CHAPTER 10

Testing for COVID-19 at quarantine hotels

10.1 The initial testing regime for the Hotel Quarantine Program

1. Testing of those detained in the Hotel Quarantine Program was clearly an important aspect of its stated aim, being to minimise the possibility of COVID-19 transmission into the community via returning travellers and to, accordingly, determine the exit management of detainees.
2. The initial testing regime for the Hotel Quarantine Program was only offered to those people placed in quarantine who reported symptoms of COVID-19. The evidence was that this was consistent with the public health advice at the time.[1] The Chief Health Officer (CHO), Professor Brett Sutton, stated that:

> In the beginning of the Hotel Quarantine Program across Australia, there was certainly a view that anyone who became symptomatic needed to be tested because they were developing the signs and symptoms of the coronavirus and they needed to be either excluded from having that illness or to be confirmed as positive and, therefore, managed in isolation.[2]

3. This initial testing regime raised three separate issues:
    A. First, what was happening to those people who had completed their 14 days of mandatory detention but had tested positive and remained so?
    B. Second, was the release of people reporting no symptoms after 14 days an appropriate strategy?
    C. Third, was there a risk that people were reporting no symptoms to ensure their release from mandatory detention?

Release of people from quarantine who had tested positive

4. Pam Williams, Department of Health and Human Services (DHHS) COVID-19 Accommodation Commander, outlined that between 28 March and 28 June 2020 and consistent with the public health advice and directions in place at that time, all returned travellers were permitted to exit quarantine once the 14-day quarantine period expired.[3]
5. In the event a returned traveller tested positive during their stay in hotel quarantine:
    A. the guest was permitted to depart if the guest could safely self-isolate, as required by the Isolation (Diagnosis) Direction[4] (as amended from time to time), consistent with the requirements that applied to members of the community who tested positive

B. travel to an interstate residence was not permitted until after the relevant isolation direction had been complied with and clearance provided

C. if the guest was subject to the Isolation (Diagnosis) Direction (as amended from time to time) and did not have a safe place to self-isolate, DHHS would support that guest with emergency relief hotel accommodation, subject to the relevant public health direction.[5]

6. In his evidence, the Deputy Public Health Commander, at DHHS Dr Finn Romanes, stated the following with respect to this policy:

> A further situation requiring judgement was what to do if someone whose detention period was ending was a confirmed case of COVID-19. Our assessment was that it was appropriate for someone to leave mandatory detention if they were a confirmed case of COVID-19 so long as we transitioned the person to a safe place to self-isolate for the remainder of their infectious period, as was required under the Diagnosed Persons and Close Contact Directions in force at the time, in keeping with other diagnosed persons already self-isolating in the community. This was because the key public health imperative was knowing whether or not someone was infected with COVID-19 and being clear with the person what actions were needed to prevent transmission. That way, we could agree and implement clear isolation arrangements, with a recognition between the person and the department that the person was potentially infectious and must carefully isolate.[6]

7. When questioned about the tension between allowing COVID-positive detainees to be released into the community after 14 days and the overriding objective of infection control, the Deputy Chief Health Officer at DHHS, Dr Annaliese van Diemen, stated:

> I see that 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.
>
> So that was a discussion that was had and there was a risk assessment that was undertaken in determining whether those people would be allowed to go home to quarantine. And one of the reasons for that was that we didn't want people to refuse to have a test because they knew that they would be kept in quarantine. So, in part, there was a degree of incentive there that, you know, if you have a test at day 10 or 11 and you're positive and you've got a safe place to go home to isolate and you're… we can see that you're cooperative and you're receiving daily phone calls and you're being required to state that you are staying home in isolation, that that was an incentive to ensure that people did report when they had symptoms and ensure that a test was undertaken. I can see that there could be a tension perceived there.[7]

8. I accept the assessments and opinions of these two public health experts with respect to their rationale for approving the release of those who tested positive and were assessed as suitable to be released on directions to self-isolate. I discussed this rationale in the Interim Report, which formed part of the basis for the recommendations for the home-based model, particularly at section 2.8: Risk of spread from non-compliance during self-quarantine.[8]

Release of people reporting no symptoms who may have been asymptomatic

9. As noted above, the initial testing regime in the Hotel Quarantine Program involved only those returned travellers reporting symptoms and consenting to a test before being released from the Program. This appeared to have been, somewhat, at odds with the more precautionary approach recommended by the Australian Health Protection Principal Committee (AHPPC) in its 29 January 2020 statement on the issue of asymptomatic and pre-symptomatic transmission of COVID-19:

> AHPPC is aware of:
>
> • very recent cases of novel coronavirus who are asymptomatic or minimally symptomatic, and
>
> • reports of one case of probable transmission from a pre-symptomatic case to other people, two days prior to the onset of symptoms.
>
> These data are very limited and preliminary and AHPPC still believes that most infections are transmitted by people with symptomatic disease. However, AHPPC believes that we should take a highly precautionary approach and is making the following new recommendations:
>
> 1. People who have been in contact with any confirmed novel coronavirus cases must be isolated in their home for 14 days following exposure;
> 2. Returned travellers who have been in Hubei Province of China must be isolated in their home for 14 days after leaving Hubei Province, other than for seeking individual medical care.
>
> Given the lower number of cases in China reported outside of Hubei Province, we do not currently recommend self-isolation for travellers from other parts of China or other countries. We are closely monitoring the development of cases outside of Hubei Province and will update this advice if necessary.
>
> AHPPC recognises that the evidence for pre-symptomatic transmission is currently limited, and this policy is highly precautionary. At this time, the aim of this policy is containment of novel coronavirus and the prevention of person to person transmission within Australia.
>
> Further details of the extent of pre-symptomatic transmission is being monitored and may result in changes to policy.[9]

10. Without doubt, asymptomatic cases had added considerable complexity to the task of addressing infection control, particularly if one was only testing on the basis of an individual presenting symptoms, which was the case at the start of the Hotel Quarantine Program.

11. In its submissions, DHHS referred to Dr van Diemen's evidence that, in the first few weeks of the Program, no jurisdictions in Australia were doing asymptomatic testing.[10] I accept that evidence and its implications as to why people in quarantine not reporting symptoms were being released, without testing, at the completion of their 14-day quarantine period.

12. However, Prof. Sutton acknowledged that the initial testing regime resulted in a situation where it was possible that people could have been released from quarantine while carrying the virus and while still infectious.[11]

13. He agreed that, in addition to a known case where a driver contracted COVID-19 from a returned traveller picked up from the Stamford Plaza Hotel, there were, potentially, other returned travellers who had been released whose COVID-19 status was undetermined.[12]

14. In his evidence, Prof. Sutton noted that the possible asymptomatic presentation of the virus or the spectrum of symptoms ranging from mild to more severe was something that became more known over time:

> What became known over time is that some people can have extremely mild symptoms, some people might develop asymptomatic illness, some with no symptoms whatsoever but potentially be infectious.[13]

Was there a risk that people were reporting no symptoms to ensure their release from mandatory detention?

15. Prof. Sutton's evidence identified that there may have been people in quarantine who minimised or downplayed their symptoms so that they would not have to be detained (or self-isolate) for longer than the 14-day quarantine period.[14] In other words, people who claimed to be symptom-free and who had not been tested, either because they were ineligible for testing or because they declined testing, were released into the community with no further requirement to quarantine.[15]

16. It was in this context that the approach to testing changed.

17. From early May 2020, a testing blitz was undertaken in Victoria. At this point, all returned travellers, even if asymptomatic, were offered voluntary COVID-19 testing on Day 3 and Day 11 of their detention. The evidence was that Victoria was the first jurisdiction to offer testing to people who were not symptomatic.[16]

18. The policy recommending testing on Day 3 and Day 11 for people in the Hotel Quarantine Program was codified in the *Operation Soteria Enhanced Testing Programme for COVID-19 in Mandatory Quarantine* on 21 May 2020, which specified that:

> Routine testing for COVID-19 is recommended for all individuals in mandatory quarantine on Day 3 and Day 11 of the quarantine period … COVID-19 testing is voluntary. Quarantined individuals cannot be forcibly tested.[17]

19. A fact sheet about the availability of Day 3 and Day 11 testing was provided to returned travellers[18] in the following terms:

Figure 10.1: Summary of routine testing process on days three and 11 from the *Operation Soteria Enhanced Testing Programme for COVID-19 in Mandatory Quarantine*

Routine testing on Day 3 and Day 11

The purpose of Day 3 testing is to detect cases of COVID-19 early in the quarantine period, so that appropriate isolation arrangements can be made both for the case and their close contacts, but also to reduce the possibility of an extended quarantine (and possibly detention) period.

The purpose of Day 11 testing is to detect cases of COVID-19 before they are due to exit mandatory quarantine, so that appropriate isolation arrangements can be put in place, and to reduce the risk of transmission in the community.

Tailored information on the Day 3 and Day 11 testing process must be provided to individuals at the beginning of the quarantine period and again before testing is carried out. Consent should be sought and documented as per the above procedure.

Day 3 and Day 11 testing will **NOT** be requested of the following groups:

- persons who are confirmed cases of COVID-19 (unless specifically indicated (e.g. if there is a specific clinical or public health indication, as determined by the treating medical practitioner and the department's CCOM)).
- persons who already have a COVID-19 test result pending.
- approved transit passengers who are generally in transit for less than 72 hours.

It should be noted that close contacts of confirmed cases who are residing at the COVID-19 designated hotel **should** be offered Day 3 and Day 11 testing, as per standard practice.

Where it is identified in advance that individuals are observing Ramadan and are unable to have a swab taken on the morning of Day 11, the test may be conducted on the evening of Day 10.

Confirmed cases should not be tested again unless specifically indicated (e.g. if there is a specific clinical or public health indication, as determined by the treating medical practitioner and the department).

Source: Exhibit HQI0131(2)_RP Annexures to witness statement of Ms Pam Williams.

20. 1 July 2020, a further public health direction[19] was issued, which required returned travellers who refused a COVID-19 test to undergo a further 10 days of hotel quarantine.[20] This was not a measure to compel testing *per se* but, rather, a measure to incentivise submission to voluntary testing by making refusal more disadvantageous. It was introduced to ensure that, in circumstances where a person refused a test, they could be detained for the full incubation period and full infectiousness period of the virus.[21]

21. In his evidence, Prof. Sutton stated that these more stringent requirements for testing were introduced to make the Hotel Quarantine Program as robust as possible.[22] Notwithstanding the acknowledged need to make the testing regime more robust, the coercive powers to require testing under the *Public Health and Wellbeing Act 2008* (Vic) (PHW Act) were not drawn upon.[23]

22. In her evidence, Dr van Diemen stated that the use of these powers was considered to ensure people were not released from quarantine while COVID-positive.[24] However, on balance, it was decided that it was less intrusive to require an additional 10 days' quarantine for people who refused to get tested.[25]

23. As explained by Prof. Sutton:

> It didn't come to mandatory testing, but there was a change in the directions, in the public health directions, which specified that those who were refusing testing at the day 11 or thereabouts mark would be held for an additional 10 days if they didn't get tested. And those additional 10 days are really a conservative measure of the infectious period if someone were to become unwell on the very last day of quarantine. Most people who develop illness have recovered and are no longer infectious before seven days are up and, certainly, the great majority will not be infectious at the 10-day mark. So that mechanism was used instead.[26]

24. The evidence was that, during the early stages of the Hotel Quarantine Program, people who were asymptomatic, not reporting symptoms or declined testing when offered were being released into the community while potentially infectious.[27]

25. DHHS submitted the following in respect of these matters:

> The Board should find that the testing policies deployed and applied in Hotel Quarantine were appropriate and adequate for the following reasons:
>
> A. throughout the program, testing was always offered to symptomatic guests as soon as they exhibit COVID-19 symptoms;
>
> B. there is no evidence of any break down in testing policies and procedures leading to unidentified community transmission. The limited circumstances of transmission because of untested positive guests leaving quarantine were isolated and, subsequently addressed by the 10-day extension to quarantine for people refusing testing;
>
> C. the Victorian position on testing was the most robust in Australia;
>
> D. the family of returned travellers at Rydges was tested and known to be positive at the time of the transmission event;
>
> E. there is no evidence to support a finding that the testing policies and procedures were not adequate or appropriate.[28]

26. The submission that testing policies deployed and applied in the Hotel Quarantine Program were not inadequate or inappropriate must come with some qualification. The extent to which testing policies prior to 1 July 2020 increased the risk of transmission was clear from the case of a guest at the Stamford Plaza Hotel guest who was released, without knowing he was COVID-positive, and infected the person who drove him away from the hotel.[29] The fact that this did not result in unidentified community transmission was fortunate, but served as a clear indication of the dangers arising from the policy at that time.[30]

27. I accept that the policy must be viewed having regard to the state of knowledge held in respect of COVID-19 at that time. Over time, as knowledge advanced and the risks posed by releasing people without testing for COVID-19 was acknowledged, the policy was revised and people refusing to be tested were subject to an additional 10 days' quarantine. I accept that this was appropriate.

10.2 Should mandatory testing powers have been used?

28. In his evidence, Professor Lindsay Grayson, Professor of Infectious Diseases at Austin Health, stated 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.[31]

29. It goes without saying, the ability to test all people at the end of quarantine depends on people consenting to tests being undertaken and the availability of mandatory testing powers in the absence of consent.

30. Under s. 113 of the PHW Act, the CHO may make an examination and testing order if the CHO believes that:[32]

> A. a person has an infectious disease or has been exposed to an infectious disease in circumstances where a person is likely to contract the disease; and
>
> B. if infected with that infectious disease, the person is likely to transmit that disease; and
>
> C. if infected with that infectious disease, a serious risk to public health is constituted by —
>
> I. the infectious disease; or
>
> II. the combination of the infectious disease and the likely behaviour of that person; and
>
> D. the making of an order under this section is necessary to ascertain whether the person has the infectious disease; and
>
> E. a reasonable attempt has been made to provide that person with information relating to the effect of the infectious disease on the person's health and the risk posed to public health or it is not practicable to provide this information before making the order.

31. The penalty for non-compliance with a mandatory examination and testing order was nearly $10,000.[33]

32. While a person to whom such an order applies may be physically detained for up to 72 hours for the purposes of undergoing a test,[34] a requirement that a person undergo an examination or test could not be applied by the use of force.[35]

33. Prof. Sutton acknowledged the existence of these powers in his evidence, but said that he did not consider using them in the context of the Program, stating:

> [The powers] have, again routinely … not routinely, but they have historically … been used from time to time for individual persons for those issues. They relate to infectious diseases and some other settings such as with respect to food safety, where directing individuals or directing premises is warranted on an individual basis. Testing orders, for example, might be applied if a healthcare worker has been exposed to a needlestick injury and you want to know the status with respect to infectious diseases, hepatitis B or C or HIV, of the person whose blood was in the syringe who was involved in that needlestick injury. And if that information is not forthcoming and if you think it's appropriate and proportionate to make sure that person is tested to find out, then those orders can be applied in that instance. So that's an example.[36]

34. When asked about the issue of using coercive powers for testing, Dr van Diemen said the following:

> I did consider it. I considered it when we were discussing implementing testing in the hotel program. I also considered it on a number of occasions early on, very early on, in the pandemic when there were returned travellers who were suspected cases of COVID and refused to be tested. And in those instances, they weren't required because the individuals decided that they would accept a test. At the time of the … when we were determining the next steps to ensure that all returned travellers were tested, it was decided that a less intrusive route would be to extend the quarantine requirements for a further 10 days for people who had refused testing, in order to ensure that should they continue to refuse a test, that they had completed both a full incubation period and a full infectiousness period, should they happen to have become infectious at the end of their 14-day incubation period.[37]

35. DHHS submitted the following in this regard:[38]

> Other coercive powers of the CHO include the power under s. 113 for the making of an examination and testing order of a person in certain quite narrow circumstances. Prof. Sutton was asked about whether he considered using any of these powers and explained that he did not consider using them because they historically have been used infrequently and in the context of individuals. He was not specifically asked to address whether the legal conditions would have been satisfied for any specific persons, such as the class of persons subject to hotel quarantine. It is relevant here to note certain of these relevant circumstances:
>
> A. a person has an infectious disease or has been exposed to an infectious disease in circumstances where a person is likely to contract the disease (s. 113(1)(a)). There is no evidence to suggest that it would have been possible to ascertain in any rapid time frame whether returning travellers would fall into this category, given that few would know if they had got COVID-19 or been exposed to it;
>
> B. if infected with that infectious disease, the person is likely to transmit it (s. 113(1)(b)), a matter which, given the evidence as to the infectious nature of COVID-19 could, contrary to the first requirement, be readily assumed; and
>
> C. if infected with that infectious disease, a serious risk to public health is constituted by –
>
> I. the infectious disease; or
>
> II. the combination of the infectious disease and the likely behaviour of that person: s. 113(1)(c) –
>
> It [sic] unlikely to be possible to make determinations about the likely behaviour of large numbers of returning travellers, so whether this requirement, properly construed, is satisfied would depend on whether the fact that a person has COVID-19 of itself constitutes a serious risk to public health.

36. I accept that the exercise of power under s. 113 of the PHW Act was subject to limitations, including:

A. The CHO would need to exercise this power, and make an examination and testing order, in respect of each person refusing to undergo a COVID-19 test. It could not be exercised in respect of a class of people.

B. In order to exercise this power, the CHO must have the requisite 'belief'. This belief must include the belief that the person has at least been exposed to an infectious disease in circumstances where the person is likely to contract the disease. The belief must be evidence-based[39] and proportionate.[40] It is doubtful this belief could be based merely on the elevated risks generally associated with overseas travel or that this power could be exercised solely by reference to a person's placement in hotel quarantine. Further considerations, such as the person's country of origin, symptomology and contact with other persons carrying COVID-19 would likely need to be taken into account.

C. The exercise of this power is subject to s. 112 of the PHW Act, which provides that, where alternative measures are equally available that are equally effective in minimising the risk that a person poses to public health, the measure that is the least restrictive of the rights of the person should be chosen. A similar condition is placed upon the exercise of this power by s. 7(e) of the *Charter of Human Rights and Responsibilities Act 2006* (Vic) (Charter), which relevantly provides that a human right may be subject, under law, only to such reasonable limits as can be demonstrably justified, taking into account relevant factors including any less restrictive means reasonably available to achieve the purpose that the limitation seeks to achieve. When compared with other available measures, such as the extension of their quarantine period, it is not certain that a naseo-pharangeal swab would be the least restrictive means of minimising the risk of spreading COVID-19 from a person refusing a COVID-19 test at the end of their quarantine period. The first course would involve an intrusion upon their liberty while the latter would necessarily involve a physical intrusion upon a person. These are not easily quantifiable matters that can conveniently be measured against one another.

37. Another power that could conceivably have been exercised to enforce mandatory testing was s. 200(1)(d) of the PHW Act, which applies where a state of emergency has been declared and provides that an Authorised Officer may give any direction they consider is reasonably necessary to protect public health. While the exercise of this power is not subject to s. 112 of the PHW Act, it is subject to the 'least restrictive' principle contained in the Charter.

38. Like s. 113, it is also subject to the requirements contained in ss. 5 and 9 of the PHW Act, which require that decision-making be evidence-based and proportionate. It seems likely that similar considerations would, therefore, have needed to be taken into account when exercising this power. That is, in order to 'consider' whether a mandatory COVID-19 test was reasonably necessary to protect public health, among other things, the Authorised Officer would likely have needed to consider where the person has travelled from, their symptomology and close contacts.

Obtaining further clarity on these matters

39. These matters created ambiguity for the CHO and his delegates about the extent of mandatory testing powers available to them. This ambiguity needs to be remedied. The Responsible Minister should take steps to achieve clarity by obtaining legal advice from the Solicitor-General on the range of circumstances in which ss. 113 and 200(1)(d) of the PHW Act may be exercised to require that those refusing testing at the conclusion of their quarantine period undertake mandatory testing.

40. The request for such advice should provide a detailed list of practical scenarios that commonly arise, or are expected to arise, in the context of returned travellers refusing to undergo testing in the Hotel Quarantine Program.

41. Recognising that it will not be possible to provide absolute certainty on the range of circumstances in which these powers may be available, the advice should provide practical guidance to the CHO and Authorised Officers in their exercise of the powers under ss. 113 and 200(1)(d) of the PHW Act and consider matters, including:

    A. whether the power under s. 200(1)(d) of the PHW Act may be exercised for the purposes of mandatory testing

    B. if so, the criteria that must be met in order to exercise that power

    C. whether the powers available under s. 113 and/or s. 200(1)(d) of the PHW Act would be available to enforce mandatory testing in the scenarios provided in the request for advice

    D. the meaning of 'exposed' as it is contained in s. 113(1)(a) of the PHW Act and the considerations that should be taken into account when determining whether that condition is satisfied

E. whether naseo-pharangeal testing is likely to be considered the least restrictive option for addressing the risks posed by returned travellers who refuse testing when compared with the option of imposing an additional 10 days' detention

F. whether the powers contained in s. 113 and/or s. 200(1)(d) of the PHW Act should be exercised to enforce mandatory testing

G. if so, how the mandatory testing regime should operate in conjunction with the option of imposing an additional 10 days' detention

I. are both options equally available?

II. if not, in what circumstances should each option be preferred?

H. having regard to these matters, whether any of the following would be warranted in order to provide more certainty and serve the public interest sought to be achieved by mandatory testing:

I. an overriding declaration made by parliament pursuant to s. 31 of the Charter stating that the Charter does not apply to the exercise of powers in s. 113 and/or s. 200(1)(d) of the PHW Act for the purposes of mandatory testing

II. a declaration by the Minister for Police and Emergency Services pursuant to s. 24(2)(b) of the *Emergency Management Act 1986* (Vic), suspending the application of the Charter and/or relevant sections of the PHW Act (for example, ss 9 and 112) to the exercise of powers in s. 113 and/or s. 200(1)(d) of the PHW Act for the purposes of mandatory testing and/or

III. temporary legislative change.

42. The request for advice should also include a request for a 'checklist' to be developed in order to assist those working in the Hotel Quarantine Program to determine when mandatory testing powers and/or the option of imposing an additional 10 days' quarantine should be exercised.

43. To accompany this advice, the Responsible Minister should identify an appropriate person who will be available to provide legal advice, at short notice and when required, to the CHO and delegates, on the exercise of mandatory testing powers and/or the option of imposing an additional 10 days' quarantine.

Testing of those working in the Hotel Quarantine Program

44. The evidence in this Inquiry established that one of the most substantial risks associated with the Hotel Quarantine Program was the risk of infection spreading from returned travellers to staff and personnel working in the Program.

45. This much was clear from the circumstances of Victoria's second wave that, as discussed in Chapter 9, involved on-site personnel becoming infected then spreading the virus to household and other close contacts who, in turn, spread the virus into the broader community.

46. Public reports of on-site personnel in hotel quarantine in other states becoming infected via those held in quarantine confirms this is a significant ongoing risk.

47. In order to address this risk, it is vital that staff working in any future quarantine program undergo mandatory and regular COVID-19 testing. Failing this, the State's efforts to prevent and minimise the spread of the virus into the community will be significantly compromised.

48. The Inquiry understands, from recent media reporting, that in the revised Victorian hotel quarantine program, all on-site personnel, including frontline workers and cleaners, will be required to undergo daily saliva testing and weekly nasal swab testing.[41] The Inquiry also understands that regular, voluntary testing will be available for the families and household members of those working in the revised program.[42]

49. In my view, these are important and appropriate measures for addressing the substantial risks associated with infection spreading from international arrivals to personnel working on-site at quarantine facilities and into the wider community.

10.3 Conclusions

50. A significant, if not dominant, purpose of the 14-day quarantine period was to ascertain the COVID-19 status of those detained in the Program, and to allow for their post-release arrangements to be managed in an informed manner. To this end, the testing regime was of fundamental importance.

51. Initially, only those who showed symptoms were offered a test, and testing in the Hotel Quarantine Program remained entirely voluntary. The mandatory testing powers contained in the PHW Act were considered but not used.

52. A new approach was implemented in July 2020, when an additional 10 days of quarantine was introduced for those who refused testing on Day 11. This new approach was justified and appropriate.

53. It is understood that this new approach will be bolstered in the revised hotel quarantine program by mandatory testing of staff and all on-site personnel working in the program, along with voluntary testing of their families and household contacts.

54. Both approaches represent sound approaches and substantial improvements to the initial testing program that risked undermining, at least to some degree, the efficacy and intentions of the Hotel Quarantine Program and, in doing so, risked transmission of COVID-19 from those detained in the Program into the community.

55. To further protect against these risks, the legal basis for, and utility of, a testing regime requiring returned travellers who refuse testing at the conclusion of their 14-day quarantine period to undergo mandatory testing should be further explored.

10.4 Recommendations

78. To provide clarity to the CHO and his delegates on the circumstances in which mandatory testing powers may be exercised and to further minimise the risks of community transmission arising from the revised hotel quarantine program:

    - the Responsible Minister should obtain detailed legal advice from the Solicitor-General on the range of circumstances in which ss. 113 and 200(1)(d) of the PHW Act may be exercised to require that those refusing testing at the conclusion of their quarantine period undertake mandatory testing
    - the request for such advice should provide a detailed list of practical scenarios that commonly arise, or are expected to arise, in the context of returned travellers refusing to undergo testing in the Hotel Quarantine Program
    - recognising that it will not be possible to provide absolute certainty on the range of circumstances in which these powers may be available, the advice should provide practical guidance to the CHO and Authorised Officers in their exercise of the powers under ss. 113 and 200(1)(d) and consider matters including those listed above in paragraphs 41.a–41.h

- the request for advice should also include a request for a 'checklist' to be developed in order to assist those working in the Hotel Quarantine Program to determine when mandatory testing powers and/or the option of imposing an additional 10 days' quarantine should be exercised
- to accompany this advice, the Responsible Minister should identify an appropriate person who will be available to provide legal advice, at short notice and when required, to the CHO and delegates, on the exercise of mandatory testing powers and/or the option of imposing an additional 10 days' quarantine.

79. To protect against the risk of infection spreading to the community via staff or personnel working in the program who have contracted the virus from returned travellers, the Responsible Minister should ensure, or continue to ensure, that:
    - all on-site staff and personnel, including frontline workers and cleaners, are required to undergo daily saliva testing and weekly nasal swab testing
    - family and household members of such frontline staff and personnel are provided with, and given support to access, voluntary testing on, at least, a weekly basis.

Endnotes

1 Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 33 [76].
2 Transcript of day 18 hearing 16 September 2020, 1463.
3 Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 32 [74].
4 See Isolation (Diagnosis) Direction, <https://www.dhhs.vic.gov.au/sites/default/files/documents/202003/Isolation%20%28Diagnosis%29%20Direction%20-%20signed.pdf>.
5 Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 32 [74].
6 Exhibit HQI0113_P Witness statement of Dr Finn Romanes, 16 [77]. Note: The Diagnosed Persons and Close Contact Directions are a more recent iteration of the Isolation (Diagnosis) Direction, issued 25 March 2020, and referred to in Ms Williams' evidence above.
7 Transcript of day 18 hearing 16 September 2020, 1551.
8 Board of Inquiry into the COVID-19 Hotel Quarantine Program (Interim Report, 6 November 2020) <https://www.quarantineinquiry.vic.gov.au/reports>.
9 Australian Health Protection Principal Committee (AHPPC), 'Australian Health Protection Principal Committee (AHPPC) Statement on novel coronavirus', Australian Government Department of Health (Statement, 29 January 2020) <https://www.health.gov.au/news/australian-health-protection-principal-committee-ahppc-statement-on-novel-coronavirus-on-29-january-2020-0>.
10 Submission 03 Department of Health and Human Services, 45 [242].
11 Transcript of day 18 hearing 16 September 2020, 1465.
12 Ibid 1464–1465.
13 Ibid 1463.
14 Ibid.
15 Transcript of day 26 hearing 28 September 2020, 2248.
16 Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 33 [77]; Transcript of day 18 hearing 16 September 2020, 1463.
17 Exhibit HQI0131(2)_RP Annexures to witness statement of Ms Pam Williams, DHS.0001.0001.2353.
18 Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 33 [78]; See also Exhibit HQI0131(1)_RP Annexures to witness statement of Ms Pam Williams, DHS.5000.0003.1670.
19 Detention and Direction Order (No. 6) <https://www.dhhs.vic.gov.au/sites/default/files/documents/202007/Direction%20-%20Detention%20Notice%20%28No%206%29.pdf>.
20 Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 33 [79].
21 Transcript of day 18 hearing 16 September 2020, 1548–1549.
22 Ibid 1464.
23 Ibid.
24 Ibid 1548.
25 Ibid 1548–1549.
26 Ibid 1464.
27 Ibid 1464–1465; Submission 03 Department of Health and Human Services, 46 [246].
28 Submission 03 Department of Health and Human Services, 45 [241].
29 Transcript of day 18 hearing 16 September 2020, 1464–1465.
30 Cf Submission 03 Department of Health and Human Services, 45 [241], where the contrary is argued.
31 Exhibit HQI0001_P Witness statement of Prof. Lindsay Grayson, 12 [56].
32 PHW Act s. 113.
33 Ibid s. 116.
34 Ibid s. 113(3)(c).
35 Ibid s. 123(2).
36 Transcript of day 18 hearing 16 September 2020, 1461–1462.
37 Ibid 1548.
38 Submission 03 Department of Health and Human Services, 4 [19].
39 PHW Act s. 5.
40 Ibid s. 9.
41 Ashleigh McMillan, 'Help Wanted: Would you work in Victoria's quarantine hotels for $85k?', The Age (online, 29 November 2020) <https://www.theage.com.au/national/victoria/help-wanted-would-you-work-in-victoria-s-quarantine-hotels-for-85k-20201129-p56ivx.html>. Quote regarding testing was from Victoria's Chief Testing Commander, Jeroen Weimar.
42 Premier of Victoria, 'A Stronger Quarantine Program to Protect What We've Built' (Media Release, 30 November 2020) 1 <https://www.premier.vic.gov.au/stronger-quarantine-program-protect-what-weve-built>.