 2020) 4 <https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200201-sitrep-12-ncov.pdf?sfvrsn=273c5d35_2>.

12 Prime Minister (Media Release, 1 February 2020) <https://www.pm.gov.au/media/updated-travel-advice-protect-australians-novel-coronavirus>.

13 Prime Minister (Media Release, 1 February 2020) <https://www.pm.gov.au/media/updated-travel-advice-protect-australians-novel-coronavirus>.

14 Prime Minister (Transcript, 29 January 2020) <https://www.pm.gov.au/media/press-conference-australian-parliament-house-act-3> and Prime Minister (Media Release, 1 February 2020) <https://www.pm.gov.au/media/updated-travel-advice-protect-australians-novel-coronavirus>.

15 Department of Health, daily and cumulative number of reported COVID-19 cases in Australia, <https://www.health.gov.au/news/health-alerts/novel-coronavirus-2019-ncov-health-alert/coronavirus-covid-19-current-situation-and-case-numbers#daily-reported-cases> ; World Health Organisation "Coronavirus disease 2019 (COVID-19) Situation Report 40' (Situation Report 29 February 2020) 4, <https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200229-sitrep-40-covid-19.pdf?sfvrsn=849d0665_2>.

16 Prime Minister, Minister for Health, Chief Medical Officer, 'Advice on Coronavirus' (Media Release, 13 March 2020) <https://www.pm.gov.au/media/advice-coronavirus>; Prime Minister, 'Press Conference with Premiers and Chief Ministers – Parramatta, NSW' (Transcript, 13 March 2020) <https://www.pm.gov.au/media/press-conference-premiers-and-chief-ministers-parramatta-nsw>.

17 Prime Minister, Minister for Health, Chief Medical Officer, 'Advice on Coronavirus' (Media Release, 13 March 2020) <https://www.pm.gov.au/media/advice-coronavirus>.

18 Ibid; Prime Minister, 'Press Conference' (Transcript, 15 March 2020) <https://www.pm.gov.au/media/transcript-press-conference>.

19 Prime Minister, 'Coronavirus Measures Endorsed by National Cabinet' (Media Release, 16 March 2020) <https://www.pm.gov.au/media/coronavirus-measures-endorsed-national-cabinet>.

20 See the Glossary at Appendix B for the meaning given to the terms 'isolate' and 'quarantine', throughout this Report.

21 Prime Minister, 'Update on Coronavirus Measures' (Media Release, 27 March 2020) <https://www.pm.gov.au/media/update-coronavirus-measures-270320>.

22 Ibid.
23 National Review of Hotel Quarantine, 'Attachment A – Quarantine – National Statistics', 34-35 <https://www.health.gov.au/sites/default/files/documents/2020/10/national-review-of-hotel-quarantine.pdf>.
24 Exhibit HQI0005_P Witness statement of Prof. Ben Howden, 2021 [101]–[104]; Transcript of day 3 hearing 17 August 2020, 86; Exhibit HQI0008_RP Witness statement of Dr Charles Alpren, 28 [130].
25 Premier of Victoria, 'Judicial Inquiry into the Hotel Quarantine Program' (Media Release, 2 July 2020) <https://www.premier.vic.gov.au/judicial-inquiry-hotel-quarantine-program>.
26 Premier of Victoria, 'Statement from the Premier' (Media Release, 30 June 2020) <https://www.premier.vic.gov.au/statement-premier-72>.
27 Ibid.
28 Department of Health and Human Services, 'Information for overseas travellers' (Webpage) <https://www.dhhs.vic.gov.au/information-overseas-travellers-coronavirus-disease-covid-19>.

Summary of key features for the future Quarantine Program

Features of the mandatory Quarantine Program for international arrivals applicable to either model

1. Defining the Quarantine Program as a public health program
2. Efficient and effective communication between State and Commonwealth officials and international arrivals
3. Controlling the numbers
4. Clear governance structure for the whole Quarantine Program
5. Clear consideration of, and support for, the health and wellbeing of all people in quarantine
6. Clear and accessible communication and provision of information throughout a person's time in quarantine
7. Efficient and effective record-keeping for all people in quarantine

Features of a facility-based model

1. Primary focus on public health and infection prevention and control
2. Clear governance structures for the facility-based model
3. Suitable facilities
4. A proper training regime for all personnel working in a quarantine facility
5. Appropriate monitoring and oversight at the facility
6. Appropriate staffing arrangements that ensure a dedicated workforce and role clarity
7. A culture of safety

Features of a home-based model

1. Thorough assessment of risk factors for individuals quarantining at home
2. Effective engagement with those assessed as suitable for home-based quarantine
3. Clear and accessible communication and provision of information
4. Provision of reasonable supports
5. Appropriate monitoring and compliance
6. Penalties for non-compliance

Recommendations

The Quarantine Program (Section 1)

Purpose of the Quarantine Program

1. The Quarantine Program for international arrivals into Victoria be clearly defined as a public health measure to address the need to contain the transmission of COVID-19 into the community while ensuring that the health and wellbeing of those placed into quarantine is properly addressed together with the need to ensure the safety of all personnel working in the Program.

Control of the numbers

Facility-based model

2. To achieve an orderly and manageable process, the Victorian Government must do all things possible to ensure appropriate and necessary processes are put in place to control the numbers of international arrivals at any given time, informed by the availability of fully operational facilities that are ready and able to receive the agreed numbers.

Home-based model

3. The numbers of international arrivals also be controlled to make practical and achievable the individual engagement and suitability assessments required for home-based quarantine (see Recommendation 59 in Section 2).

Information gathering

4. The Victorian Government takes all possible steps to obtain the co-operation and assistance of Commonwealth agencies and officials, to ensure that the best available and most relevant information is provided to State officials as far in advance as possible for each international arrival, in order to facilitate an informed suitability assessment for appropriate placement in the Quarantine Program (including suitability to quarantine at home).

Electronic record-keeping

5. The Victorian Government liaises with the Commonwealth to develop a process whereby such information about each international arrival bound for a Victorian point of entry can be placed in an electronic file made available to the state authorities as expeditiously as possible prior to the arrival, and for that file to contain targeted information for State officials to assist in the management of the necessary quarantine arrangements.

6. All necessary actions be taken to have that electronic file follow the individual from international arrival through to the completion of their quarantine obligations and include all relevant information to assist in that person's safe transition into the community.

Safe and suitable physical environment for a quarantine facility

7. Given there are currently no identified specific purpose-built quarantine facilities in Victoria, that hotels remain a reasonable and viable option for international arrivals needing to be placed into quarantine. Relevant criterion for selecting suitable locations as quarantine facilities include:
    - A. sufficient proximity to a hospital
    - B. being within commuting distance for adequate numbers of appropriately skilled personnel for the facility
    - C. the facility's:
        - I. ability to allow for the physical separation of people
        - II. ability to properly implement all necessary infection control requirements, as far as practicable
        - III. capacity to make necessary modifications and additions to minimise the risk of transmission, as far as practicable
        - IV. ability to provide safe access to outside areas for fresh air and exercise breaks
        - V. ability to provide for specific needs such as mobility issues or the need to cater for infants.

Governance structure

8. The Victorian Government ensures that at the ministerial and departmental level, clear control and accountability structures are in place for the operation of the Quarantine Program (including the facility-based program together with any home-based program), to be operated by one Cabinet-approved department, with support from other departments as necessary, but in accordance with a clear line of command vesting ultimate responsibility in the approved department and Minister.
9. The Victorian Government ensures that the Minister and department approved as the single agency to be accountable for the operation of the Quarantine Program is the department that is the sole agency responsible for any necessary contracts.
10. The responsible Minister ensures that the departmental structure for the operation of the Quarantine Program has clearly defined roles that have the necessary expertise and advice embedded at appropriate levels of seniority in the operational structure (the departmental governance structure).
11. The responsible Minister ensures that the appropriate senior members of that governance structure form a body ('Quarantine Governing Body') that meets regularly, is chaired by the Secretary to the responsible Minister, maintains records of its meetings including records of all decisions reached, and provides reports to the Minister from those meetings including in respect to decisions reached.

12. The responsible Minister ensures that the Quarantine Governing Body provides regular, timely and accurate reports to the Minister as to the operation of the Quarantine Program, across all sites, and including all aspects of the entire Quarantine Program, including full and accurate reports as to compliance, monitoring and risks measured against the Purpose (as set out in Recommendation 1).
13. The responsible Minister ensures that the Quarantine Governing Body sets clear and consistent lines of accountability across all individual sites operating as quarantine facilities.
14. The Quarantine Governing Body ensures that each individual quarantine facility site has provided role clarity to all personnel working on-site.
15. The Quarantine Governing Body ensures that each quarantine facility has a Site Manager responsible for the overall operation of that facility, who is accountable to the Quarantine Governing Body.
16. The Site Manager role should be filled by a person who has experience in the management of complex healthcare facilities.

On-site role clarity

17. The Site Manager ensures that all personnel working in the quarantine facility understand their role and responsibilities.
18. The Site Manager ensures that all personnel on-site understand to whom they report and all lines of reporting and accountability on-site.

Appropriate mix of personnel on-site

19. The model contained in paragraph 21 of Section 1 be considered an appropriate model for the operating structure of a quarantine facility.
20. The Chief Commissioner of Police be requested to provide a 24/7 police presence on-site at each quarantine facility.
21. The responsible Minister and Quarantine Governing Body ensure that infection prevention and control expertise is embedded in each quarantine facility site, together with the necessary clinical personnel, to meet the mental and physical health needs of people in quarantine. To this end, the model presented and expanded upon at paragraph 21 of Section 1 should be considered a good basis for all quarantine facilities.

Dedicated personnel

22. Accepting the need to bring in expertise, every effort must be made to ensure that all personnel working at the facility are not working across multiple quarantine sites and not working in other forms of employment.
23. To achieve the aims of Recommendation 20, every effort should be made to have personnel working at quarantine facilities salaried employees with terms and conditions that address the possible need to self-isolate in the event of an infection or possible infection, or close contact exposure, together with all necessary supports, including the need to relocate if necessary and have a managed return to work.

Infection prevention and control unit on each site

24. The Quarantine Governing Body ensures that each quarantine facility has a properly resourced infection prevention and control unit embedded in the facility with the necessary expertise and resources to perform its work.

Training and workplace culture

25. The Site Manager be responsible for ensuring that all personnel working on-site are inducted into a culture of safety, focussed on infection prevention and control provided by those with the expertise to deliver such training.
26. The culture of safety to be fostered by the Site Manager should encourage collaboration, open discussion as to mistakes and oversights and speaking up about concerns and potential health and safety risks.
27. The Site Manager be responsible for ensuring that all personnel working on-site are engaged in ongoing training in infection prevention and control provided by those with the expertise to deliver such training tailored to the specific roles to be performed on-site.
28. The Site Manager ensures that the personnel on-site who have the expertise in infection prevention and control are engaged in ongoing monitoring and supervision of all of the requirements in place for infection prevention and control, which includes matters such as individual behaviour, the use of personal protective equipment (PPE) and cleaning practices.

Acquisition and use of PPE

29. The Site Manager ensures that the infection prevention and control experts direct the acquisition, distribution and use of PPE with specific, clear and accessible directions to all personnel on-site (acknowledging that such instructions may vary according to role).

Cleaning practices in quarantine facilities

30. The Site Manager ensures that all cleaning practices throughout the site are developed, directed and overseen by personnel with infection prevention and control expertise, and include ‘swab’ testing as directed by the infection prevention and control experts.

Independent safety auditing

31. The Quarantine Governing Body ensures that each quarantine facility site has regular, independent safety audits performed (as against the Purpose set out in Recommendation 1) with reports from those safety audits to be provided to both the Site Manager and the Quarantine Governing Body.

Period of quarantine

32. A 14-day period in quarantine is appropriate, unless the current state of expert opinion changes, or as otherwise directed by the Chief Health Officer or their delegate.

Cohorting of positive cases

33. Any decision to cohort known positive cases at a particular quarantine facility should only occur after proper consultation with the appropriate experts as to suitability of the facility, any necessary adjustments to the facility, and the experts being satisfied that all necessary infection prevention and control precautions are in place at that facility.

Testing

34. All people in quarantine, whether facility or home-based, should be tested on such days as directed by the Chief Health Officer or their delegate, regardless of reported symptoms.

35. For those assessed as suitable for home-based quarantine, it should be a condition of such placement that a person agrees to be tested, as directed by the Chief Health Officer or their delegate.

Clinical equipment on-site

36. On advice from the appropriate experts, adequate and readily accessible on-site clinical equipment to address the range of possible health needs of those in quarantine should be placed at each quarantine facility, together with the necessary resources to effectively sanitise any such equipment.

Safe transport arrangements

37. Given the possible COVID-19-positive status of an individual in a quarantine facility or home-based quarantine, arrangements and protocols for the safe transporting of a person for either urgent or non-urgent health reasons should be developed.

Contact tracing unit

38. That the Quarantine Governing Body ensures that each quarantine facility has a contact tracing unit embedded in the facility that can build familiarity and trust with on-site personnel and has accurate and up-to-date information for such personnel, to enable a rapid and efficient response to any possible outbreak and provide ongoing training to all personnel as to what is required in the event of potential or actual infection.

Evacuation procedure on-site

39. Each Site Manager should develop an emergency evacuation plan for the site and ensure it is well understood and regularly rehearsed by all personnel working in the facility and communicated to each of those placed in the quarantine facility.

Health and wellbeing of people in quarantine

Daily health and welfare checks

40. The Quarantine Governing Body ensures that daily health and welfare checks be embedded into the operation of each quarantine facility.

41. Site Managers arrange standard daily health and welfare checks on people in quarantine, to be conducted with the assistance of available technology, such as a visual telehealth platform, where the individual is willing and able to participate in this way or as otherwise directed by the Clinical Manager (as per the model in paragraph 21 of Section 1).

42. The Quarantine Governing Body provides direction, advice and resourcing as to the use of visual telehealth platforms to enable a case management approach to an individual's health needs, which may enable family, interpreters, existing or preferred healthcare professionals and supports to participate in case conferencing directed to the health and wellbeing of those in quarantine facilities.

43. That the daily health and welfare checks be conducted by appropriately skilled personnel who are also able to screen for any unmet needs or concerns, rather than limited to a check on COVID-19 symptoms.

44. Suitable health and welfare checks by appropriately skilled personnel should be conducted on those in home-based quarantine.

Fresh air and exercise breaks

45. The Quarantine Governing Body ensures the ability to provide daily fresh air and exercise breaks for people placed in quarantine facilities is factored into not only the physical layout, but also the staffing of the facility, to ensure there is provision for safe, daily opportunity for people in quarantine facilities to have access to fresh air and exercise breaks.

Communication with and to people in quarantine facilities or prior to entry into the Quarantine Program

46. The Quarantine Governing Body ensures that each facility program operates on an understanding and acknowledgment that a number of people placed in quarantine facilities will experience a range of stressors as a result of being detained in a quarantine facility for 14 days.

47. The Quarantine Governing Body ensures that all reasonable steps are taken to assist those who will be particularly vulnerable and require additional skilled support by reason of their being held in quarantine.

48. The Quarantine Governing Body ensures that every effort is made to provide multiple forms of communication of information throughout the period of quarantine to assist in reducing the distress and anxiety that some people will experience in quarantine.

49. The Quarantine Governing Body should address the need to provide accurate, up-to-date and accessible information to all people seeking to enter Victoria through international points of entry, including in community languages, to ensure best efforts at communication are made for all international arrivals.

50. Site Managers ensure that clear, accessible and supportive styles of communication should be regularly used to enable people to have consistent and accurate information about what supports are available to them and who to contact if they have a complaint, a concern or an enquiry while quarantined in a facility.

51. To assist in creating support for people in quarantine facilities and ensuring that there is information available in a range of formats and languages, Site Managers should assign a role to an appropriate person who can coordinate communications and use various platforms (for example visuals, signs, social media, etc.) to encourage those in quarantine facilities to connect with one another. These platforms can also be used to regularly communicate general and relevant information.

Exemptions and temporary leave

52. Authorised Officers ensure that each person placed in quarantine, whether facility or home-based, is made aware of the process for requesting temporary leave or an exemption and the criteria upon which such requests will be assessed.

53. Authorised Officers make decisions about whether or not to grant an exemption or temporary leave as promptly as practicable.

54. Authorised Officers ensure that any conditions or restrictions on such grants should be clearly communicated to the person making the request, address the need to manage the risk of transmission of COVID-19 while that person is in the community and is monitored for compliance.

55. To assist Authorised Officers and enhance consistent decision-making, that each Authorised Officer be provided with a checklist and guidance material on all relevant considerations when determining applications for exemptions and temporary leave applications.

Language is important

56. Language such as ‘resident’ rather than ‘detainee’ be used to reduce the risk of such language having a negative effect on the culture of the facility and to reflect that quarantine is a health measure and not a punitive measure.

Transitioning out of quarantine facilities

57. People leaving quarantine facilities should be offered an opportunity for a 'de-brief' to assist with their transition out of the facility and also to enable the opportunity for feedback to be passed to the Site Managers to assist in maintaining a culture of continuous improvement.

Home quarantine model (Section 2)

Home quarantine as an option

58. In conjunction with a facility-based model program for international arrivals, the Victorian Government develops the necessary functionality to implement a supported home-based model for all international arrivals assessed as suitable for such an option.

Control on numbers arriving

59. The Victorian Government does all things possible to ensure that appropriate controls are put in place to limit the number of international arrivals at any given time to make the necessary individual engagement and assessment for a home-based model practical and achievable.

Assessment of risk factors for home quarantine

60. The Victorian Government engages the appropriate expertise to develop a list of risk and protective factors to be used in the assessment of individual suitability for the home-based model.

61. To assist the Chief Health Officer and Authorised Officers in making such assessments, the Victorian Government engages personnel with the appropriate expertise and training, supported by the necessary resources, to support the Chief Health Officer and Authorised Officers to apply those risk factors to the individual circumstances of international arrivals.

62. The Victorian Government ensures that the Chief Health Officer and Authorised Officers are provided with the capacity and necessary resources to efficiently confirm the accuracy of information being provided for individual assessments of international arrivals.

Individual engagement

63. The Victorian Government takes all necessary steps to address the language and cultural needs of all international arrivals to ensure that accurate information is both obtained for assessment purposes and received and understood by the person subject to the Home Quarantine Directions.

64. The Victorian Government takes all reasonable steps to assess and provide any reasonable supports that may assist an individual or family to quarantine at home.

Conditions of Home Quarantine Direction accepted in the form of a personal undertaking

65. Accepting the need to do all things necessary to mitigate against the risk of non-compliance with a Home Quarantine Direction made by the Chief Health Officer or Authorised Officer, the Chief Health Officer or Authorised Officer could consider making the Home Quarantine Direction conditional upon the eligible person entering into a written undertaking, which could contain specific requirements that they must agree to, including (but not limited to):

    A. to submit to such COVID-19 testing during the period of home quarantine as is specified by the Chief Health Officer or Authorised Officer

    B. to allow such people as are required to carry out such testing to enter the premises at which the person is detained to conduct such testing

    C. to provide during the period of detention such information as is reasonably required by the Chief Health Officer or Authorised Officer in order to review whether their detention continues to be reasonably necessary.

66. Further, to underscore the gravity of any non-compliance, such an undertaking or agreement could also include an assurance from each person (over the age of 18 years) that they understand and agree to comply with each of the conditions of their quarantine and have understood the penalties that apply to any breaches.

Monitoring and compliance

67. The Victorian Government considers enhancing the range of methods for monitoring compliance with Home Quarantine requirements, such as electronic monitoring using smart phone technology and the use of ankle or wrist monitoring systems.

Penalties for non-compliance

68. The Victorian Government, in recognition of the risks to public health associated with any non-compliance with the Home Quarantine Directions, considers whether the current penalty regime is sufficiently weighted to enforce compliance.

69. The Victorian Government, in recognition of the risks to public health associated with any non-compliance with the Home Quarantine Directions, considers whether an offence should be created to apply to any person who knowingly enters a place where a person has been directed to Home Quarantine, unless that person has been authorised by the Chief Health Officer or Authorised Officer to do so.

Victoria's Quarantine Program: future options

1. This Interim Report and its recommendations are provided to address future options for a Quarantine Program in Victoria in response to relevant issues raised throughout the course of the Inquiry.
2. Any mandatory quarantine program will have requirements (such as the need for a clear governance model and obtaining information for all incoming arrivals) that will be generic; that is, required irrespective of the model used to realise the program. Others will be specific to the model in question. For the sake of clarity, wherever the expression 'Quarantine Program' is used in this Interim Report it is intended to refer to a program incorporating both the generic requirements as well as the facility-based and home-based features of either model identified and recommended herein unless the context indicates to the contrary.
3. The recommendations contained in this Interim Report are not purporting to be an exhaustive list of all matters that must be addressed for every aspect of a Quarantine Program, but rather are responsive to the issues raised throughout the Inquiry to date.
4. It is clear from numerous sources of information in the public domain that the spread of COVID-19 remains active in many places around the world.[1] In the absence of a readily available, safe and approved vaccine, it is impossible to predict how long this situation will continue.
5. This Interim Report envisages that a Quarantine Program for Victoria would involve the use of two models operating concurrently: a facility-based model (such as the Hotel Quarantine Program was) and a home-based model. For some people, where assessed as suitable, it may be appropriate to use a combination of the two models.
6. While Section 1 of this Interim Report identifies features that are largely specific to a facility-based quarantine model, some aspects of Section 1 apply (either wholly or in part) generally to both the home and facility-based components of the Quarantine Program. To avoid unnecessary duplication, it was considered more helpful to incorporate these more general features into Section 1, while making clear where the requirement is to be incorporated right across the Quarantine Program.
7. It follows that some of the recommendations from Section 1, such as the need for a clear governance model, controlling the incoming numbers, and providing and obtaining information for all incoming arrivals are intended to cover the overall operation of the Quarantine Program. Other recommendations from Section 1 are specific to the operation of a facility-based model. The recommendations from Section 2 for a home-based model are to be read in conjunction with those relevant general recommendations from Section 1.

Section 1 – Features of a facility-based model[2]

8. This section discusses the general features of a Quarantine Program and the specific features of a facility-based model, and provides recommendations arising from the Inquiry about what features an overall Quarantine Program should have, as well as those specific features of a facility-based model.

Section 2 – The option of a home-based model[3]

9. This section of the Interim Report will discuss a home-based quarantine model with recommended measures for risk assessment, support, communication, compliance monitoring and penalty provisions.

Endnotes

1 World Health Organization, Weekly Epidemiological Update: Coronavirus Disease 2019 (COVID-19) (Report, 12 October 2020) <https://www.who.int/docs/default-source/coronaviruse/situation-reports/20201012-weekly-epi-update-9.pdf>.

2 The use of the words 'facility-based model' incorporates the use of a hotel or other facility assessed as suitable to accommodate all of the necessary requirements identified in this Interim Report.

3 The use of the words 'home-based model' incorporates the option of a person being directed to quarantine in their own home or other suitable residence.

SECTION 1

What are the necessary features of a facility-based model?

1. Notwithstanding that some people who return to Victoria from overseas are likely to be assessed as suitable to quarantine at home or in a suitable nominated residence with the necessary monitoring, compliance and penalty provisions, there will be people who, for a range of reasons are assessed as unable or unsuitable to do so. For such people, a facility-based model will be needed.
2. Having examined various iterations and developments of Victoria's Hotel Quarantine Program to date, I have formed the view that there are principles, objectives and features that should be the foundation of a facility-based model operating in the context of this current pandemic.
3. At the outset, it must be said that any such facility operating in the context of this highly infectious virus will always carry risks of infectious outbreaks. The focus must be on taking every step to minimise the possibility of any such outbreak and to have rigorous systems in place to quickly identify them and rapidly respond.

1.1 Objectives of a facility-based model

4. In her evidence, Ms Melissa Skilbeck, Deputy Secretary, Regulation, Health Protection and Emergency Management at the Department of Health and Human Services (DHHS), outlined that 'the overarching objective of the enforced quarantine measures was to prevent the transmission of COVID-19 from returned travellers entering the community, noting that this was the predominant mode of transmission of COVID-19 into Australia at that time'.[1] In early October, when discussing the current model of hotel quarantine for people in the community needing quarantine, Corrections Victoria Commissioner, Dr Emma Cassar, flagged that there would be 'end-to-end healthcare for when people transition back to the community'.[2]
5. Given the circumstances of the outbreaks from the Hotel Quarantine Program in May and June 2020, being that transmissions occurred from returned travellers to personnel working on-site, when determining the objectives of the Quarantine Program, the need to ensure not only the safety of those placed in the program, but also the safety of those working in the program, including clinical and non-clinical personnel, must also be paramount.

1.2 Principles to underpin a facility-based model

Quarantine is a public health measure

6. To ensure that the proper focus, culture, workplace safety, care, governance and hierarchy of decision-making is established for those being placed in quarantine and those working in quarantine, the program must be clearly characterised as a public health program. While any Quarantine Program will have logistical and compliance elements, those elements are called in aid of its health objectives. The fundamental purpose of the Quarantine Program, and the reason for its existence, is the public health objective of containing the spread of disease[3] (see Recommendation 1).

The facility should be operated with the presumption that those in quarantine are potentially infected until it is known that they are not infected

7. Professor Lindsay Grayson, Professor of Infectious Diseases at Austin Health, observed that an 'efficacious and appropriate quarantine environment fundamentally starts from a position of assuming that all those who are in quarantine are potentially infected, until proven otherwise'.[4] This was echoed by Dr Simon Crouch, a senior medical adviser in the Communicable Diseases Section of the Health Protection Branch of DHHS.[5]

Some people directed to undertake quarantine will be vulnerable and require particular support by reason of their being in quarantine

8. No person who is being directed to spend 14 days in any form of quarantine is there because they have done something wrong. The evidence and information provided to the Inquiry made clear that the 14-day period of detention in hotel rooms proved extremely difficult and traumatic for some. The evidence of clinical psychologist Dr Rob Gordon was that about 20 per cent of the people coming into quarantine were likely to experience considerable difficulty in these circumstances.[6]

9. These principles should inform the objectives and design of the Quarantine Program as well as decision-making within the program, whether people are placed in the facility or home-based part of the program (or a combination).

1.3 Features of a facility-based model

Role clarity and governance structure

10. For a program that carries such risks with it, a governance structure that not only sits across the entire program but has clear lines of accountability and clarity of roles at each level within it, including on each site at each facility, is imperative. Fragmented lines of responsibility and ambiguity, and uncertainty about where accountabilities lie, compromise a system that carries with it such weighty consequences.

11. The need to have complete responsibility for the operation of the program residing in one department was accepted in a series of decisions made by the Crisis Council of Cabinet during June and July 2020. This has resulted in full responsibility for the quarantine hotels currently operating now residing with the Department of Justice and Community Safety (DJCS)[7] and a transfer of the relevant emergency powers under the *Public Health and Wellbeing Act 2008* (Vic) (PHW Act) from the Minister for Health to the Attorney-General.[8] Information provided to the Inquiry indicates that the present plan, when international arrivals to Victoria resume, is that DJCS will be the department responsible for quarantine arrangements and that this will include being the agency responsible for any necessary contracts.[9]

12. At ministerial and departmental level, clear control and accountability for the operation of the entire Quarantine Program includes the need to have one agency responsible for any necessary contracts. Those lines of control and accountability need to be reinforced by structures that ensure decision-making is informed by the appropriate expertise and oversight, and that there is an accurate and timely information flow across the entire program (see Recommendations 8–16).

13. The need for role clarity and a clear governance structure identified here also applies to the home-based model.

14. The issues that arose as to governance and role clarity during the Hotel Quarantine Program will be addressed in full in the Final Report.

On-site management

15. The departmental governance structure must set clear expectations as to on-site requirements for all personnel and maintain appropriate monitoring and oversight at the facility itself. This requires a clearly identified Site Manager position. This position should be described and identifiable at the facility as the person who holds the authority on-site for the overall operation of the quarantine facility.

16. It is recommended that this role be filled by a person who has experience in the overall management of complex healthcare facilities. This person should be responsible for reporting to the Quarantine Governing Body (see Recommendations 11, 15–16).

On-site role clarity

17. Every person working in a quarantine facility should understand their role and responsibilities, to whom they report and who has the ultimate authority to make decisions and control the site.

18. On this issue, Safer Care Victoria, in the wake of one of its investigations and in reporting to DHHS, made the following recommendation:

> Co-develop with staff detailed descriptions for all roles in the hotel quarantine system, and a visual and simple written guide to how these roles work together. Provide this to all existing and future staff and include this information in staff orientation and in-service training.[10]

19. This practical recommendation from Safer Care Victoria is an appropriate way of ensuring that all on-site personnel are clear about their roles and the roles of all other on-site personnel (see Recommendations 17 and 18).

An appropriate mix of on-site personnel

20. The evidence to the Inquiry makes clear that, in order to meet the health objectives of a quarantine facility a suitable mix of personnel must be engaged on-site. Infection prevention and control should be proactive as well as reactive, and infection prevention and control experts should be embedded at each quarantine facility. Appropriately qualified clinical personnel should also be available on-site to meet the mental and physical health needs of people in quarantine (see Recommendation 21).

21. A good foundation for a facility-based model is that presented in evidence provided by Ms Simone Alexander, the Chief Operating Officer of Alfred Health, about the roles of those engaged to work at Health Hotels.[11] Consideration should be given to the expansion of this model as follows.

Role	Presence	Key responsibilities include
Site Manager	On-site each day during business hours and on call at other times	Overall operation of the quarantine facility Liaison point between facility and the Quarantine Governing Body
Infection prevention expert	On-site each day	Supervising and monitoring compliance with infection prevention and control processes and practices Providing training to personnel Identifying transmission risks Suggesting improvements to infection prevention control processes and practices Providing ongoing guidance and advice about infection prevention and control
Contact tracing unit	On-site each day (or as directed by the Clinical Manager)	Undertaking contact tracing where necessary Engaging and liaising with on-site personnel
Clinical Manager	On-site during business hours and on call at other times	Ensuring availability of clinical workforce Supervising compliance with clinical standards (including standards of infection prevention and control) Escalating issues when necessary
Clinical team leader	On-site at all times	Coordinating healthcare workers Leading daily implementation of infection prevention and control measures
General practitioners	On-site at all times (or available on call)	Undertaking clinical assessments Responding to the needs of people in quarantine

Role	Presence	Key responsibilities include
General nurses (enrolled nurses and registered nurses)	On-site at all times	Undertaking clinical assessments Responding to the needs of people in quarantine
COVID-19 Testing Team	On-site during business hours	Testing people for COVID-19
Alternative healthcare workers (including social workers)	On-site at all times	Attending to the needs of people in quarantine, as directed by registered nurses and clinical team leaders
Mental health clinician	On-site at all times	Providing assessment and intervention for guests experiencing mental health challenges
Drug and alcohol specialists	Available and on call	Providing interventions at the request of the on-site mental health clinician
Authorised Officer	On-site at all times	Supervising detention arrangements and legal compliance
Operational team leader	On-site at all times	Overseeing logistical arrangements
Cleaning team leader	On-site at all times	Supervising cleaning
Cleaners	On-site at all times	Undertaking cleaning of communal areas, including cleaning of high touchpoints and pathogen rooms and any areas where fresh air breaks are undertaken Cleaning rooms after people in quarantine have left
Food services	On-site as required	Preparing meals and snacks for people in quarantine Preparing meals and snacks for personnel
Service personnel	On-site at all times	Responding to non-clinical requests from people in quarantine, for example delivery of parcels
Bag screeners	On-site at all times	Checking bags of people entering quarantine to ensure that they are not carrying any dangerous or prohibited items Checking deliveries to the quarantine facility
Security manager	On-site during business hours and on call at other times	Ensuring availability of security workforce Supervising compliance with standards of conduct Escalating issues when necessary
Security team leader	On-site at all times	Leading security personnel
Security personnel	On-site at all times	Maintaining a constant presence at the entrances and exits of the facility Enforcing directions and detention orders, including assisting with fresh air breaks and exercise as directed by the Authorised Officer Responding to safety incidents, as needed Accompanying clinical personnel where there is an identified risk

Security personnel

22. The nature of the personnel engaged to maintain security in the Hotel Quarantine Program has been the subject of much attention throughout the course of this Inquiry. As is clear from the evidence to date, the majority of the personnel who contracted the virus and seeded the two outbreaks into the community were private security personnel engaged by way of contracting arrangements that carried with them a range of complexities.[12] This aspect of the Inquiry's work will be examined in full in the Inquiry's Final Report.

23. The range of issues that arose with respect to the use of private security personnel on hotel quarantine sites included:

    A. personnel working at multiple sites

    B. the nature and level of training and understanding about infection prevention and control requirements, including the use of personal protective equipment, social distancing and hand sanitising requirements

    C. on-site supervision

    D. role clarity as to the work to be performed by on-site security

    E. the complexities of having personnel, in a highly complex and dangerous environment, who are engaged on a casual basis and not engaged directly by the management of the facility to enable support and instruction as to requirements in the event of a positive transmission.[13]

24. All of these issues must be addressed by the structure and management of the overall program and at each site level. The identified features of a facility-based model contained in this section are aimed at addressing each of these issues (see Recommendations 8–28).

25. Further, on the issue of the necessary features of personnel utilised as on-site security/supervision, it is understood that the majority of the workforce currently being utilised on the Hotel Quarantine operating sites are personnel who have been directly employed by Corrections Victoria and who are therefore bound by the Code of Conduct for Victorian Public Sector Employees. It is understood these personnel are engaged on the basis that they have the requisite skills in supervision, communication, de-escalation, conflict management, and maintaining professional boundaries.[14] These workforce features for on-site security personnel are appropriate and should be formally incorporated into the requirements of the operating model (see Recommendation 19).

26. The information provided to the Inquiry was that, under the new model transferred to DJCS, a request was made to Victoria Police on 16 July 2020 to provide a 24/7 on-site presence, and that Victoria Police agreed to that request.[15] That police presence takes the form of controlling access, entry and exit, having a presence in the foyer, and having a mobile presence patrolling the floors to support the supervision being provided by Corrections Victoria personnel.[16]

27. Chief Commissioner of Police Shane Patton produced and described the documentation developed to support the police presence.[17] He explained that a full risk assessment had been conducted for his members to work on the sites, which had led to the creation of detailed procedures to ensure member safety.[18] These procedures included a Senior Sergeant of Police taking the role of Safety Officer, briefings for all members, written instructions for different roles, the delineation of 'green' and 'red' zones on-site (see glossary at Appendix B for definitions), training for contamination events and specific locations for decontamination.[19]

28. The engagement of Victoria Police members to perform the roles described on a 24/7 basis, with the supports described, is an important and valuable addition to the on-site operation of any future facility-based model, and one that should be maintained (see Recommendation 20).

Dedicated personnel at each site

29. Where possible, personnel working within a facility-based model should not work across multiple quarantine sites, nor should they work in any other environment. Having dedicated, salaried personnel, will help to minimise the risk of transmission between quarantine sites and onwards into the community. This applies equally to clinical and non-clinical personnel. The evidence throughout the Inquiry was replete with examples of problems associated with workers being engaged on a casual and itinerant basis.[20]

30. For example, Ms Alexander gave evidence that an on-site audit of infection prevention measures had identified, among other things: '[r]isks associated with nurses working from agencies, who may pose additional risk due to the disincentive to absent themselves when symptomatic or were working at multiple sites.'[21] In his evidence, Dr Crouch also indicated that his preference would be to not have people working across multiple sites.[22]

31. While it is understood that some medical and clinical personnel may have roles to perform elsewhere, every effort should be made to ensure on-site personnel does not work in other environments. To this end, it will be necessary to ensure that those working at the quarantine facility, as far as possible, be engaged in their roles on a salaried basis. This will require all on-site personnel to be appropriately remunerated. In my view, this is an appropriate cost for the program to bear, given the evident risks associated with not doing so. A dedicated workforce enables a strong basis for the building of the right culture, training and understanding on-site (see Recommendations 22 and 23).

32. A dedicated workforce also requires terms and conditions that provide paid sick leave in the event of either a positive diagnosis, however contracted, or the need to isolate for whatever reason.

33. Safer Care Victoria recommended that the Hotel Quarantine Program should have a 'surge capacity' to respond to an influx of travellers, and shifting cohorts as follows:

    A. Based on experience to date and personnel input, revise methods for determining the staffing level and mix needed around the time of large returned traveller influxes and implement revised models of staffing and rostering based on these. Ensure readily available increased staffing capacity for surges in workload associated with arriving cohorts of returned travellers.[23]

    B. Undertake ongoing needs analyses to strategically match the number and designation of personnel rostered on shifts to ensure there are adequate personnel available to be able to provide a rapid response surge capacity to meet the dynamic needs of specific cohorts of returned travellers. This should include a mechanism by which if necessary additional resources can be mobilised to respond to evolving situations.[24]

34. These recommendations made good sense in the context of the unknown numbers, profiles, and characteristics of arrivals into the state. However, in the re-opening of any Quarantine Program for international arrivals as noted below, it is recommended that every effort must be made to control the numbers arriving at any given time. It is hoped that such a process will thereby address the need for a 'surge capacity' (see Recommendations 2 and 3).

Training and workplace culture

35. Having dedicated personnel working in the facility is the foundation for having a proper training regime, in which management can be assured that those working in the facility have been inducted into a culture of proper infection prevention and control and a culture of safety and support.

36. Every person working in a quarantine facility should be appropriately trained in infection control requirements and should understand PPE usage, physical distancing and hand hygiene. As Prof. Grayson observed, '[q]uarantine environments are self-evidently "dangerous spaces" and the rigour and processes in place need to reflect and reinforce this'.[25]

37. Ms Alexander provided practical examples of the infection prevention and control measures in place at the facilities now being operated by Alfred Health, including the following:

    A. Alfred Health implemented infection control measures and requirements for its personnel on-site – including for use of PPE, hand hygiene, temperature measuring and social distancing – consistent with those measures in place in hospital settings.[26]

    B. Alfred Health implemented a system of conducting a team meeting at the commencement of all shifts for all personnel on-site at the hotels (irrespective of which organisation they were employed by) to provide briefing as to any developments and a reminder regarding PPE use and infection control requirements. This meeting often incorporated a practical demonstration of correct technique for PPE donning and doffing.[27]

38. Every person working on-site must have a thorough understanding of the range of COVID-19 symptoms, as well as the need to get tested and self-isolate if they experience those symptoms. This understanding should be continually reinforced, supervised and monitored by the Site Managers (see Recommendations 22–27).

Contact tracing unit embedded in the facility-based model

39. Effective and properly resourced contact tracing in the event of a transmission is crucial to the containment of the spread of the virus. Contact tracing proved problematic for the Hotel Quarantine Program. DHHS epidemiologist, Dr Charles Alpren, explained that most information for contact tracing is obtained through interviewing people who have tested positive for COVID-19 about their movements during the period of time they could have been transmitting the disease. This allows the contact tracing team to identify people who could have been exposed to the disease and to advise those contacts to isolate.[28]

40. In a facility-based model where, as best as can be achieved, all on-site personnel are salaried personnel, not only can the proper training and culture of safety be instilled into the personnel, but also the need for rapid access to all necessary information for contact tracing purposes can be reinforced at on-site induction and in ongoing training.

41. Embedding a dedicated contact tracing unit in the quarantine facility and ensuring all personnel understand their obligations to quickly supply accurate information to that team for contact tracing purposes, is far more likely to be effective at containing outbreaks than relying upon engagement with external contact tracers. A contact tracing unit embedded in the facility is not only able to assist with embedding and reinforcing the right culture and responding rapidly to outbreaks from the quarantine facility, but it is also able to develop trust with the personnel and enhance good and accurate information being collected to give the best chance of rapidly containing further spread (see Recommendations 19 and 38).

A workplace culture of safety

42. A culture of safety must be actively fostered and reinforced on-site at each facility. In her evidence before the Inquiry, Ms Alexander identified that it was necessary for there to be a team-based comprehensive approach, with clear communication, governance and leadership to ensure appropriate infection prevention and control measures are established and maintained[29] (see Recommendations 25 and 26).

43. Ms Alexander emphasised the need to avoid people working in silos.[30] In part, this was achieved by instilling a collaborative, team-based approach to infection prevention and control, by focusing on education and auditing all personnel and processes on-site,[31] and by ensuring clear and apparent lines of escalation.[32]

44. For example, a security guard, Mr Craig Arundel, gave evidence about his experience working at what he described as a 'COVID Hotel' within the Hotel Quarantine Program, where Alfred Health was responsible for clinical oversight. He observed that it was 'run like a hospital ward'[33] and explained that the culture focussed on infection control:

> Anyone entering the COVID Hotel was temperature checked. It was methodical and regimented – 'army-like.'[34]

45. Mr Arundel also gave evidence about the collaborative culture that was engendered:

> ...everyone was looking out for each other as well. A nurse might politely say, 'Your mask is not quite fitting properly over your nose.' So, they would offer advice. It was very much we're all in this and we're all looking out for each other. There were some with more experience in infection control than others, so no-one was made to feel silly or out of place. It was just a matter of, 'No, that's fine. Do it this way' or 'Do it that way'. Even the nurses were the same. When they were doffing their PPE, they would help each other out. So, yes, people were just constantly reminding each other of the procedures.[35]

46. Returned traveller and healthcare worker, Ms Liliana Ratcliff, gave evidence about the importance of having a culture that is open to discussion about mistakes and shortcomings: 'In a hospital, when something bad happens, we talk about what went wrong. That's how things change.'[36]

47. It is also important that there is a culture that encourages all people on-site to speak up if they notice risks. Witness Nurse Jen, who worked as an on-site nurse in the Hotel Quarantine Program, described the 'duty' of nurses to speak up:

> As a nurse, I was taught to advocate for my patients. I was taught about the 'Swiss cheese' model. Sometimes nurses are the end of the line. We have a duty to prevent harm to patients (and others) by speaking up when we notice risks.[37]

Additional measures to enhance the culture of safety

48. The following additional infection prevention and control measures should be considered, based on Victoria Police's instructions to its members currently engaged as safety officers:[38]

    A. health screening prior to entering the facility

    B. changing PPE after arrival

    C. leaving uniforms and equipment at the facility

    D. briefing upon entry

    E. employing specific decontamination procedures following risk of contamination, including physical contact with a person known to have COVID-19 or suspected of having COVID-19

    F. a proper assessment of the access to and rules around movement in and around common facilities such as toilets, tea rooms, lifts, and shared personnel spaces.

Support to enable self-isolation for facility-based personnel

49. The evidence of Ms Alexander was that best practice for a quarantine facility has an infection prevention and control unit on-site. In the event of a positive case identified amongst any person working in the facility, the infection prevention and control unit makes contact with that person and provides instructions on what to do as well as determining any support needed. At the end of the 14-day period directed for isolation, the infection prevention and control unit makes contact to follow up and confirm a negative test result before the worker is cleared to return to work.[39]

50. Dr Alpren highlighted that 'while people seek to engage in behaviours to limit transmission of disease, competing priorities (such as financial or caring obligations) can conflict with this agenda'.[40]

51. On 19 June 2020 Prof. Murphy wrote to Victoria's Chief Health Officer, Professor Brett Sutton, and Victoria's Deputy Chief Health Officer, Dr Annaliese van Diemen (among others), noting that he had been reflecting on quarantine breaches and an issue that Dr van Diemen raised 'where a hotel worker continued to work while symptomatic and didn't identify because of fear of income loss'.[41] Prof. Murphy made the following suggestion:

> Is it possible to write into the hotel quarantine contracts a provision that any hotel or security worker who has to quarantine (as a contact) or isolate (for COVID + status) would be paid their 'normal weekly hours' for the two week period. It would be a minor expense but would fix this as an issue?[42]

52. As noted at paragraphs 31 and 32, the terms and conditions of any person working at a quarantine facility should require that, if the person becomes unwell or at risk of contracting COVID-19, they will be financially supported so that they can self-isolate without loss of income. Guaranteed financial support for self-isolation will help to foster a strong culture of reporting of risks or possible exposure. Any person working at the facility who is required to self-isolate should only return to work following a negative swab result and should be supported to self-isolate until that time (including in respect of any need they may have to be placed away from home) (see Recommendation 23).

53. All personnel, at induction and regularly through ongoing training, should have a clear understanding of their employment responsibilities in the event of the need for contact tracing. Personnel should also be thoroughly educated and supported about the need for contact tracing in the event of any infection, as well as the importance of close contacts being tested and self-isolating when necessary.

Personal protective equipment

54. A range of issues arose during the Inquiry about the supply and use of PPE. These matters will be addressed in detail in the Final Report. For the purposes of this Interim Report, the following matters have been identified.

Supply of PPE

55. Appropriate PPE[43] should be available on-site at each quarantine facility, in adequate quantities (including in appropriate sizes).[44] PPE should be supplied by the Site Manager upon the advice of the infection prevention and control unit on-site.

56. Advice as to the appropriate use of PPE is required in the range of situations that may arise in quarantine facilities and may also be site-dependent. That advice should be regularly updated to account for evolving knowledge about transmission of the disease (see Recommendation 29).

Training in the use of PPE

57. Every person who needs to use PPE must be trained in its use. The evidence was that improper use of PPE will compromise its effectiveness in preventing transmission of COVID-19 and may even increase the risk of transmission. In evidence, Prof. Grayson explained that:

> People must be properly trained in the wearing and use of PPE for it to be most effective. For instance, to be optimally effective, both surgical masks and N-95 (P2) masks need to be appropriately fitted to fully cover the nose and mouth and to avoid air leaks. Health professionals are themselves regularly trained in appropriate use of PPE and other infection control measures.[45]

58. Those delivering training should have expertise in the use of PPE:

> Those with an acute understanding of infection control measures should be involved in training about how to use PPE whenever PPE is required. Without detailed appropriate training, PPE use can be ineffective and both the wearer and patient (should the wearer become infected) are placed at high-risk of infection. Appropriate training in PPE needs to result in improved knowledge and understanding, as well as demonstrable compliance with the use of PPE, as observed by an objective trained professional with detailed understanding in PPE use and infection control.[46]

59. Training should be delivered (at least in part) in person:

> In my opinion, remote or online training alone is not sufficient. There must be an experiential component where there is physical supervision and instruction to ensure that people understand PPE, the reasons and circumstances of its use (and problems associated with mis-use), as well as knowing how to correctly fit, remove and dispose of their PPE correctly.[47]

60. People should be tested on their understanding of PPE and their ability to use it correctly before being allowed to work in quarantine environments:

> People should not be permitted to work in potentially dangerous environments such as healthcare facilities and quarantine areas unless they can demonstrate that they know when to use PPE and can fit, remove and dispose of it correctly.[48]

61. Use of PPE should be monitored and supervised:

> Inherent in PPE training (or indeed any safety training) is a regular objective system of monitoring to ensure adherence, resolve any practice questions and to provide constructive feedback to users. Thus, an ongoing 'system of supervision' should be established for infection control regimens to regularly reinforce the importance of adherence to the appropriate procedures and standards, and to ensure that adequate protections are maintained, even when one may be tired or distracted. People must understand the potential danger of infection in order to appreciate the importance of adhering to the training.[49]

62. These observations and recommendations about provision and use of PPE apply equally to any necessary support personnel required to attend upon those in home-based quarantine (see Recommendation 29).

Independent auditing and rapid response to identified issues

63. In order to maintain standards of best practice and continuous improvement in infection prevention and control and workplace safety, there must be regular and independent auditing of compliance with accepted best practice standards at each facility. Audits should be undertaken by independent experts and the results of those audits should be provided to the Quarantine Governing Body and Site Manager to ensure any concerns are responded to quickly and effectively (see Recommendation 31).

64. Ms Alexander provided the following evidence about the system that Alfred Health implemented for regular auditing of infection control measures at sites where Alfred Health provided clinical personnel as part of the Hotel Quarantine Program:

    A. This incorporated on-site review of processes, compliance with infection control measures and identifying areas for rectification and improvement, consistent with what would routinely occur in a tertiary hospital setting (including at Alfred Health sites).

    B. Areas of risk and steps for improvement were identified and these were discussed with the clinical team leaders on-site and escalated both to DHHS and internally at Alfred Health. The approach to rectification by Alfred Health was consistent to the approach taken at its hospital sites, with an expectation that rectification occurs immediately or with in a 24-48 hour period, depending on the level of risk and the urgency identified.

    C. The outcomes of infection control auditing influence Alfred Health's understanding of the current risk of infection and how well it is managed. This understanding is recorded on an internal risk register covering Alfred Health's participation in the Hotel Quarantine Program. That register is maintained and updated by Alfred Health and discussed at a weekly (internal) governance meeting for the Alfred Health COVID-19 response.[50]

65. This model of regular internal auditing and the maintenance of a risk register should be seen as a proper and necessary practice at each quarantine facility. The risk register should be made available for the purposes of the independent safety audits referred to in paragraph 63.

Cleaning practices in quarantine facilities

66. Issues with respect to cleaning practices across hotel sites were the subject of considerable evidence. The issues identified in the evidence will be dealt with in the Inquiry's Final Report.

67. Given the evidence of Prof. Grayson and Dr Sarah McGuinness, Infectious Diseases Physician at Monash University and Alfred Health, as to the risks of fomite transmission in quarantine facilities,[51] every aspect of cleaning practice in quarantine facilities is an obvious part of infection prevention and control, including the expertise needed to train and direct cleaning personnel, the areas to be treated, the products to be used and the methods to be engaged in by the cleaning personnel. To be clear, all aspects of such practice should also be the subject of independent auditing.

68. Included in the auditing of cleaning practices, industry standard swab testing from surfaces on a regular basis should be undertaken to assist in ensuring best practice standards are being met[52] (see Recommendation 30).

Controlling the numbers

69. The scale and unpredictability of people arriving into Victoria during the Hotel Quarantine Program made the logistics of operating the program very challenging, especially in circumstances where the program was being developed with no existing model to use as people were arriving back into the state.

70. The difficulties faced by the Hotel Quarantine Program of unknown and uncontrolled numbers of international arrivals requiring quarantine at any given time must be addressed. Across the Quarantine Program every effort must be made to ensure the numbers of people arriving at any given time are controlled and informed by the availability of facilities that are fully operational and ready and able to receive the agreed numbers. To not do so, runs the risk that the system will be overwhelmed and not able to take all steps necessary to operate safely.

71. This same issue applies to the home-based model. Uncontrolled numbers would also compromise the ability to manage the 'triaging' by way of risk assessment and engagement to operate the home-based quarantine model discussed in Section 2.

72. The ability to control numbers will obviously need engagement with, and co-operation between, Commonwealth and State officials to achieve a more orderly and manageable arrival procedure (see Recommendations 2 and 3).

Cohorting of positive cases

73. From early April 2020, the Rydges Hotel in Carlton was a designated 'COVID-19 positive hotel' (or 'hot hotel'). Dr Crouch gave evidence that it was appropriate to have a 'hot hotel' in order to minimise the risk of further transmission to others in the Quarantine Program. While any returned traveller should be managed as a suspected case, he explained, a model in which known positive cases are located at one facility provides the best oversight and public health management option.[53]

74. Importantly, Dr Crouch clarified that his opinion depended on several assumptions, including the following:

    A. that the personnel managing those in quarantine are trained appropriately to manage the confirmed cases

    B. that those personnel have the knowledge and skills to do that effectively.[54]

75. Dr van Diemen agreed that 'cohorting' of positive COVID-19 cases, preferably in a single location (in this case a hotel), is a recognised public health preventative measure.[55]

76. The weight of the expert evidence before the Inquiry is that 'cohorting' of known positive cases at a designated quarantine site, subject to appropriate precautions, is a reasonable public health response. Having said this, irrespective of whether a specific site is designated for known positive cases, it should remain the presumption (at all sites) that those in quarantine are infected until it is known that they are not infected[56] (see Recommendation 33).

Good communication between Commonwealth and State officials to facilitate more timely, detailed and better-quality information as to numbers and needs

77. Each person entering quarantine should be assessed so that their individual needs and clinical risk factors are understood (as completely as possible) to assist in the maintenance of their health and wellbeing while in quarantine. This applies to facility-based quarantine as well as home-based quarantine.

78. To facilitate such assessments, the proactivity with which information is sought prior to the arrival of people into quarantine, and the quality of such information, must be considerably improved. Commonwealth and State agencies need to create effective and timely information-sharing arrangements to ensure that good quality information is available to relevant Victorian officials as early as possible.

79. Such engagement was foreshadowed in early October 2020 by Dr Cassar:

> [We will] do a lot of active engagement with returned travellers before they leave - and we know this has been a real challenge in Victoria and other jurisdictions...the quicker we get information about returned travellers - their needs, their requirements, especially for larger families - we can accommodate them better. So this will be up on the website and we'll be really encouraging that early engagement.[57]

80. In this regard, Safer Care Victoria made the following recommendation:

> Co-develop agreed formal processes with relevant entities (e.g. Australian Border Force, the Department of Foreign Affairs and Trade) to improve the accuracy, detail and optimise timeliness of information received about incoming returned traveller cohorts to facilitate planning and preparedness.[58]

81. This recommendation is supported by the experiences of those who were required to rely on such information to place and care for returned travellers. Ms Rachaele May, Executive Director, Emergency Coordination and Resilience, the Department of Jobs Precincts and Regions (DJPR) explained:

> At the beginning of the program the flight manifest information often arrived with the flight. Towards the end of the program it was arriving in a more timely manner, although often the day before, and the flight manifest was important for us to be able to determine how many singles or families or children could be expected on a flight in order to be able to allocate the most appropriate hotel room.[59]

82. Ms May indicated that had the flight manifests been provided earlier and been more detailed, it would have assisted in understanding the practical nature of the job of allocating people to accommodation.[60] This was echoed in the evidence of hoteliers who outlined that they 'would receive the manifest any time from four hours prior to the arrival or up to the day prior'[61], which created difficulties in proactively placing people into appropriate rooms, including placing families together or in adjoining rooms.[62] Failure to provide early information also created lengthy delays in checking in guests.[63]

83. Further, hoteliers had problems in gaining access to information about dietary requirements, which, in the words of Travelodge Docklands Executive General Manager, Mr Ram Mandyam, 'caused (...) a huge challenge for us'[64], as they were not provided sufficient opportunity to plan to meet such demands.

84. All of the above speaks to the importance of receiving complete and timely information for people coming into quarantine.

Record-keeping for people in the Quarantine Program

85. Issues about record-keeping for people in quarantine and their management were raised throughout the course of the Inquiry. There were issues ranging from inaccurate information about who was actually in quarantine, and what and where information was being stored about matters such as dietary requirements, through to concerns being expressed about medical and health records. These matters will be dealt with in detail in the Final Report.

86. Self-evidently, given the size and nature of the Hotel Quarantine Program, initial paper-based documentation systems posed obvious dangers, including that important information would not be passed on, that those delivering clinical care would be unaware of people's needs and risk factors, and that agencies might lose track of individuals in quarantine.

87. On this issue, after one of its investigations, Safer Care Victoria made the following recommendation:

> Implement an off-the-shelf, fit-for-purpose (or easily customised), single, centralised and real-time information sharing and tracking system containing all individual returned traveller information (including their health and welfare), accessible by all staff with a role in providing services, care, support and oversight for returned travellers. This should include functionality to provide 'alerts' to identify to staff working on each shift, returned travellers with significant health and/or welfare risks requiring monitoring or follow-up.[65]

88. Safer Care Victoria also made the following related recommendations:

- Co-design with frontline personnel and implement the use of specific fit-for-purpose materials, methods and systems suitable for recording returned traveller health and welfare information in a consistent, comprehensive and systematic way. This includes record-keeping templates and information systems. Ensure the availability of resources so these systems are readily accessible to all relevant personnel, and feedback mechanisms ensure continuous evaluation and improvement relating to the suitability of related current policies and processes.
- Develop and implement formal policies and procedures for recording information provided by external health providers about returned travellers in quarantine, and ensure that relevant information be reviewed, actioned as needed and evaluated by an appropriate clinician on-site.
- Implement formal processes for conducting handover and communication within and between teams working in the hotels in the quarantine system.[66]

89. The issues about record-keeping for people in facility-based quarantine and their management identified here applies equally in a home-based model.

Electronic files

90. Information about each person in quarantine, whether in a facility or home-based model, should be held in an electronic record that follows people through the system, ideally from at least the time when they commence their journey to Victoria's points of international entry, until they are satisfactorily discharged from quarantine directions. The evidence to the Inquiry suggests that at the least, the following non-exhaustive list of information would be valuable to properly plan for arrivals into quarantine and give care and support to those people who remain in quarantine facilities, or indeed to assist in an assessment as to the suitability for a home or residence-based quarantine direction as well as people's care and support needs:

A. any disclosure of COVID-19 symptoms at the commencement of their journey and updates accordingly throughout the quarantine period

B. information about the person's recent travel history

C. language/s spoken

D. whether they are travelling with others (including children)

E. whether the person is a returning permanent resident of Victoria

F. what form of accommodation is available to the person in Victoria

G. relevant personal information including mental and physical health information including a self-assessed ability to 'home quarantine' with reasons

H. whether the person is a smoker

I. details of any dietary requirements (including due to existing health conditions like diabetes, allergies, intolerances and those due to religious beliefs)

J. the person's physical location in quarantine (for example, site name and room number) or home or residence-based quarantine if relevant

K. the start and end date of the person's quarantine period

L. any exemption or temporary leave that is granted from quarantine

M. notes from welfare checks

N. notes from healthcare workers

O. pharmaceutical scripts

P. COVID-19 test results

Q. every review of detention.

91. Among other things, such software could have alerts built in, prompting personnel when a person in a quarantine (either facility-based or at home) has missed a scheduled check such as a welfare check or a check for COVID-19 symptoms or a home-based check for monitoring or compliance (see Recommendations 5 and 6).

Thorough handover

92. Communication between personnel at a facility is also critical. In that regard, Safer Care Victoria made the following recommendation: 'Implement formal processes for conducting handover and communication within and between teams working in the hotels in the quarantine system.'[67]

93. The maintenance of good records will form the foundation to ensure that important information, in particular, about the health and wellbeing of those in facility or home-based quarantine, including any specific needs that must be addressed, will be able to be properly tracked and followed up.

The period of quarantine

94. Under the Hotel Quarantine Program, the period of quarantine for returned travellers was 14 days. Prof. Sutton explained the rationale for the 14-day period of quarantine as follows:

> The AHPPC determined the 14-day period on the basis that most people would exhibit symptoms or become infected (including without symptoms) within that period. The period commences with when a person may have first been in contact with the virus and ends in 14 days, on the understanding most people will exhibit symptoms for COVID-19 within 14 days. The median incubation period for the virus is 4.9-7 days.[68]

95. Prof. Grayson similarly explained that '[t]he rationale behind the 14-day quarantine period is that, for those who will develop symptoms, those symptoms are highly likely to start within 14 days of exposure to the virus (the so-called "incubation period", with a median incubation period of 5 to 6 days).'[69]

96. However, Prof. Grayson highlighted the limitations of relying on symptoms as a marker of the disease:

> ...it has been reported that some individuals may not be symptomatic until up to 24 days after exposure. The effectiveness of a defined quarantine period also relies on symptoms being an accurate marker that a person has contracted the virus, whereas we now know that it is possible for asymptomatic people to have contracted SARS-CoV-2 and to be contagious.[70]

97. Based on the evidence about when infected people are likely to become symptomatic, the evidence did not provide a basis for departure from the 14-day quarantine period. That said, based on the expert evidence to the Inquiry, testing for COVID-19 is critical in order to identify people who have contracted the disease but are not experiencing symptoms (or who have not disclosed minor symptoms) before being discharged from quarantine.

Testing of people in the Quarantine Program

98. The evidence is that people with the virus can infect others even if they are not themselves symptomatic. Further, the evidence was that people infected with COVID-19 may show only mild symptoms. The possibility of asymptomatic and pre-symptomatic transmission underscores the importance of testing for COVID-19, regardless of reports as to symptoms (see Recommendations 34 and 35).

99. Prof. Grayson recommended that:

> …it would be sensible to test all people at the end of their quarantine period to see whether they are infected with the virus, irrespective of symptoms. If the criteria that people are not showing symptoms after 14 days is used as the sole determinant for whether people are released from quarantine, a proportion of those who are infected with the virus and potentially infectious, but who remain asymptomatic, could be released into the community.[71]

Temporary exemptions from quarantine

100. DHHS advised the Inquiry that, within the Hotel Quarantine Program, more than 439 temporary leave permissions were granted to allow people to take temporary leave from quarantine for compassionate reasons (including to attend a funeral or to visit a family member in hospital) and to receive medical treatment.[72]

101. A check-list and guidance material should also be developed, based on medical advice regarding the risk of infection and wellbeing issues, and legal advice regarding considerations including those arising under the PHW Act and the *Charter of Human Rights and Responsibilities Act 2006* (Vic) (Charter), to ensure those considering applications for exemptions are able to do so in a structured, sound and consistent manner.

102. Any requirement for mandatory detention in a Quarantine Program needs a process for allowing exemptions, either temporary, partial or complete. That process should be made known to those people being placed in quarantine and the criteria by which the request will be assessed. This will need to apply equally to facility or home-based quarantine.

103. Where a temporary exemption is sought, a decision about whether or not to grant the exemption should be made and communicated as promptly as possible. Any necessary conditions upon the temporary exemption put in place to manage the risk of transmission of COVID-19 while the person is outside the quarantine facility should be communicated clearly and placed on the individual's file accordingly (see Recommendations 52–55).

Safe transport arrangements

104. A range of specific transport needs will arise from time to time for people in either facility-based quarantine or home-based quarantine, which will need to be addressed with a range of relevant options tailored to the circumstances. Given the possible COVID-19-positive status of an individual in quarantine who may need urgent or non-urgent transport for medical or health reasons, safe transport arrangements need to be developed (see Recommendation 37).

105. In this regard, Safer Care Victoria made the following recommendation, relating to ambulance services:

> Co-develop and implement a formal agreement between all relevant parties in the hotel quarantine system and Ambulance Victoria regarding the ambulance service requirements of returned travellers. This agreement must provide specific guidance to support decision-making by frontline staff; reflect the rights and role of consumers (returned travellers or their significant others) in participating in these decisions; and provide clear guidance on ambulance dispatch and cancellation.[73]

106. Potential transport options include private transport, other non-emergency patient transport, St. John's Ambulance Australia (SJAA) community transport, and Ambulance Victoria (AV) emergency ambulances.[74] Safe transport arrangements may differ, depending on whether a person requires emergency or non-emergency transport, and whether the reason for transport is for clinical (for example, transfers to hospital) or non-clinical (for example, transfers from hotel-to-hotel) reasons, therefore a triage process is important. An effective triaging process that manages these differing transport requirements is vital.

107. Implementing a safe transport model will naturally require personnel administering the triaging process to be appropriately skilled, sufficiently trained and supported to be able to execute their roles effectively.

108. Implementing safe transport arrangements will also require proper planning and co-ordination. A theme arising from AV's initial response was that the best outcomes were achieved when operations 'were well planned, were coordinated on the ground by experienced AV Incident Health Commanders and used pre-booked SJAA and patient transport resources without impacting on ambulance operations'.[75] AV outlined that ideally, non-emergency transport 'should be planned with AV's Ambulance Emergency Operations Centre (AEOC) which would arrange for AV resources to be used with minimal impact on emergency ambulance operations'[76] (see Recommendation 37).

Evacuation procedures for quarantine facility sites

109. As demonstrated by the evidence as to the complexities involved in moving potentially infectious people in and out of quarantine facilities for fresh air and smoking breaks, the need for an emergency evacuation of the facility poses significant challenges and complexities.

110. Each quarantine facility will be different and require its own well-developed and understood plan. For this reason, each Site Manager must develop an emergency evacuation plan for the facility that is well understood by all personnel and regularly rehearsed. The plan must address not only the need to safely evacuate during an emergency, but the need to do so in a manner consistent with the risk of infection to guests, personnel and the community (see Recommendation 39).

Clinical equipment on-site

111. Given the range of medical needs of people entering quarantine facilities, clinical equipment should be made available on-site in accordance with advice from suitably qualified medical professionals (see Recommendation 36).

112. In the wake of one of its investigations, Safer Care Victoria made the following recommendation, which I accept and endorse:

> As a matter of priority and in consultation with clinical leads, implement measures to ensure adequate and readily accessible on-site clinical equipment and the resources required to effectively sanitise this equipment. This would ensure timely assessment, monitoring and first line treatment of returned travellers.[77]

Welfare and health needs of those in a Quarantine Program

113. Evidence before the Inquiry showed that some of the travellers returning to Australia had a range of complex needs. The range of issues that arose in the course of the Inquiry will be discussed in detail in the Final Report.

114. For present purposes, I note that the Hotel Quarantine Program accommodated people with a broad range of needs, including people who:

A. were elderly

B. had pre-existing physical health conditions or injuries

C. were dependent on drugs or alcohol

D. were experiencing (or had recently experienced) family violence

E. had serious pre-existing mental health conditions

F. were alone

G. engaged in threatening or abusive behaviour

H. were experiencing grief

I. were pregnant

J. did not speak English

K. harmed themselves or were at risk of harming themselves in quarantine.

115. The health and welfare needs of people in the Hotel Quarantine Program had a very considerable impact on the manner in which the program operated and developed.[78] These needs created myriad problems in circumstances where the program had to be deployed to receive hundreds of people at great speed, with little or no information about returning travellers before they arrived.[79]

116. In some instances, the manner in which these needs were handled increased the risk of transmission, detrimentally affected the health and wellbeing of people detained in quarantine and created considerable strain on those working in the program. In order to address these issues, the health, wellbeing and needs of those in quarantine must be a central feature of the Quarantine Program.

117. In his statement to the Inquiry, Dr Gordon, observed that '[o]n average, about 20% of the community have various forms of need, instabilities or personal issues which mean that they have an increased need for support, often including government support, and will for that reason have an increased level of contact with government agencies or bodies. That includes those living with:

    - Diagnosed mental health problems
    - Undiagnosed mental health problems
    - Disabilities
    - Social disadvantage
    - Other problems, such as loss, illness, or various forms of crisis.

    It also includes those who, by reason of being active in an area of community life or advocacy, have a lot of contact with services.'[80]

118. Dr Gordon premised these observations on the understanding that the cohort of returned travellers entering hotel quarantine reflected the spectrum of people in the Victorian community.[81] Nothing before the Inquiry has caused me to doubt this premise.

Health and welfare checks in the Quarantine Program

119. Within the Hotel Quarantine Program, there was a range of tensions between the need to keep on-site workers distant from those in quarantine wherever possible, and the need to attend to the health and wellbeing of those in quarantine, including the accepted need to conduct health checks and provide fresh air and exercise breaks.

120. The need for on-site healthcare workers to remain distant from people in quarantine (to reduce the risk of transmission of COVID-19), while meeting individual health and welfare needs through traditional, face-to-face assessments and clinical examinations, was an ongoing balancing exercise. In their endeavour to maintain this balance, clinical and non-clinical personnel often assessed the health and wellbeing of patients over the telephone, without the benefit of visually assessing the person.[82]

121. Evidence and information provided to the Inquiry showed there were some people who required hospitalisation due to COVID-19, and others due to other serious health conditions.[83] In any Quarantine Program best practice must be to place people requiring high levels of monitoring and care in a hospital or suitable, equivalent and dedicated health facility to meet those needs, rather than in a quarantine facility.

122. Even where such high levels of care and monitoring are not required, there is still a need for a consistent, appropriate and safe method for medical, nursing and healthcare personnel to maintain daily health and welfare checks on people in quarantine. Building on the benefits associated with visual health and wellbeing checks, Safer Care Victoria made the following recommendation in one of its investigative reports:

> Develop and implement processes to enable clinical staff working in the hotel quarantine system to conduct visual telehealth (i.e. video calls) consultations for returned travellers who are willing and able to use these methods, particularly those identified as higher risk. This would enhance initial 'contactless' clinical assessments for returned travellers.

> These processes should be co-designed. The visual telehealth platform should be capable of including external family members, community caregivers in telehealth consultations, at the discretion of the returned traveller, particularly in circumstances requiring a case management approach. The visual telehealth platform should also enable participation of language interpreters, consider the specific needs of returned travellers with visual or hearing impairment and other physical and/or mental disabilities, as needed.[84]

123. This recommendation by Safer Care Victoria provides a sound and sensible procedure for addressing a range of other needs and supports that may be necessary to care for the needs of a person in a quarantine facility.

124. As to the content of 'checks', Safer Care Victoria made the following recommendation:

> Expand the daily COVID-19 assessment symptom screening calls to include other basic health and welfare questions to screen for unmet support needs or issues. For returned travellers with medium to high-risk health conditions, this presents an opportunity to discuss their specific issues. Ensure adequate, dedicated and appropriately qualified staff are available to conduct these calls daily for the duration of returned travellers' period of mandatory quarantine.[85]

125. Consideration should be given to how readily available technology can best be used to maximise care to those in quarantine. Using such technology also has the advantage of being able to minimise the numbers of people needed at the facility, as such checks can be done by appropriately qualified healthcare workers without the need for them to be physically present at the facility (See Recommendations 40–44).

126. In the same way, such health and wellbeing checks as are necessary for people in home-based quarantine may be adapted for use in the home-based model.

A safe and suitable physical environment: 'the facility'

127. Prof. Grayson observed: 'When you come to hotel quarantine, the key word is "quarantine". "Hotel" is just a description of the geography of the site.'[86]

128. Hotels have so far been used for the mass quarantine of returned travellers during the COVID-19 pandemic in Victoria, and indeed in other states and territories of Australia. There was no evidence before the Inquiry as to other possible suitable locations in Victoria that could be adapted to meet the objectives of quarantine.

129. However, that does not discount the possibility that other suitable facilities can be identified. Such considerations should be part of the thinking and discussions that sit behind the planning for the Quarantine Program.

130. In this regard, the evidence from the Inquiry identified that there was a range of issues that needs to be considered.

131. Geographically, any COVID-19 quarantine facility should be sufficiently proximate to a hospital, so that people in quarantine can quickly access urgent medical care when necessary.[87]

132. Quarantine facilities should also be within commuting distance for adequate numbers of appropriately skilled personnel.

133. The facility should allow for the physical separation of people and the proper implementation of infection prevention and control requirements as assessed by those with that expertise (see Recommendation 7).

134. In order to minimise the risk of transmission, the features of the environment should facilitate physical separation of people. As Prof. Grayson explained:

> Basic quarantine principles demand a high degree of rigour in terms of spatial (and at times, physical barrier) separation of quarantined people and careful restriction of movement to avoid possible cross-contamination in shared spaces both indoors and outdoors. Indoor shared spaces such as hallways, meal and recreation rooms can be particularly problematic if there is a possibility of either droplet or localised airborne transmission. For outdoor areas, such as exercise zones, to meet quarantine requirements, there should be no possibility of contact (and therefore no possible cross contamination) with other people who are in quarantine or with those who are not in quarantine.[88]

135. Where it is necessary for children to spend time in a quarantine facility, every effort should be made to provide a physical environment suitable for them. Those caring for infants may need access to specific facilities (for example, for heating milk or sterilising bottles). Young children, and those caring for them, are likely to experience acute challenges in confined spaces. Every effort should be made to provide the capacity for parents to be able to take children outside regularly for fresh air and exercise. In particular, single parents who have to manage infants and small children need to be recognised as requiring extra support to manage in a quarantine facility for 14 days.

136. Those with nicotine, drug or alcohol dependencies also experienced particular difficulty and in turn this created challenges for facility personnel.[89] No doubt, the stressors any person is apt to experience in a quarantine facility would be compounded by nicotine, drug or alcohol withdrawal. There was evidence of actions to assist smokers such as supplying them with relief in the form of nicotine substitutes and other forms of therapeutic assistance.[90] It is necessary to address the particular supports that can be provided to this cohort to alleviate this additional distress that will be experienced in a quarantine facility.

A process for facilitating fresh air breaks

137. The most suitable quarantine facility is one that can provide a physical environment that facilitates safe access to fresh air for all people in quarantine.

138. The availability of fresh air and the capacity to have some space to exercise should feature in a human-rights-based analysis of which facilities are appropriate for use for quarantine.

139. The United Nations Standard Minimum Rules for the Treatment of Prisoners (known as the Nelson Mandela Rules) outline that '[e]very prisoner who is not employed in outdoor work shall have at least one hour of suitable exercise in the open air daily if the weather permits'[91]. People in quarantine are not prisoners. They should be afforded at least the same opportunity for one hour of exercise in open air each day to assist in the maintenance of their health and wellbeing during their state-directed mandatory stay in a quarantine facility.

140. Fresh air breaks are necessary and will need to be factored into not only the criteria for the physical layout of the facility, but also a robust and appropriately developed process for safely facilitating such breaks. The process should include clear instructions to facility personnel as to how these breaks are to be safely conducted, together with good communication with people in quarantine as to what they can expect, and what they are required to do and not do during such breaks (see Recommendation 45).

Importance of communication and provision of information to people in quarantine to assist in maintenance of wellbeing

141. Dr Gordon gave evidence about the likely impact on some people of being detained in a hotel room for 14 days. He spoke about the 'threats' that some people placed in hotel quarantine were likely to perceive, being the threat posed by the virus itself, the threat posed by the disruption of lifestyle and the threat posed by isolation.[92] Dr Gordon suggested ways of reducing the intensity of people's stress responses to those perceived threats, through effective communication[93] (see Recommendations 46–51).

142. As stated by Dr Gordon, it is important to provide people with information structured in a way that explains the virus, how it works, and the measures required to protect themselves.[94] He stated that it is reasonable to expect that those undertaking quarantine in a facility will be more likely to view the virus as the greater threat, and understand that the quarantine measures being imposed (which are themselves perceived as threats by some) are proportional measures required to combat the larger threat.[95] By clearly communicating the link between the virus and the arrangements in place to combat its spread, it is reasonable to expect that compliance with, and trust in, the program will increase.[96]

143. This will have the benefit of not only assisting those who are experiencing distress as a result of being contained in a quarantine facility, but also reduce the challenges for personnel working in the facility.

144. Dr Gordon gave evidence that '[o]pportunities for regular, caring, informal unsolicited communication support a person's sense of identity, as well as providing emotional support and confidence.'[97] He suggested that one way of achieving this is through a daily check-in: 'this should be a genuine chat in which being a human being is the focus rather than just checking for symptoms or needs'.[98]

145. Dr Gordon's evidence was that, as well as being a positive support for people in quarantine, a daily check-in may assist in identifying people who are at risk. He recommended that any system of quarantine should plan to 'monitor for detachment and withdrawal amongst passengers [being people in quarantine], as this can be an indicator of increased risk'.[99]

Supportive communication

146. Dr Gordon described what it means to create a 'supportive environment':

> Support is a quality of interpersonal contact. It is qualitative not quantitative characteristic of communication. A person will feel supported if they know who to contact with their concerns and if they get timely and consistent responses. Support is created when the person needing support gets a clear understanding that the person they are talking to understands their experience, even if they cannot do anything to change the situation.[100]

147. He stated that in order to ensure that communication in quarantine is supportive:

> Everyone working in a...quarantine program could be briefed on how to present a supportive style of interaction. This could include brief training packages on psychological first aid, personal support and helpful listening skills, de-escalation skills, etc.[101]

148. Whilst Dr Gordon's observations here were addressing a hotel program there are lessons to be learned for care of people's health and wellbeing in the home-based model.

Communicating effectively

149. Dr Gordon explained that quarantine is likely to affect the way that people receive information:

> There is a need to constantly repeat fundamental information in emergency situations - people in a heightened state of arousal tend to be looking through a narrow focus of attention for the specific information they need at that time and do not take in information if they feel it is not relevant; some time later, when their focus or needs or level of arousal change, they need different information and cannot remember it was given to them and may not even think to re-read handouts that were given at an earlier time.[102]

150. Again, whilst Dr Gordon's observations here were addressing a hotel program, these same lessons need to be adapted to people in the home-based model.

Process for complaints and concerns

151. Dr Gordon gave evidence that providing 'opportunities for people to give feedback and communicate their needs' is a constructive way of reducing the intensity of people's stress responses in quarantine.[103]

152. These views align with another recommendation from Safer Care Victoria:

> On arrival, all returned travellers and their external family members should be routinely provided with clear information about how to escalate unaddressed or inadequately addressed concerns. This information should be easily accessible for those from culturally and linguistically diverse backgrounds, the elderly, the visually impaired, and be suitable for varying levels of health literacy.[104]

153. Again, while these views were addressing the hotel program environment, a process for complaints and concerns is needed for those placed in the home-based model.

Community solidarity and support

154. Another way of reducing the intensity of people's stress responses recommended by Dr Gordon in the context of the Hotel Quarantine Program was 'to create a sense of community solidarity and support amongst those in quarantine'.[105]

155. Consistent with this, a number of the returned travellers who gave evidence or provided information to the Inquiry mentioned that they had joined Facebook groups for people in quarantine, to receive information and to share experiences. Others mentioned that they were in phone contact with friends or acquaintances in quarantine at different locations.

156. Dr Gordon explained the benefits that a sense of community solidarity and support can foster among people in quarantine:

> Creating a sense of community solidarity and support amongst quarantined people would give the 80% of the quarantine population who are more resilient opportunities to support and reassure the 20% who are more likely to be struggling with the situation. The constructive effects of promoting community formation and interactions for supporting and managing distress are well understood in the emergency management context. Emergency management workers use information, humour, satire, shared experiences, problem solving and morale boosting. Communication networks encouraging them to express their fears, which helps to think about them and manage them. Being part of a group reduces the sense of solitary exposure.[106]

157. As explained by Prof. Grayson, in-person contact between people in quarantine would undermine the primary objective of preventing the spread of disease:

> Quarantined people should not be permitted to interact with one-another since this could facilitate disease transmission. Even among people who are in quarantine and known to be infected, they should not be allowed to interact with other infected individuals unless it is absolutely certain that both individuals are known to have exactly the same strain of infection - even in such circumstances, extreme care should be taken to avoid unnecessary contact.[107]

158. Notwithstanding those constraints, constructive and beneficial opportunities for interaction and fostering of community support exist. As identified by Dr Gordon, one way of facilitating community solidarity and support within a quarantine facility is moderated discussion groups hosted online.[108]

159. The in-house television channels available to hotels provide an option for disseminating daily updates, answers to frequently asked questions and fostering a sense of community through televised exercise programs and the like, tailored specifically for guests in the quarantine facility.

160. Dr Gordon outlined that social media can be a great 'resilience resource' for people, but stated that developing such a community of solidarity in the hotel quarantine environment ought to be:

> managed and designed and possibly facilitated, because you've got to counteract the contagion effect of anxiety and anger and high emotion with the community-building, supportive process.[109]

161. Dr Gordon also stated that:

> it would be much more effective to then integrate that into the Government communication process, because it's in that environment that the information about what the virus is and why the quarantine measures are necessary and how to do PPE and how to do hygiene and all these things, that will get processed, and that's the environment in which this information can be helped to circulate.[110]

Access to means of communication

162. There will no doubt be communication barriers for some people in any part of a Quarantine Program. It is predictable that some people in quarantine, either in a facility or in home-based quarantine, will not speak English, have a disability that means that they communicate non-verbally, or have sight or hearing impairments that require additional supports to communicate. While most people are likely to have access to mobile phones, it cannot be assumed that all people in quarantine will have a mobile phone.

163. These individual issues need to be assessed as soon as is reasonably practicable, and all steps possible taken to address these communication needs for people being mandated into quarantine either in a facility or at home (see Recommendations 46–51).

164. On the issue of access to mobile phones, in the wake of one of its investigations, Safer Care Victoria made the following recommendation:

> On arrival, all returned travellers should have suitable access to a functioning mobile telephone for the duration of their mandatory detention, (e.g. telephone handsets, chargers, Australian SIM cards and access to credit and top-up methods to be able to make calls).[111]

Language that reflects the program's health objectives

165. Following its investigation of the second of two serious clinical incidents that occurred within the Hotel Quarantine Program, Safer Care Victoria identified that '[t]here was inconsistent language used to describe returned travellers in hotel quarantine (e.g. passengers, guests, detainees)' and observed that '[s]ome of the terms have connotations that could bring unconscious bias to the way they are cared for by the personnel working in the hotel quarantine environment.'[112]

166. That inconsistency in language persisted throughout the Inquiry's hearings, where people in quarantine were variously referred to as 'returned travellers', 'detainees', 'guests' and 'patients'. It is laudable that the hospitality personnel of hotels consistently referred to the people in quarantine as 'guests'. It is a far gentler term.

167. The language used to describe the people in quarantine in a facility is important and will add a quality to the culture of the facility that is likely to reflect behaviour. Language that is dehumanising or derogatory or invokes a sense of fault or blame in those being contained in a quarantine facility risks having a negative effect on the culture of the facility. I understand that the word 'detainee' is derived from the section of the PHW Act that provides the power to issue a Detention Direction mandating people into quarantine.

168. However, inside the facility it would be appropriate to adopt more neutral language such as 'resident' rather than 'detainee' when referring to those people compelled to stay there through no fault of their own (see Recommendation 56).

Supported transition out of quarantine

169. Dr Gordon gave evidence that, in his opinion, it was important to provide a de-briefing process for people who are exiting a quarantine facility: 'One of the learnings of trauma psychology is the importance of a debrief or reflection process after the trauma has passed'.[113]

170. Dr Gordon explained that de-briefing would serve a number of purposes:

- Many people benefit from the opportunity to go back over a traumatic experience, and to reflect on the emotions they experienced and what they discovered about themselves during the period of stress.[114]
- Like deep-sea divers coming up to the surface of the water, people emerging from quarantine may experience a 'decompression response'.[115]
- It is also possible that, for a small number of people, the experience may have activated previous traumatic experiences where there were experiences of loss of control, coercive control and feelings of helplessness… Although it is likely to be a small number of people the provision of some form of standardised debriefing or reflective session would allow such needs to be identified and followed up.[116]
- Finally, the request for feedback in the form of a conversation provides the feeling that their experience is valued for the authorities to learn and enables a feeling of a participation in an important new initiative that the authorities are still learning about.[117]

171. There were consistent themes in the evidence and information provided to the Inquiry about concerns regarding matters including:

- access to fresh air
- access to good quality food
- the state of cleanliness of the facility
- the infection risks associated with mandatory quarantine in the facility
- information being inconsistent and difficult to access
- confusion about how and to whom concerns could be communicated.

172. A de-briefing or exiting process provides an opportunity for the Site Manager to be made aware of such issues and respond to them accordingly by way of continuous improvement processes (see Recommendation 57).

1.4 Features of the Quarantine Program: Recommendations 1–57

Taking into account all of the above, and accepting the existing legal framework and powers currently in place under the PHW Act to direct people into quarantine (whether that be in a facility or at home), I recommend that:

Purpose of the Quarantine Program

1. The Quarantine Program for international arrivals into Victoria be clearly defined as a public health measure to address the need to contain the transmission of COVID-19 into the community while ensuring that the health and wellbeing of those placed into quarantine is properly addressed together with the need to ensure the safety of all personnel working in the Program.

Control of the numbers

Facility-based model

2. To achieve an orderly and manageable process, the Victorian Government must do all things possible to ensure appropriate and necessary processes are put in place to control the numbers of international arrivals at any given time, informed by the availability of fully operational facilities that are ready and able to receive the agreed numbers.

Home-based model

3. The numbers of international arrivals also be controlled to make practical and achievable the individual engagement and suitability assessments required for home-based quarantine (see Recommendation 59 in Section 2).

Information gathering

4. The Victorian Government takes all possible steps to obtain the co-operation and assistance of Commonwealth agencies and officials, to ensure that the best available and most relevant information is provided to State officials as far in advance as possible for each international arrival, in order to facilitate an informed suitability assessment appropriate placement in for the Quarantine Program (including suitability to quarantine at home).

Electronic record-keeping

5. The Victorian Government liaises with the Commonwealth to develop a process whereby such information about each international arrival bound for a Victorian point of entry can be placed in an electronic file made available to the State authorities as expeditiously as possible prior to the arrival, and for that file to contain targeted information for State officials to assist in the management of the necessary quarantine arrangements.
6. All necessary actions be taken to have that electronic file follow the individual from international arrival through to the completion of their quarantine obligations and include all relevant information to assist in that person's safe transition into the community.

Safe and suitable physical environment for a quarantine facility

7. Given there are currently no identified specific purpose-built quarantine facilities in Victoria, that hotels remain a reasonable and viable option for international arrivals needing to be placed into quarantine. Relevant criterion for selecting suitable locations as quarantine facilities include:
    - A. sufficient proximity to a hospital
    - B. being within commuting distance for adequate numbers of appropriately skilled personnel for the facility
    - C. the facility's:
        - I. ability to allow for the physical separation of people
        - II. ability to properly implement all necessary infection control requirements, as far as practicable
        - III. capacity to make necessary modifications and additions to minimise the risk of transmission, as far as practicable
        - IV. ability to provide safe access to outside areas for fresh air and exercise breaks
        - V. ability to provide for specific needs such as mobility issues or the need to cater for infants.

Governance structure

8. The Victorian Government ensures that at the ministerial and departmental level, clear control and accountability structures are in place for the operation of the Quarantine Program (including the facility-based program together with any home-based program), to be operated by one Cabinet-approved department, with support from other departments as necessary, but in accordance with a clear line of command vesting ultimate responsibility to the approved department and Minister.
9. The Victorian Government ensures that the Minister and department approved as the single agency to be accountable for the operation of the Quarantine Program is the department that is the sole agency responsible for any necessary contracts.
10. The responsible Minister ensures that the structure for the operation of the Quarantine Program has clearly defined roles that have the necessary expertise and advice embedded at appropriate levels of seniority in the operational structure.
11. The responsible Minister ensures that the appropriate senior members of that governance structure form a body (Quarantine Governing Body) that meets regularly, is chaired by the Secretary to the responsible Minister, maintains records of its meetings including records of all decisions reached, and provides reports to the Minister from those meetings including in respect to decisions reached.
12. The responsible Minister ensures that the Quarantine Governing Body provides regular, timely and accurate reports to the Minister as to the operation of the Quarantine Program, across all sites, and including all aspects of the entire Quarantine Program, including full and accurate reports as to compliance, monitoring and risks measured against the Purpose (as set out in Recommendation 1).
13. The responsible Minister ensures that the Quarantine Governing Body sets clear and consistent lines of accountability across all individual sites operating as quarantine facilities.
14. The Quarantine Governing Body ensures that each individual quarantine facility site has provided role clarity to all personnel working on-site.
15. The Quarantine Governing Body ensures that each quarantine facility has a Site Manager responsible for the overall operation of that facility and accountable to the Quarantine Governing Body.
16. The Site Manager role should be filled by a person who has experience in the management of complex healthcare facilities.

On-site role clarity

17. The Site Manager ensures that all personnel working in the quarantine facility understand their role and responsibilities.
18. The Site Manager ensures that all personnel on-site understand to whom they report and all lines of reporting and accountability on-site.

Appropriate mix of personnel on-site

19. The model contained in paragraph 21 of Section 1 be considered an appropriate model for the operating structure of a quarantine facility.
20. The Chief Commissioner of Police be requested to provide a 24/7 police presence on-site at each quarantine facility.

21. The responsible Minister and Quarantine Governing Body ensure that infection prevention and control expertise is embedded in each quarantine facility site, together with the necessary clinical personnel, to meet the mental and physical health needs of people in quarantine. To this end, the model presented and expanded upon at paragraph 21 of Section 1, should be considered as a good basis for all quarantine facilities.

Dedicated personnel

22. Accepting the need to bring in expertise, every effort must be made to ensure that all personnel working at the facility are not working across multiple quarantine sites and not working in other forms of employment.

23. To achieve the aims of Recommendation 20, every effort should be made to have personnel working at quarantine facilities salaried employees with terms and conditions that address the possible need to self-isolate in the event of an infection or possible infection, or close contact exposure, together with all necessary supports, including the need to relocate if necessary and have a managed return to work.

Infection prevention and control unit on each site

24. The Quarantine Governing Body ensures that each quarantine facility has a properly resourced infection prevention and control unit embedded in the facility with the necessary expertise and resources to perform its work.

Training and workplace culture

25. The Site Manager be responsible for ensuring that all personnel working on-site are inducted into a culture of safety, focussed on infection prevention and control provided by those with the expertise to deliver such training.

26. The culture of safety fostered by the Site Manager should encourage collaboration, open discussion as to mistakes and oversights and speaking up about concerns and potential health and safety risks.

27. The Site Manager be responsible for ensuring that all personnel working on-site are engaged in ongoing training in infection prevention and control provided by those with the expertise to deliver such training, tailored to the specific roles to be performed on-site.

28. The Site Manager ensures that the personnel on-site who have the expertise in infection prevention and control are engaged in ongoing monitoring and supervision of all of the requirements in place for infection prevention and control, which includes matters such as individual behaviour, the use of PPE and cleaning practices.

Acquisition and use of PPE

29. The Site Manager ensures that the infection prevention and control experts manage the acquisition, distribution and use PPE with specific clear and accessible directions to all personnel on-site (acknowledging that such instructions may vary according to role).

Cleaning practices in quarantine facilities

30. The Site Manager ensures that all cleaning practices throughout the site are developed, directed and overseen by personnel with infection prevention and control expertise, and include 'swab' testing as directed by the infection prevention and control experts.

Independent safety auditing

31. The Quarantine Governing Body ensures that each quarantine facility site has regular, independent safety audits performed (as against the Purpose set out in Recommendation 1) with reports from those safety audits to be provided to both the Site Manager and the Quarantine Governing Body.

Period of quarantine

32. A 14-day period in quarantine is appropriate, unless the current state of expert opinion changes, or as otherwise directed by the Chief Health Officer or their delegate.

Cohorting of positive cases

33. Any decision to cohort known positive cases at a particular quarantine facility should only occur after proper consultation with the appropriate experts as to suitability of the facility, any necessary adjustments to the facility, and the experts being satisfied that all necessary infection prevention and control precautions are in place at that facility.

Testing

34. All people in quarantine, whether facility or home-based, should be tested on such days as directed by the Chief Health Officer or their delegate, regardless of reported symptoms.
35. For those assessed as suitable for home-based quarantine, it should be a condition of such placement that a person agrees to be tested, as directed by the Chief Health Officer or their delegate.

Clinical equipment on-site

36. On advice from the appropriate experts, adequate and readily accessible on-site clinical equipment to address the range of possible health needs of those in quarantine should be placed at each quarantine facility, together with the necessary resources to effectively sanitise any such equipment.

Safe transport arrangements

37. Given the possible COVID-19-positive status of an individual in a quarantine facility or home-based quarantine, arrangements and protocols for the safe transporting of a person for either urgent or non-urgent health reasons should be developed.

Contact tracing unit

38. The Quarantine Governing Body ensures that each quarantine facility has a contact tracing unit embedded in the facility that can build familiarity and trust with on-site personnel and has accurate and up-to-date information for all such personnel, to enable a rapid and efficient response to any possible outbreak and provide ongoing training to all personnel as to what is required in the event of potential or actual infection.

Evacuation procedure on-site

39. Each Site Manager should develop an emergency evacuation plan for the site and ensure it is well understood and regularly rehearsed by all personnel working in the facility and communicated to each of those placed in the quarantine facility.

Health and wellbeing of people in quarantine

Daily health and welfare checks

40. The Quarantine Governing Body ensures that daily health and welfare checks be embedded into the operation of each quarantine facility.

41. Site Managers arrange standard daily health and welfare checks on people in quarantine, to be conducted with the assistance of available technology, such as a visual telehealth platform, where the individual is willing and able to participate in this way or as otherwise directed by the Clinical Manager (as per the model in paragraph 21 of Section 1).

42. The Quarantine Governing Body provides direction, advice and resourcing as to the use of visual telehealth platforms to enable a case management approach to an individual's health needs, which may enable family, interpreters and existing or preferred healthcare professionals and supports to participate in case conferencing directed to the health and wellbeing of those in quarantine facilities.

43. The daily health and welfare checks be conducted by appropriately skilled personnel who are also able to screen for any unmet needs or concerns, rather than limited to a check on COVID-19 symptoms.

44. Suitable health and welfare checks by appropriately skilled personnel should be conducted on those in home-based quarantine.

Fresh air and exercise breaks

45. The Quarantine Governing Body ensures the ability to provide daily fresh air and exercise breaks for people placed in quarantine facilities is factored into not only the physical layout but also the staffing of the facility, to ensure there is provision for safe, daily opportunity for people in quarantine facilities to have access to fresh air and exercise breaks.

Communication with and to people in quarantine facilities or prior to entry into the Quarantine Program

46. The Quarantine Governing Body ensures that each facility operates on an understanding and acknowledgment that a number of people placed in quarantine facilities will experience a range of stressors as a result of being detained in a quarantine facility for 14 days.

47. The Quarantine Governing Body ensures that all reasonable steps are taken to assist those who will be particularly vulnerable and require additional skilled support by reason of their being held in quarantine.

48. The Quarantine Governing Body ensures that every effort is made to provide multiple forms of communication of information throughout the period of quarantine to assist in reducing the distress and anxiety that some people will experience in quarantine.

49. The Quarantine Governing Body should address the need to provide accurate, up-to-date and accessible information to all people seeking to enter Victoria through international points of entry, including in community languages, to ensure best efforts at communication are made for all international arrivals.

50. Site Managers ensure that clear, accessible and supportive styles of communication should be regularly used to enable people to have consistent and accurate information about what supports are available to them and who to contact if they have a complaint, concern or enquiry while quarantined in a facility.

51. To assist in creating support for people in quarantine facilities and ensuring that there is information available in a range of formats and languages, Site Managers should assign a role to an appropriate person who can coordinate communications and use various platforms (for example visuals, signs, social media, etc.) to encourage those in quarantine facilities to connect with one another. These platforms can also be used to regularly communicate general and relevant information.

Exemptions and temporary leave

52. Authorised Officers ensure that each person placed in quarantine, whether facility or home-based, is made aware of the process for requesting temporary leave or an exemption and the criteria upon which such requests will be assessed.

53. Authorised Officers make decisions about whether or not to grant an exemption or temporary leave as promptly as practicable.

54. Authorised Officers ensure that any conditions or restrictions on such grants should be clearly communicated to the person making the request and address the need to manage the risk of transmission of COVID-19 while that person is in the community and is monitored for compliance.

55. To assist Authorised Officers and enhance consistent decision-making, that each Authorised Officer be provided with a checklist and guidance material on all relevant considerations when determining applications for exemptions and temporary leave applications.

Language is important

56. Language such as ‘resident’ rather than ‘detainee’ be used to reduce the risk of such language having a negative effect on the culture of the facility and to reflect that quarantine is a health measure and not a punitive measure.

Transitioning out of quarantine facilities

57. People leaving quarantine facilities should be offered an opportunity for a ‘de-brief’ to assist with their transition out of the facility and also to enable the opportunity for feedback to be passed to the Site Managers to assist in maintaining a culture of continuous improvement.

Endnotes

1 Exhibit HQI0125_RP Witness statement of Ms Melissa Skilbeck, 6 [34].
2 The Age (Web Page, 2 October 2020) <https://www.theage.com.au/national/coronavirus-updates-live-staff-worked-in-quarantine-hotel-while-infectious-queensland-border-to-stay-shut-until-november-20201002-p56195.html>.
3 Professor Grayson explained that 'quarantine is a public health measure, by which people who have or may have an infectious disease are isolated to prevent the spread of that disease. It is a method designed to ensure observation of those who may be infected (or who present a higher than usual probability of being infected), so as to prevent further spreading of a disease.' Exhibit HQI0001_P Witness statement of Prof. Lindsay Grayson, 11 [51].
4 Exhibit HQI0001_P Witness statement of Prof. Lindsay Grayson, 12 [53].
5 Transcript of day 14 hearing 8 September 2020, 1066.
6 Exhibit HQI0176_P Witness statement of Dr Rob Gordon, 7 [29], 11 [43] and 15 [58].
7 Exhibit HQI0178_RP Annexures to first witness statement of Mr Christopher Eccles, DPC.0012.0001.0832, DPC.0012.0001.0835, DPC.0001.0001.6538; Exhibit HQI0186_RP First witness statement of Ms Kym Peake, 49 [254].
8 Exhibit HQI0178_RP Annexures to first witness statement of Mr Christopher Eccles, DPC.0012.0001.0838, DPC.0001.0001.6536, DPC.0001.0001.6537, DPC.0001.0001.6538; Exhibit HQI0186_RP First witness statement of Ms Kym Peake, 49 [254].
9 Exhibit HQI0178_RP Annexures to first witness statement of Mr Christopher Eccles, DPC.0012.0001.0835, DPC.0012.0001.0836, DPC.0012.0001.0838; Exhibit HQI0186_RP First witness statement of Ms Kym Peake, 53 [274].
10 Exhibit HQI0117_RP Annexures to first witness statement of Prof. Euan Wallace AM, DHS.0001.0002.0053.
11 Exhibit HQI0099_RP Witness statement of Ms Simone Alexander, 8-9 [38], 14-15 [54].
12 Exhibit HQI0107_RP Annexures to witness statement of Dr Sarah McGuinness, DHS.0001.0036.0146; Exhibit HQI0098_RP Annexures to witness statement of Dr Clare Looker, DHS.0001.0036.0204.
13 Transcript of day 26 hearing 28 September 2020, 2214-2217; Exhibit HQI0153_P Witness Statement of Prof. Brett Sutton, 39 [215] - 40 [221]; Exhibit HQI0103_RP Witness statement of Dr Simon Crouch, 9 [42(d)].
14 Exhibit HQI0219_RP Annexures to the Witness statement of the Hon. Daniel Andrews, MP, DPC.0012.0001.0468.
15 Exhibit HQI0169_RP Witness statement of Chief Commissioner Shane Patton, 4 [3.1]; Transcript of day 19 hearing 17 September 2020, 1652.
16 Transcript of day 19 hearing 17 September 2020, 1657.
17 Exhibit HQI0171_RP Victoria Police safety officer instructions.
18 Transcript of day 19 hearing 17 September 2020, 1657.
19 Ibid.
20 Exhibit HQI0153_P Witness Statement of Prof. Brett Sutton, 20 [161]; Exhibit HQI0211_P Witness Statement of the Hon. Jenny Mikakos MP, 14 [73]; Submission 03 Department of Health and Human Services, 15 [82].
21 Exhibit HQI0099_RP Witness statement of Ms Simone Alexander, 17 [59](b)], noting Ms Alexander's further evidence that 'Alfred Health did not engage agency nurses to work at any hotels in the Hotel Quarantine Program'.
22 Transcript of day 14 hearing 8 September 2020, 1069-1070.
23 Exhibit HQI0117_RP Annexures to first witness statement of Prof. Euan Wallace AM, DHS.0001.0002.0053.
24 Ibid DHS.0001.0002.0052.
25 Exhibit HQI0001_P Witness statement of Prof. Lindsay Grayson, 15 [65].
26 Exhibit HQI0099_RP Witness statement of Ms Simone Alexander, 16 [58(a)].
27 Ibid [58(d)].
28 Exhibit HQI0008_RP Witness statement of Dr. Charles Alpren, 9-10 [40]-[41].
29 Transcript of day 14 hearing 8 September 2020, 1025-1026.
30 Ibid 1025.
31 Ibid 1025-1028, 1030, 1047.
32 Ibid.
33 Exhibit HQI0029_P Witness statement of Mr Craig Arundel, 7 [44].
34 Ibid [45].
35 Transcript of day 7 hearing 24 August 2020, 344.
36 Exhibit HQI0020_P Witness statement of Ms Liliana Ratcliff, 11 [90].

37 Exhibit HQI0009_RP Witness statement of 'Nurse Jen', 17 [144].
38 Exhibit HQI0171_RP Victoria Police safety officer instructions.
39 Transcript of day 14 hearing 8 September 2020, 1036.
40 Exhibit HQI0008_RP Witness statement of Dr. Charles Alpren, 11[46].
41 Exhibit HQI0159_RP Emails between DHHS Commanders and Prof. Brett Sutton, DHS.5000.0034.6970.
42 Ibid.
43 With regard to PPE, Safer Care Victoria made the following recommendation: 'As a matter of priority, implement measures to ensure an adequate and reliable onsite supply of Personal Protective Equipment (PPE) that is readily accessible to all staff working in the hotel quarantine system.' Exhibit HQI0117_RP Annexures to first witness statement of Prof. Euan Wallace AM, DHS.0001.0002.0052.
44 Noting the evidence from Nurse Michael Tait about the unsuitability of large sized gloves: 'Most of the nurses were young females so they had small hands and could not wear large size gloves'. Exhibit HQI0014_RP Witness statement of Mr Michael Tait, 9 [81].
45 Exhibit HQI0001_P Witness statement of Prof. Lindsay Grayson, 14 [61].
46 Ibid.
47 Ibid 15 [62].
48 Ibid [63].
49 Ibid [64].
50 Exhibit HQI0099_RP Statement of Ms Simone Alexander, 16-17 [58(e)].
51 Exhibit HQI0001_RP Witness statement of Prof. Lindsay Grayson, 8 [38], 9 [42], 13 [59], 17 [70(a)(iii)], 19 [76]; Exhibit HQI0106_RP Witness statement of Dr Sarah McGuinness, 6-9 [24]-[31].
52 Transcript of day 16 hearing 11 September 2020, 1252-1253.
53 Transcript of day 14 hearing 8 September 2020, 1065-1066; Exhibit HQI0103_RP Witness statement of Dr Simon Crouch, 9 [42(a)].
54 Transcript of day 14 hearing 8 September 2020, 1066.
55 Exhibit HQI0160_P Witness statement of Dr Annaliese van Diemen, 29 [136].
56 Exhibit HQI0001_RP Witness statement of Prof. Lindsay Grayson, 12 [55].
57 The Age (Web Page, 2 October 2020) <https://www.theage.com.au/national/coronavirus-updates-live-staff-worked-in-quarantine-hotel-while-infectious-queensland-border-to-stay-shut-until-november-20201002-p56195.html>.
58 Exhibit HQI0117_RP Annexures first witness statement of Prof. Euan Wallace AM, DHS.0001.0002.0053.
59 Transcript of day 13 hearing 4 September 2020, 969.
60 Ibid.
61 Transcript of day 9 hearing 28 August 2020, 516.
62 Ibid.
63 Ibid 515-516.
64 Ibid 516.
65 Exhibit HQI0117_RP Annexures to first witness statement of Prof. Euan Wallace AM, DHS.0001.0002.0052.
66 Ibid DHS.0001.0002.0053.
67 Ibid.
68 Exhibit HQI0153_P Witness statement of Prof. Brett Sutton, 33 [181].
69 Exhibit HQI0001_P Witness statement of Prof. Lindsay Grayson, 12 [55].
70 Ibid.
71 Ibid 12 [56].
72 Exhibit HQI0228_RP Letter from MinterEllison dated 25 September 2020, responsive to questions posed to Ms Kym Peake, 1.
73 Exhibit HQI0117_R Annexures to first witness statement of Prof. Euan Wallace AM, DHS.0001.0002.0053.
74 Exhibit HQI0215_RP Initial responses from parties, AMBV.0003.0003.0003.
75 Ibid.
76 Ibid AMBV.0003.0003.0002.
77 Exhibit HQI0117_R Annexures to first witness statement of Prof. Euan Wallace AM, DHS.0001.0002.0052.
78 Submission 03 Department of Health and Human Services, 59-60 [329].
79 Exhibit HQI0162_P Witness Statement of Ms Andrea Spiteri, 15 [59].
80 Exhibit HQI0176_P Witness statement of Dr Rob Gordon, 7 [29].
81 Ibid 7 [28].

82 Transcript of day 15 hearing 10 September 2020, 1153; Exhibit HQI0117_R Annexures to first witness statement of Prof. Euan Wallace, DHS.0001.0002.0044.
83 Exhibit HQI0009_RP Witness statement of 'Nurse Jen', 10 [87]; Exhibit HQI0133_RP Minutes of Operation Soteria Meeting 10 April 2020, DJP.102.007.3065; Exhibit HQI0119_RP Annexures to second witness statement of Dr Euan Wallace AM, DHS.0001.0002.0058.
84 Exhibit HQI0117_RP Annexures to first witness statement of Prof. Euan Wallace AM, DHS.0001.0002.0052.
85 Ibid.
86 Transcript of day 3 hearing 17 August 2020, 43.
87 Ms Merrin Bamert, Commander, Operation Soteria, stated that 'The majority of guests were well and required a primary care model with escalation points as needed, and diversion to the hospital system for high-acuity concerns': Exhibit HQI0135_RP Witness statement of Ms Merrin Bamert, 19 [58].
88 Exhibit HQI0001_P Witness statement of Prof. Lindsay Grayson, 12 [54].
89 Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 8-9 [22(b)]-[22(c)]; Exhibit HQI0014_RP Witness statement of Mr Michael Tait, 8 [65]; Exhibit HQI0009_RP Witness statement of 'Nurse Jen', 10-11 [85]-[95]; Transcript of day 11 hearing 2 September 2020, 787; Transcript of day 13 hearing 4 September 2020, 910.
90 Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 8-9 [22(d)]; Exhibit HQI0014_RP Witness statement of Mr Michael Tait, 8 [65]; Exhibit HQI0033.RP Annexures to witness statement of Ms Claire Febey, DJP.102.009.1880.
91 United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules), GA Res 175, UN GAOR, 70th sess, Agenda item 106, UN Doc A/RES/70/175 (8 January 2016, adopted 17 December 2015), r 23(1).
92 Exhibit HQI0176_P Witness statement of Dr Rob Gordon, 8 [35].
93 Ibid 11 [45], 18 [67].
94 Transcript of day 20 hearing 18 September 2020, 1729.
95 Exhibit HQI0176_P Witness statement of Dr Rob Gordon, 11 [44]-[45].
96 Transcript of day 20 hearing 18 September 2020, 1729.
97 Exhibit HQI0176_P Witness statement of Dr Rob Gordon, 15 [60].
98 Ibid [60.1].
99 Ibid 17 [66.6].
100 Ibid 14 [56].
101 Ibid 15 [57].
102 Ibid [60.2].
103 Ibid 14 [55.4].
104 Exhibit HQI0117_RP Annexures to first witness statement of Prof. Euan Wallace AM, DHS.0001.0002.0053.
105 Exhibit HQI0176_P Witness statement of Dr Rob Gordon, 14 [55.2].
106 Ibid 15 [58].
107 Exhibit HQI0001_P Witness statement of Prof. Lindsay Grayson, 12 [54].
108 Exhibit HQI0176_P Witness statement of Dr Rob Gordon, 15 [59].
109 Transcript of day 20 hearing 18 September 2020, 1736.
110 Ibid 1736-37.
111 Exhibit HQI0117_RP Annexures to first witness statement of Prof. Euan Wallace AM, DHS.0001.0002.0053.
112 Ibid DHS.0001.0002.0051.
113 Exhibit HQI0176_P Witness statement of Dr Rob Gordon, 19 [74].
114 Ibid [75].
115 Ibid [76].
116 Ibid 20 [78].
117 Ibid [79].

SECTION 2

Home-based model

1. The previous Section has examined the necessary features of a Quarantine Program, both generally and specific to a facility-based model.
2. Apart from the physical limitations of hotels as quarantine facilities, in that they are not designed as such, a major risk of the hotel model is the daily movement of personnel in and out of the facility and then into communities in which they live. Even in a best practice model, which has dedicated personnel not moving between facilities, clinical and non-clinical personnel are, of necessity, coming in and out of a facility which, by definition, contains potentially infected people.
3. Minimising the numbers of people working in such environments by only having those unable to quarantine at home, in the facility, reduces this risk of transmission to the broader community. As previously noted, the ever-present risks of transmission events to even the best practice in infection prevention and control, and the impact on the health and wellbeing of individuals inherent in mass quarantining in hotels, strongly suggests other options for mandatory quarantine must be considered.

2.1 Alternative locations for mandatory quarantine

4. Having regard to the evidence particularly as it relates to infection prevention and control, and health and wellbeing issues, I have formed the view that any future Quarantine Program should provide for the option of people quarantining in their own homes, or at some other suitable residential premises, where the necessary assessments have been done, compliance and enforcement provisions are in place, the individual has received a formal explanation of the penalties for failing to comply and has signed an undertaking as to the conditions of home quarantining and acknowledgment of the penalties[1].
5. In my view, the powers under the PHW Act that were employed to give effect to the Hotel Quarantine Program are equally available to direct international arrivals to quarantine at home.
6. Moreover, the evidence to date leads me to the view that a period of quarantine served in the home would:
    A. likely be more consistent with, and successful in achieving, the fundamental aim of any quarantine program; namely to prevent or restrict the transmission of the virus by international arrivals into the community
    B. likely ameliorate the health and welfare consequences of mandatory quarantine served in a facility for many people to a considerable extent
    C. be consistent, perhaps even more so than quarantine served in a facility, with the rights and obligations vested by the Charter.

7. A model that has the option of quarantining in the home wherever this is assessed as suitable does not eliminate the need for designated facilities such as hotels from its overall operation. As was originally envisaged by the Victorian Government when it allocated $80 million to the emergency accommodation program in response to the COVID-19 pandemic,[2] and contemplated by the AHPPC's advice to National Cabinet on 27 March 2020,[3] hotels or similar facilities will be necessary for 'high-risk' cases and for those who are assessed as unable to safely quarantine in a private premises, be it their own home or some other suitable residence.

8. That said, the likely reduction in numbers requiring facility-based quarantine under such a model should have the collateral benefit of allowing for a more selective approach to which hotels or similar facilities are suitable venues for quarantine (that is, those with balconies, opening windows, dedicated open-air recreational areas and self-catering facilities).

9. My views as to the necessary considerations for such a model for quarantining at home wherever possible are set out below. These conditions and recommendations are to be read in conjunction with the overall recommendations contained in this Interim Report.

2.2 The potential to reduce the risks associated with a facility-based model

10. One of the foremost reasons for consideration of a home-based model is that, properly constructed and operated, it would be at least as effective as a facility-based model in achieving the primary objective of any quarantine system, being prevention of the further transmission of the virus.

11. One only has to look at the risks of infectious outbreaks in any healthcare facility to appreciate that putting infectious or potentially infectious people together and, of necessity, then having considerable numbers of workers of all types being required to come in and out of that facility, creates considerable complexity and risk. The evidence to this Inquiry makes that plain. There is a risk associated with concentrating large numbers of people who are infectious in a single environment. Specifically, there is a risk that they will infect one another, and that they will infect clinical and non-clinical personnel working within the quarantine facility.[4]

12. If one adds to this the increased risks of transmission by having people escorted in and out of the facility to provide for fresh air, smoking breaks and some exercise in order to address health and welfare needs, the case for an option for home quarantining in certain cases becomes stronger.

13. Where a person can safely quarantine at home this avoids the risk of putting that person in physical proximity with others who are suspected of having COVID-19. It also reduces the number of workers required in the quarantine facility, thereby reducing the number of people potentially being exposed to the risk of contracting the virus.

14. Such a program needs to include substantially improved communication methods to ensure people understand the gravity and nature of directions issued pursuant to s. 200 of the PHW Act (Directions), and the very substantial consequences of non-compliance with them. It also needs to involve robust methods for monitoring compliance with Directions, and heavy penalties for non-compliance with them.

2.3 Health and welfare concerns and the Charter

15. Being able to quarantine at home lessens the potential impact on people's health and wellbeing that might otherwise occur as a result of their 14-day containment in a hotel room, which is currently the most likely quarantine facility. It also addresses concerns raised by DHHS witnesses and others about the need to balance the impact of obligations under the Victorian Charter of Human Rights and Responsibilities with the need to protect the health of all Victorians.[5]

16. It was variously said that people would have felt less vulnerable to infection in their own homes; they would have felt more comfortable and less anxious, better equipped to care for children, and better able to manage pre-existing physical and mental health conditions.[6]

17. Mr Hugh de Kretser, Executive Director of the Human Rights Law Centre, gave evidence to the Inquiry about his experience as a returned traveller detained at the Rydges Hotel in Carlton between 27 June and 9 July 2020, with his wife and children.[7] He also provided an insightful submission to the Inquiry, drawing upon his professional familiarity with human rights law. Mr de Kretser observed that detention, in particular the detention of children, is a serious restriction upon human rights that should only be used as a last resort.[8] He further observed that detention in any form involves risks around safety, mental health and mistreatment, and that detention in a quarantine facility carries additional risks of virus transmission to otherwise healthy people who are being detained, as well as to personnel.[9] He submitted that requiring a person to quarantine in their own home will reduce risks to that person's safety and welfare and to personnel but may carry with it increased risks to the community.[10]

18. Dr van Diemen received advice about the human rights considerations associated with the issuing of individual detention notices at the time the Hotel Quarantine Program commenced. That advice relevantly concluded:

> Accordingly, hotel detention for international arrivals constitutes a reasonably necessary course of action in the current exceptional circumstances. On current medical evidence, it is also the least restrictive means reasonably available to stem the spread and effect of 2019-nCoV, particularly since less restrictive measures for international arrivals previously proved ineffective, with some persons returning from overseas failing to self-isolate in their homes for 14 days — in clear defiance of previous directions — thereby causing the further spread of the virus.[11]

19. An ability to have had a closer examination of the evidence as to 'non-compliance' provides a better understanding of what needs to be addressed to establish a sophisticated, well supported home-based model.

20. Ms Pam Williams, DHHS COVID-19 Accommodation Commander, expressed the view that the program could have adopted a more nuanced assessment of the balance between transmission risk and guest health, wellbeing and human rights.[12]

21. In my view, a more nuanced and informed assessment of the capacity and suitability of each returning traveller or international arrival to home quarantine would be consistent with the Charter requirement to take the least restrictive means reasonably available in reducing the risk to public health.

2.4 Financial cost of the Hotel Quarantine Program

22. The Inquiry received information that the direct financial cost of the Hotel Quarantine Program to the State[13] was around $195 million. Broken down by department:

    A. The Department of Jobs, Precincts and Regions (DJPR) spent approximately $133.4 million to 30 June 2020

    B. The Department of Health and Human Services (DHHS) spent approximately $51.288 million to 16 September 2020

    C. The Department of Justice and Community Safety (DJCS) spent approximately $10.90 million to 30 September 2020.

23. On any measure, the cost of the Hotel Quarantine Program until the end of September 2020 has been considerable. The amount incurred by DJPR alone demonstrates the considerable cost involved in securing hotel rooms, engaging security guards and acquiring specialised cleaning services.

24. A range of resources will be needed to support people quarantining at home such as extra nursing, food delivery and compliance checking (whether by electronic means and/or personnel based) to give effect to a properly supported and managed home-based model. The costs of home quarantine on a per capita basis may well be less than the model examined during this Inquiry.

25. Without proper financial analysis and modelling it is not possible to make such a comparison, but that work should be undertaken. It is not suggested that when doing all things necessary to combat this virus that cost should be a deciding factor for a quarantine model; the matter is raised here for consideration.

2.5 AHPPC advice

26. The decision to require returning travellers to quarantine in 'designated facilities' such as hotels was made by National Cabinet on 27 March 2020.[14] However, on the best evidence available to the Inquiry (noting the limitations on the capacity of the Inquiry to obtain National Cabinet-in-Confidence material), was that this decision was not endorsed by the AHPPC either immediately prior to or immediately following the National Cabinet meeting.[15]

27. Insofar as the evidence to the Inquiry indicates, the AHPPC's earliest express concurrence with National Cabinet's decision to require returning international arrivals to quarantine for 14 days in a designated facility was not until June 2020, by which time the program in each state and territory was already at least two-and-a-half months old.[16]

28. In its advice, provided on the morning prior to the National Cabinet meeting on 27 March 2020, the AHPPC recommended enforcing the monitored placement of returned travellers in facilities such as hotels, only in **high-risk** [emphasis added] cases where those persons would normally reside with others at home.[17]

29. Following National Cabinet's decision on 27 March 2020, the AHPPC met to consider a national response to COVID-19. However, the best evidence before the Inquiry is that on this occasion the AHPPC again did not agree or resolve to advise that all returning travellers be required to undertake 14 days' quarantine at a designated facility.[18]

30. This position appears to have changed in the months following the implementation of the Hotel Quarantine Programs across Australia. On 26 June 2020, the AHPPC published a statement noting that, on the advice of the Communicable Diseases Network Australia (CDNA), the AHPPC considered two options for addressing what it described as, at that time, an increasing risk of COVID-19 in returning travellers:[19]

    A. reducing the time of quarantine in a hotel for international travellers. This includes most spending part of the time in home quarantine

    B. continuing the current model of 14-day quarantine in a hotel.

31. The statement noted that, having considered these options, the AHPPC:

    A. considered that there was not enough data to justify reducing the need for hotel quarantine

    B. recommended that all international travellers continue to undertake 14 days' quarantine in a supervised hotel.

32. On the evidence, this is the first indication of advice from the AHPPC about what was by then hotel quarantine programs across the country. Until this statement, there does not appear to have been agreement about the merits of mass quarantine in designated facilities such as hotels.

33. Since that AHPPC statement on 26 June 2020, on 29 September 2020, Prime Minister Scott Morrison announced that the AHPPC would again consider the role of home quarantine in Australia's continued response to COVID-19, stating:

> Now, I think home quarantine can play a role in the future and it's something that is being considered by the AHPPC and particularly as we sort of move beyond the phase we're in now and we do look to see, to have others, our borders open up at some point to safe locations whether it be New Zealand or parts of the Pacific or places like South Korea or Japan or countries that have had, I think, a much, higher rate of success, then there are opportunities to look at those alternative methods, a triaging if you like. And many countries do this. I mean Denmark operates on a traffic light system which goes along those sorts of lines. In Greece, they have an algorithm which triages people based on where they've come from and where they've been and that quantifies the risk. Because at the end of the day, the answer to your question is really about how you're going to manage risk and how you're going to identify it and then apply the right solution to the risk that presents and I think as time goes on, we will need a more flexible approach that gives us more options for managing this, so I think that is something that is under active consideration, when it comes in, well that will obviously be determined principally by the health advice that can provide a green light to those sorts of options again but I'm hopeful it's something we can move to.[20]

34. The advice given by the AHPPC to National Cabinet in March (and I infer, which remained unchanged through April and May, and most of June 2020) is consistent with the views I have expressed in respect of the availability of a home-based model. It also accords with the more 'flexible' or 'nuanced' approaches identified as apparently emerging from the AHPPC in September, as mentioned by the Prime Minister (above) and Ms Williams in her evidence to the Inquiry.[21]

2.6 Opinions as to the possibility of a home-based model

35. In her statement to the Inquiry, Ms Williams observed:

> Hotel quarantine was based on the simple premise that detaining a person arriving from overseas inside a hotel room for 14 days would reduce the risk of transmission of the virus into the Australian community. Underpinning this premise is an assumption that the detention is possible (i.e. appropriate facilities exist and people will be compliant) and that the detention can be achieved without undue impact on the health and wellbeing of the detainee.[22]

36. When asked by Counsel Assisting about alternative options for containing the spread of COVID-19 from returned travellers, Ms Williams raised the possibility of a hybrid system, where travellers spend at least some of their 14-day quarantine period isolated in their own homes. Ms Williams also observed that when increased testing among returned travellers was introduced, DHHS found that most people who were carrying the virus returned positive tests results within the first seven-to-eight days of their quarantine. She said, 'the major risk of identifying people occurred in that first week or a little bit. So it may have been possible to detain people for a shorter period, and then ask them to self-isolate.'[23]

37. Ms Jane Halton, Chair of the Coalition for Epidemic Preparedness Innovations, recently identified that successful models of home quarantine have been implemented in the ACT and that 'there are other models that can be used successfully, whilst protecting the community'.[24]

38. Prof. Sutton also gave evidence about alternative approaches to quarantining based on risk stratification. He said:

> Certainly we've had continuing discussions nationally about other potential approaches to mandatory quarantine, that attempts to risk-stratify and to do so on the basis, for example, of country of origin, how much testing is being done there and what the prevalence might be in those countries. Obviously there have been discussions with New Zealand about a travel bubble and an exemption to that quarantine process, and I'm aware of other Western Pacific nations like the Solomon Islands, like Vanuatu, that appear to be free of COVID-19. So I think going forward, **it's not unreasonable to look at a risk-stratified approach** (emphasis added)**.**[25]

39. Ms Skilbeck gave evidence that in May 2020 in particular, DHHS observed a pattern that indicated all but 0.3 per cent of positive cases were identified by the day three test (or, in other words, 99.7 per cent of positive cases had been identified in this timeframe).[26]

40. While this led to some consideration within DHHS as to whether a model incorporating some home-based quarantine could be used as a means of increasing capacity in the Hotel Quarantine Program, that did not eventuate.[27] In response to questions as to why the idea did not progress, Ms Skilbeck identified the following:

    A. The initial observation that all but 0.3 per cent of positive cases were identified by the day three test was not maintained. By June, the demographic of returning travellers had changed and involved more people repatriating to Australia and higher positive rates were being observed.[28] Therefore, she suggested, the risk of only relying upon the day three test results became 'unreasonable'.[29]

    B. Public expectation about the management of the virus was very high. She described the issue as 'emotionally held' and requiring 'as close to perfection as possible'. She said it was very difficult to provide that level of confidence.[30]

    C. The proposal relied upon the availability of a rapid and accurate testing system that could be administered on day seven to confirm with certainty a day three COVID-negative result.[31]

    D. The proportion of travellers that had a home in Victoria that was suitable for self-isolation was, at most, probably 50 to 60 per cent. The large majority of the remainder had homes interstate and around 10 per cent of returned travellers had no premises in which they could safely isolate from the community.[32]

41. All of these issues were properly worthy of consideration and remain so.

42. The impact of community expectations on the perception of home-based quarantine being a suitable alternative model was echoed by Prof. Sutton. In his evidence, Prof. Sutton observed that home-based quarantine might be a reasonable approach to take in other jurisdictions such as European countries, but that in the Australian context community expectations may not allow it:

> If we are in a situation like Europe, home quarantine is a very reasonable approach to take because there is no way that they're going to get to zero community transmission. But with much of Australia already at that level and with the potential prospect of the whole of Australia getting to that point, the tolerance for having one in 1,000 or even one in 10,000 travellers, knowing how many come through each week, bringing coronavirus to the community is probably extremely quite low. And they wouldn't like it in another jurisdiction, with the prospect of them not being able to ensure open borders or free travel across the country. So I think it's not out of the question and there are probably ways to mitigate the risk very substantially with testing, with other mechanisms of ensuring compliance with home quarantine, but it hasn't been explored in full or agreed nationally, which is really a key consideration for me.[33]

43. The evidence from Ms Skillbeck and Prof. Sutton suggests that public perception was at least part of the reason for mandating quarantining in hotels rather than in the home.

44. The importance of the public's perception about the efficacy and sufficiency of a government's response to an emergency such as a pandemic is completely understandable. Equally, the public must have confidence that government decision-makers are acting prudently and on sound expert advice.

45. In light of what is now known, and in the absence of the intense exigencies of time that applied to the implementation of the Hotel Quarantine Program across a weekend, the future Quarantine Program should be developed with these lessons in mind. Public perception is one thing — and it is an important thing — but in a program designed to curtail the spread of a potentially deadly pathogen, an evidence-based, humane and health-focussed response must be the primary driver. Those considerations, where conflicting with public perception, must carry the day and drive the nature of the response.

2.7 Previous forms of communicating and enforcing initial requirements for self-quarantine

46. Following National Cabinet's announcement on 15 March 2020, the Commonwealth Government, through the Australian Border Force (ABF) and the Department of Agriculture, Water and the Environment (DAWE), put arrangements in place to inform all returning travellers of the need to self-quarantine for 14 days. Those arrangements involved:[34]

    A. Requiring aircrew of incoming flights to make announcements over the aircraft's public address systems and throughout the airport.

    B. Providing incoming travellers with an Isolation Declaration Card – Coronavirus (COVID-19). These were printed in English and Chinese and stated that the person was required to quarantine for 14 days, outlined non-specific potential consequences of non-compliance, asked travellers to sign a declaration stating that they understood the need to quarantine for 14 days and requiring them to specify the address at which they would undertake their 14-day mandatory quarantine.

    C. Biosecurity officers from the DAWE being available to meet incoming travellers at their aircraft and provide them with an information sheet outlining the requirement that they self-quarantine for 14 days.

    D. Information being provided through various Commonwealth Government social media and advertising initiatives, and on websites hosted by the Commonwealth Government.

47. Victoria put in place additional measures to inform incoming travellers of the self-isolation requirements, including:

    A. On 15 and 16 March 2020, DHHS updated its website.

    B. On 16 March 2020, the Premier made announcements to the public.

    C. On 17 March 2020, DHHS further updated its website, specifically its 'Frequently Asked Questions' section.

    D. On 20 March 2020, DHHS added a document titled 'COVID-19 self-quarantine for international arrivals – what you need to know' to its website. The document was later printed and distributed to returning travellers by departmental personnel.

    E. On 21 March 2020, DHHS made further updates to the 'Frequently Asked Questions' section of its website, including the addition of an entire section for returned travellers.[35]

48. On 16 March 2020, to assist in enforcing the Directions including the Self-Quarantine Directions in place at the time (Self-Quarantine Directions),[36] the Chief Health Officer requested assistance from Victoria Police under s. 202(2) of the PHW Act.[37]

49. In my view, this communication and enforcement regime fell well short of what is needed for an effective home-based model. In my view, nothing short of face-to-face individual engagement with each adult returning to Victoria is required in order for a home-based model to function effectively.

50. I accept that the opportunity for the communication and enforcement regime applying to the Self-Quarantine Directions to improve over time was short-lived. The first Self-Quarantine Directions were issued on 16 March 2020.[38] Just 12 days later, on 28 March 2020, the Self-Quarantine Directions were revoked and replaced with Direction and Detention Notices requiring people to quarantine in hotels.[39]

51. As indicated in paragraphs 53–66 below, a contributor to the transition from self-quarantine at home to detention in hotels appears to have been reports of non-compliance with the Self-Quarantine Directions.

52. These reports indicate that non-compliance rates at the time were due, at least in part, to a lack of understanding about the requirements of the Self-Quarantine Directions by those required to self-quarantine. In any home-based model, communication methods will need to be fundamentally changed to avoid such misunderstandings.

2.8 Risk of spread from non-compliance during self-quarantine

53. Dr van Diemen gave evidence that, around 27 March 2020, she formed an independent view that it was necessary to require people to enter quarantine at a hotel rather than self-quarantine at home in part because of the perceived increase in transmissions from returned travellers who were not adhering to the Self-Quarantine Directions.[40]

54. Dr van Diemen stated:

> [W]e had observed, through cases that were identified and subsequently interviewed and outbreaks had occurred, that there were people not adhering to the current requirements. Despite having signed the arrivals card when they got into the state to say that they would quarantine, that they had in fact not done that. And these were just the people who told us that they hadn't done that when they got diagnosed, not necessarily the ones that we didn't find out about because they were not diagnosed or the ones who decided not to tell us that they had not been adhering to the home quarantine.[41]

55. Later in her evidence, Dr van Diemen was asked about a tension between people, including those who were COVID-19 positive, being allowed to return to their homes at the end of their 14-day hotel quarantine period and the overarching principle of containment espoused by the Hotel Quarantine Program. She said:

> I see a tension could be perceived. I believe that people's behaviour shifts significantly when they know that they have an infectious disease that is causing a worldwide pandemic, compared to when they have not been diagnosed with that condition, and that people … most people don't believe they will get COVID until they get it, if that makes sense. I also know that the compliance and daily check activities around cases was significantly greater than for contacts and returned travellers before the Hotel Quarantine Program, simply by virtue of numbers. There was physically no way of calling every returned traveller who was coming into the country in early March; there was tens of thousands of them.[42]

56. Dr van Diemen went on to explain the types of checks that were carried out on COVID-positive guests released following 14 days of hotel quarantine as follows:

> …those people were receiving daily phone calls from the Case and Contact Management Team, they were receiving intermittent checks from police and they were also receiving daily text messages in which they were required to confirm that they were continuing to isolate at their address. So there were a number of compliance activities being undertaken for these particular people as well.[43]

57. That is, insofar as DHHS assessed at that time, for the reasons given by Dr van Diemen, it was considered satisfactory to allow those who had tested positive to COVID-19 to be released home, subject to Diagnosed Persons and Close Contact Directions, with the compliance monitoring and checks in place at that time.

Actual rates of non-compliance with the Self-Quarantine Directions

58. During a press conference held on 23 March 2020, then Chief Commissioner of Police Graham Ashton made the following comments on the level of compliance with directions then in place:

> We've had instances where in the spot checks people haven't been at home when they should have been at home and people that have [indistinct] said we're at home for some of the time, other times we're out shopping; we're out doing things. So clearly the message hasn't been getting through to the degree that we really need to see to make sure that we can deal with this health emergency in a proper way.[44]

59. On 25 March 2020, Mr Ashton made the following further comments:

> To date, so far we've had … about 88 visits today … as of today, and we've been doing a lot more today with the extra numbers out from today. But of those 88, we've had 70 people home and doing what they were supposed to be doing as far as isolating themselves. Seven people were not home. We're doing follow ups as to where those people are. We had a couple of people who had provided the wrong details to Border Force as to where they were supposed to be going to when they returned from overseas, so obviously following those up as well.
>
> …
>
> We haven't fined anyone yet because people that we have found that haven't been complying haven't quite understood it, haven't got it, deeply apologetic and they're doing the right thing now. So, we've applied the common sense principle to that. If we get someone that is absolutely flouting it, absolutely we'll be processing the paperwork.[45]

60. Mr Ashton elaborated on the compliance checking process in his evidence. He stated that he received daily reports that included instances where people were found not to be at home during compliance checks. He added that in many cases people were isolating, but not at the places the ABF thought they would be. He said that, as a result, Victoria Police had to adjust its records and 'clean the data a lot on where people actually were'.[46]

61. Victoria Police advised that it receives notices that individual community members are COVID-19-positive and therefore subject to the Self-Isolation Directions by way of a secure information portal managed by DHHS, pursuant to an Information Sharing Agreement between DHHS and Victoria Police.[47] It is unclear what process was in place for notifying Victoria Police about people subject to Self-Quarantine Directions. Victoria Police advised that notification occurred in such cases via daily situation reports from DJPR, which included the names of people arriving into Melbourne, the flights they were on and the hotels to which they had been allocated. This is despite the fact that people subject to Self-Quarantine Directions would have been required to quarantine at home rather than in hotels.

62. Whatever process was in place, in any home-based model, there needs to be a clear, timely and accurate method of communicating the details of those subject to Home Quarantine Directions to the body responsible for conducting monitoring and compliance activities so that they may discharge those duties effectively.

63. Victoria Police advised the Inquiry that, as at 16 September 2020, its members had issued approximately 87 infringement notices relating to breaches of Self-Isolation and Self-Quarantine Directions, and 172 warnings.[48] Victoria Police did not advise when these alleged breaches occurred, nor the proportion of breaches relating to each class of Direction.

64. On 15 August 2020, Prof. Sutton said during a press conference that still more needed to be done to engage with culturally and linguistically diverse communities during the pandemic.[49] As noted above, this was an issue also experienced in respect to contact tracing, particularly in relation to the outbreaks from the Rydges and Stamford Plaza hotels.[50] The evidence suggests that the messaging from the government to certain segments of the Victorian community was inadequate in general, and specifically in relation to the Self-Quarantine Directions.

65. Furthermore, there have been concerns expressed publicly that suggest that there were inadequacies in the quality of communications with the public about the requirements of various Directions. These breakdowns in communication were raised again in July 2020 when cases amongst residents of public housing towers in Melbourne surged. At that time, community leaders were reported publicly as observing that communication of public health orders was insufficient, particularly for non-English speakers, and that this was exacerbated as restrictions rapidly changed throughout May.[51]

66. The concerns about non-compliance are proper and must be addressed in a home-based model. The very generalised communications and information to all international arrivals such as that which existed prior to 29 March 2020 must be changed to individualised engagement both for assessment and to ensure all people being assessed as suitable to quarantine at home fully understand what they are being directed to do and what the penalties are for failing to comply with those Directions (see Recommendations 60–67).

2.9 Assessment and engagement

67. The process or mechanics of how such assessment and engagement can take place will self-evidently need to be addressed.

68. However, general announcements on aeroplanes in Chinese and English, signing generic cards and being handed leaflets at the airport will not address what is necessary to support a robust home-based model. The model must be supported by a proper evidence-based risk assessment process underwritten by engagement that provides any necessary language and cultural supports to ensure all aspects of compliance are understood and accepted.

69. It is apparent that this engagement and assessment would stand little prospect of being able to be managed with the necessary rigour in circumstances where unknown and uncontrolled numbers of international arrivals recommenced coming in through international points of entry into Victoria.

70. Creating an appropriate grid or checklist for the proper consideration of criteria for assessment as to suitability for home quarantine must be done by those with the necessary expertise. Those who are assigned to apply those criteria must also be appropriately qualified, trained and supported with the necessary resources to make those assessments (see Recommendations 60–62).

71. The need for far better liaison, information gathering and sharing between State and Commonwealth officials is reiterated here. It is fundamental to those engaged with the responsibility to make the risk assessments that they be provided with as much information as can be practicably obtained, as far in advance as possible of a person's arrival into Victoria (see Recommendation 4).

72. Given the evidence as to some inaccuracies in information that was provided, it would be appropriate to ensure that any necessary checks as to the accuracy of information being provided, such as the proposed address for home-based quarantine, be confirmed by some form of appropriate check. The development of a home-based model, as a minimum, must therefore address all of these issues.

2.10 A home-based model: Recommendations 58–69

Taking into account all of the above, I recommend that:

Home-based quarantine as an option

58. In conjunction with a facility-based model for international arrivals, the Victorian Government develops the necessary functionality to implement a supported home-based model for all international arrivals assessed as suitable for such an option.

Control on numbers arriving

59. The Victorian Government does all things possible to ensure that appropriate controls are put in place to limit the number of international arrivals at any given time to make the necessary individual engagement and assessment for a home-based model practical and achievable.

Assessment of risk factors for home quarantine

60. The Victorian Government engages the appropriate expertise to develop a list of risk and protective factors to be used in the assessment of individual suitability for the home-based model.

61. To assist the Chief Health Officer and Authorised Officers in making such assessments, the Victorian Government engages personnel with the appropriate expertise and training, supported by the necessary resources, to support the Chief Health Officer and Authorised Officers to apply those risk factors to the individual circumstances of international arrivals.

62. The Victorian Government ensures that the Chief Health Officer and Authorised Officers are provided with the capacity and necessary resources to efficiently confirm the accuracy of information being provided for individual assessments of international arrivals.

Individual engagement

63. The Victorian Government takes all necessary steps to address the language and cultural needs of all international arrivals to ensure that accurate information as to legal obligations and penalties for non-compliance is both obtained for assessment purposes and received and understood by the person subject to the Home Quarantine Directions.

64. The Victorian Government takes all reasonable steps to assess and provide any reasonable supports that may assist an individual or family to quarantine at home.

Conditions of Home Quarantine Directions accepted in the form of a personal undertaking

65. Accepting the need to do all things necessary to mitigate against the risk of non-compliance with a Home Quarantine Direction made by the Chief Health Officer or Authorised Officer, the Chief Health Officer or Authorised Officer could consider making the Home Quarantine Direction conditional upon the eligible person entering into a written undertaking, which could contain specific requirements that they must agree to, including (but not limited to):

    A. to submit to such COVID-19 testing during the period of home quarantine as is specified by the Chief Health Officer or Authorised Officer

    B. to allow such people as are required to carry out such testing to enter the premises at which the person is detained to conduct such testing

    C. to provide during the period of detention such information as is reasonably required by the Chief Health Officer or Authorised Officer in order to review whether their detention continues to be reasonably necessary.

66. Further, to underscore the gravity of any non-compliance, such an undertaking or agreement could also include an assurance from each person (over the age of 18 years) that they understand and agree to comply with each of the conditions of their quarantine and have understood the penalties that apply to any breaches.

Monitoring and compliance

67. The Victorian Government considers enhancing the range of methods for monitoring compliance with Home Quarantine requirements, such as electronic monitoring using smart phone technology and the use of ankle or wrist monitoring systems.

Penalties for non-compliance

68. The Victorian Government, in recognition of the risks to public health associated with any non-compliance with the Home Quarantine Directions, considers whether the current penalty regime is sufficiently weighted to enforce compliance.

69. The Victorian Government, in recognition of the risks to public health associated with any non-compliance with Home Quarantine Directions, considers whether an offence should be created to apply to any person who knowingly enters a place where a person has been directed to Home Quarantine, unless that person has been authorised by the Chief Health Officer or Authorised Officer to do so.

Endnotes

1 For the purposes of this report, the expression 'home' or 'home-based' is hereafter intended to include both a private residence that is a person's home and any other suitable form of private residence except where otherwise indicated.
2 Parliament of Victoria, Public Accounts and Estimates Committee, Inquiry into the Victorian Government's response to the Covid-19 Pandemic- Interim Report, (July 2020) <https://parliament.vic.gov.au/images/stories/committees/paec/COVID-19_Inquiry/Report/PAEC_59-07_Vic_Gov_response_COVID-19_Interim_report.pdf>.
3 Exhibit HQI0218 Witness statement of the Hon. Daniel Andrews MP, 3 [13].
4 ExhibitHQI0204_RP Annexures to witness statement of 'DHHS Infection Control Consultant', DHS.0001.0112.0022.
5 Exhibit HQI0186_RP First witness statement of Ms Kym Peake, 35 [175]-[178]; Exhibit HQI0153_RP Witness statement of Prof. Brett Sutton, 17 [85], 18 [89], 21 [110]-[111]; Exhibit HQI0160_P Witness statement of Dr Annaliese van Diemen, 8 [37].
6 Exhibit HQI0014_RP Witness statement of Mr Michael Tait, 7 [56]; Transcript of day 5 hearing 20 August 2020, 199-200; Transcript of day 6 hearing 20 August 2020, 257; Exhibit HQI0022_RP Annexure to witness statement of Ms Liliana Ratcliff.
7 Exhibit HQI0016_P Witness statement of Hugh de Kretser, 1 [7].
8 Ibid 11 [83].
9 Ibid.
10 Ibid [84].
11 Exhibit HQI0226_RP Bundle of notices and advices tendered by DHHS, DHHS.0001.0004.1873 [12].
12 HQI0130_RP Witness statement of Ms Pam Williams, 36 [94].
13 By letter dated 9 October 2020 from the Department of Premier and Cabinet.
14 Exhibit HQI0177_RP First witness statement of Mr Christopher Eccles, 18-19 [77].
15 Exhibit HQI0153_P Witness statement of Prof. Brett Sutton, [117], [176]-[177].
16 AHPPC, Australian Health Protection Principal Committee (AHPPC) statement on hotel quarantine (News Release, 26 June 2020) <https://www.health.gov.au/news/australian-health-protection-principal-committee-ahppc-statement-on-hotel-quarantine>.
17 Exhibit HQI0218_P Witness statement of the Hon. Daniel Andrews MP, 3 [13].
18 Exhibit HQI0153_P Witness statement of Prof. Brett Sutton, 32 [176]-[177].
19 AHPPC, Australian Health Protection Principal Committee (AHPPC) statement on hotel quarantine (News Release, 26 June 2020) <https://www.health.gov.au/news/australian-health-protection-principal-committee-ahppc-statement-on-hotel-quarantine>.
20 Prime Minister of Australia, The Hon. Scott Morrison MP, 'Press Conference Australian Parliament House, ACT' (Transcript, 29 September 2020) <https://www.pm.gov.au/media/press-conference-australian-parliament-house-act-25>.
21 Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 36 [94]; Transcript of day 16 hearing 11 September 2020, 1273.
22 Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 36 [94].
23 Transcript of day 16 hearing 11 September 2020, 1276.
24 'Interview with Jane Halton AO, Chair of the Coalition for Epidemic Preparedness Innovations', Radio National Breakfast, (ABC Radio National, 9 October 2020) <https://www.abc.net.au/radionational/programs/breakfast/09-10-20/12746482> 01:39:10.
25 Transcript of day 18 hearing 16 September 2020, 1482.
26 Transcript of day 15 hearing 10 September 2020, 1220.
27 Ibid.
28 Transcript day 8 hearing 27 August 2020, 493; Transcript day 15 hearing 10 September 2020, 1228.
29 Transcript day 15 hearing 10 September 2020, 1228.
30 Ibid.
31 Ibid.
32 Ibid 1228-1229.
33 Transcript of day 18 hearing 16 September 2020, 1482.
34 Exhibit HQI0188_RP Second witness statement of Ms Kym Peake, 2-3 [12].
35 Ibid 3-4 [13].

36 Direction from the Chief Health Officer in accordance with emergency powers arising from declared state of emergency issued, <https://www.localgovernment.vic.gov.au/__data/assets/pdf_file/0023/458411/BULLETIN-8_2020-DIRECTION-FROM-THE-CHIEF-HEALTH-OFFICER-ATTACHMENT.pdf>.
37 Exhibit HQI0188_RP Second witness statement of Ms Kym Peake, 9 [18]; Exhibit HQI0190_RP Annexures to the second witness statement of Ms Kym Peake, DHS.5000.0055.3884.
38 These were replaced on 18 March 2020 by the relevantly equivalent Airport Arrivals Directions, <https://www.dhhs.vic.gov.au/sites/default/files/documents/202003/state-of-emergency-signed-direction-airport-arrivals-%28DCHO%29-20200318.pdf>.
39 See Revocation of Airport Arrivals Direction and Cruise Ship Docking Direction, <http://www.gazette.vic.gov.au/gazette/Gazettes2020/GG2020S167.pdf>; Direction and Detention Notice (No 3), <https://www.dhhs.vic.gov.au/sites/default/files/documents/202003/detention-notice-signed-2020-03-28.pdf>.
40 Transcript of day 18 hearing 16 September 2020, 1536-1537.
41 Ibid 1537.
42 Ibid 1551.
43 Ibid 1559.
44 Exhibit HQI0220_P Transcript of press conference by the Hon. Daniel Andrews MP, 8.
45 Exhibit HQI0221, Transcript of former Chief Commissioner Graham Ashton's press conference, 2-4.
46 Transcript of day 19 hearing 17 September 2020, 1681.
47 Letter from Norton Rose Fulbright on behalf of Victoria Police, 16 September 2020, 1.
48 Ibid 2.
49 Yara Murray-Atfield, 'Victorian coronavirus response 'not doing enough' to reach key groups, Chief Health Officer says', ABC (online, 15 August 2020) <https://www.abc.net.au/news/2020-08-15/victorian-coronavirus-messaging-could-reach-more-people-cho-says/12560986>.
50 Exhibit HQI00097_RP Witness statement of Dr Clare Looker, 21 [95].
51 Frances Mao, 'Coronavirus: Why has Melbourne's outbreak worsened', BBC (online, 3 July 2020) <https://www.bbc.com/news/world-australia-53259356>.

Appendices

Appendix A: List of Abbreviations

Acronym	Meaning
ABF	Australian Border Force
AEOC	Ambulance Emergency Operations Centre
AHPPC	Australian Health Protection Principal Committee
AV	Ambulance Victoria
CHO	Chief Health Officer
CDNA	Communicable Diseases Network Australia
DAWE	Department of Agriculture, Water and Environment (Cth)
DCHO	Deputy Chief Health Officer
DHHS	Department of Health and Human Services (Victoria)
DJCS	Department of Justice and Community Safety (Victoria)
DJPR	Department of Jobs, Precincts and Regions (Victoria)
PHW Act	Public Health and Wellbeing Act 2008 (Vic)
PPE	Personal protective equipment
SJAA	St. John's Ambulance Australia

Appendix B: Glossary

Term	Definition
Authorised Officer	A person appointed under the *Public Health and Wellbeing Act 2008* (Vic) with power to enforce compliance with Detention Directions
Cases	Individuals who test positive to COVID-19
Charter	*Charter of Human Rights and Responsibilities Act 2006* (Vic)
Contacts	Individuals who may have been exposed to COVID-19
Detention Direction	A direction issued by the Chief Health Officer or their delegate under the *Public Health and Wellbeing Act 2008* (Vic) mandating an individual into quarantine
Fomite transmission	Fomites are surfaces or objects (including hands) that may become contaminated and serve as an intermediary vehicle for transmission
Green zone	A designated 'clean' area in a quarantine facility where no PPE is to be worn
Infection prevention and control	A scientific and risk management approach designed to prevent harm caused by infection to patients and health workers
Infectious period	The length of time an individual can transmit COVID-19
International arrivals	People who may visit Victoria and be required to quarantine under the new Quarantine Program
Isolate / quarantine	The terms 'isolate' and 'quarantine' are given distinct and separate meanings on DHHS' website: https://www.dhhs.vic.gov.au/self-quarantine-coronavirus-covid-19#when-do-i-isolate. The term 'isolate' is used to describe the process of separating people with COVID-19 from people who do not have the virus. The term 'quarantine' is used describe the process of separating and restricting the movement of people who have been or may have been exposed to COVID-19. Notwithstanding this distinction, the terms 'isolate' and 'quarantine' were often used interchangeably throughout the evidence to this Inquiry. In this report, where witness evidence containing the terms 'isolate' or 'quarantine' is quoted or otherwise referred to, the terminology adopted by that witness is used. In all other contexts, the report adopts the distinction outlined above, and uses the terms 'isolate' and 'quarantine' accordingly
Personal protective equipment (PPE)	PPE refers to anything used or worn to minimise risk to workers' health and safety. PPE for COVID-19 includes surgical masks, particulate filter respirators (such as P2 or N95), gloves, goggles, glasses, face shields, gowns and aprons. See Department of Health website for further information: https://www.health.gov.au/news/health-alerts/novel-coronavirus-2019-ncov-health-alert/coronavirus-covid-19-advice-for-the-health-and-disability-sector/personal-protective-equipment-ppe-for-the-health-workforce-during-covid-19
Quarantine Governing Body	A body that consists of appropriate senior members of the governance structure, which meets regularly, is chaired by the Secretary to the responsible Minister, maintains records of its meetings including records of all decisions reached, and provides reports to the Minister from those meetings and in respect of decisions reached
Red zone	A designated area in a quarantine facility where PPE must be worn
Returned travellers	People who returned to Victoria and quarantined in the initial Hotel Quarantine Program
Safer Care Victoria	A Victorian State authority that leads quality and safety improvements in healthcare settings
Swab testing	Swabbing of areas after they have undergone an infectious clean to verify the area is actually clean

Appendix C: Terms of Reference

You are required to inquire into, report and make any recommendations considered appropriate in relation to the following terms of reference:

1. The decisions and actions of Victorian government agencies, hotel operators and Private Service Providers, including their personnel/contractors and any other relevant personnel involved in the Quarantine Program (each Relevant Personnel), relating to COVID-19 Quarantine Containment;
2. Communications between Victorian government agencies, hotel operators and Private Service Providers relating to COVID-19 Quarantine Containment;
3. The contractual arrangements in place across Victorian government agencies, hotel operators and Private Service Providers to the extent they relate to COVID-19 Quarantine Containment;
4. The information, guidance, training and equipment provided to Relevant Personnel for COVID-19 Quarantine Containment and whether such guidance or training was followed, and such equipment was properly used;
5. The policies, protocols and procedures applied by Relevant Personnel for COVID-19 Quarantine Containment; and
6. Any other matters necessary to satisfactorily resolve the matters set out in paragraphs 1 to 5.

Appendix D: Order in Council - 29 October 2020 - Extension of reporting date for Board of Inquiry

Inquiries Act 2014

AMENDED TERMS OF REFERENCE FOR THE BOARD OF INQUIRY INTO THE COVID-19 HOTEL QUARANTINE PROGRAM

ORDER IN COUNCIL

The Governor in Council, on the recommendation of the Premier under section 53 of the **Inquiries Act 2014**, amends the Order in Council dated 2 July 2020 (as amended by a further Order in Council dated 5 August 2020) establishing the Board of Inquiry into the COVID-19 Hotel Quarantine Program by:

1. For the words "You must report your findings and any recommendations to the Governor as soon as possible, and not later than 6 November 2020" under the heading "Reporting Dates" **substituting** "You must report your interim findings and any recommendations to the Governor as soon as possible, and not later than 6 November 2020, and you must report your final findings and any recommendations to the Governor as soon as possible, and not later than 21 December 2020".

This Order comes into effect on the date it is published in the Government Gazette.

Dated: 29 OCT 2020

Responsible Minister:

The Hon Daniel Andrews MP
Premier

C. Chisholm
Clerk of the Executive Council

OFFICIAL

COVID-19
Hotel Quarantine Inquiry

COVID-19
Hotel Quarantine Inquiry
Interim Report and Recommendations

WWW.QUARANTINEINQUIRY.VIC.GOV.AU