CHAPTER 12

Building consideration of returned travellers' rights and welfare into a future program

1. This chapter analyses whether and how the rights and welfare of returned travellers were approached in the Hotel Quarantine Program and considers how a future quarantine program could be strengthened in this regard. It comprises two sections:
   A. **Section 12.1** — discusses the *Charter of Human Rights and Responsibilities Act 2006* (Vic) (Charter) and its application to the Hotel Quarantine Program during its establishment. It also considers whether there may be less restrictive measures to combat the threat of COVID-19 entering the community
   B. **Section 12.2** — highlights the psycho-social impacts of quarantine on returned travellers and how a future program can better support the health and wellbeing of returned travellers during their quarantine period.

12.1 The Victorian Charter of Human Rights and Responsibilities

12.1.1 The relationship between mandatory quarantine and the *Charter of Human Rights and Responsibilities Act 2006* (Vic)

2. The existence of the Charter has relevance to the Hotel Quarantine Program. It was not contentious that compelling people to undertake 14 days in a quarantine facility had obvious and significant impacts on their rights and liberties. As the Premier explicitly recognised in his 27 March 2020 media conference:

> It's a big step to take away someone's liberty — in effect to make them go to a certain place and stay there for two weeks — but this is life and death. There's too much at stake to do otherwise.[1]

3. The principle that mandatory quarantine was an acceptable public health response to a pandemic such as this was also not in dispute during the Inquiry.
4. Nor was it in dispute that the Charter was applicable to the actions of the Victorian Government, such as it related to the decision to issue the Direction and Detention Notice (Direction) mandating people into the Hotel Quarantine Program.

5. Whether there was compliance with the rights protected under the Charter was not a matter over which this Inquiry had any jurisdiction. However, given that those various government officials engaged in decision-making central to the Hotel Quarantine Program were bound to make their decisions in accordance with the Charter, it would have been unfair and artificial to ignore the considerations they were required to observe. It was for this reason that some attention was paid to the Charter.
6. The second purpose for consideration of the Charter was its contextual relevance to recommendations for the features of a future Quarantine Program as contained in the Interim Report, which I adopt in this Final Report.

12.1.2 The application of the Charter in this context

7. The Charter's main purpose is to protect and promote human rights, including by setting out rights that the Victorian Parliament specifically seeks to protect and promote,[2] and by imposing an obligation on all public authorities to act in a way that is compatible with these rights.[3]
8. It was important, therefore, to identify those rights protected by the Charter, insofar as they were particularly relevant to the Hotel Quarantine Program, before turning to how public authorities must act compatibly with them.
9. The rights protected are set out in Part 2 of the Charter. Importantly, for the Hotel Quarantine Program, those rights are not without limitation. Rights under the Charter may be limited in accordance with s. 7(2) of the Charter. That is, they may be subject, under law, only to such reasonable limits as can be demonstrably justified in a free and democratic society, based on human dignity, equality and freedom, taking into account all relevant factors.[4] Those factors include:
   A. the nature of the right
   B. the importance of the purpose of the limitation
   C. the nature and extent of the limitation
   D. the relationship between the limitation and its purpose
   E. any less restrictive means reasonably available to achieve the purpose of the limitation.[5]

12.1.3 Several relevant rights are protected by the Charter

10. In the context of a mandatory quarantine program, intended to stop the transmission of an infectious disease into the Victorian community by restricting the movement and ability of returned travellers to go about their ordinary lives, six Charter rights are particularly important. They are set out below.

A person has a right to life

11. Section 9 of the Charter provides that every person has the right to life and the right not to be arbitrarily deprived of life.[6] The Victorian Government has an obligation to give proper consideration to the right to life of all persons when making its decisions.[7] A mandatory quarantine program, designed to protect the lives of Victorians, necessitates consideration of that right.

A person has a right to liberty and security of person

12. Section 21 of the Charter provides that:

    A. every person has the right to liberty and security

    B. a person must not be subjected to arbitrary arrest or detention

    C. a person must not be deprived of his or her liberty except on grounds, and in accordance with procedures, established by law.

13. Quarantining involves a person's detention and, thus, a restriction of their liberty. A person's rights under s. 21 may be limited, but only where their detention is not arbitrary, is done in accordance with the law, and the limitation is reasonable and proportionate in all the circumstances, consistent with s. 7(2) of the Charter.

14. Section 200(6) of the *Public Health and Wellbeing Act* (Vic) (PHW Act) requires a review, every 24 hours, of the decision to detain a person to ascertain whether the continued detention is reasonably necessary. Failure to conduct such a review may render the detention unlawful for the purposes of s. 21 of the Charter.

15. The issue of *how* those reviews were conducted during the period of the Hotel Quarantine Program was the subject of some evidence before the Inquiry and the subject of some closing submissions as to whether there was or was not compliance with the Charter. DHHS, in its closing submissions, took exception to the issue being raised, but addressed it in any event.[8]

16. DHHS submitted that the reviews were based on the medical advice of the Chief Health Officer (CHO) and the Deputy Chief Health Officer (DCHO) that returned travellers should spend 14 days in quarantine on the basis of what was understood about the incubation period of the virus. Thus, the review was constituted by checking as to whether or not a returned traveller had completed his or her 14 days. DHHS provided various memoranda it had received containing legal advice on this issue that appear to support its submission and are summarised below.

17. A DHHS memorandum from Jacinda de Witts, Deputy Secretary, Legal and Executive Services Division and General Counsel to DHHS, to Dr Annaliese van Diemen, DCHO, dated 28 March 2020 (and signed by Dr Van Diemen on the same date), noted that the Legal Services Branch had assessed that the Isolation (International Arrivals) Detention Notices were compatible with the Charter.[9]

18. Part B of the same memorandum contained a section called 'Charter Assessment' and contemplated the human rights considerations in paragraphs 8–13 therein. For example, paragraph 9 told Dr van Diemen that her decision to sign the Isolation (International Arrivals) and Detention Notices would be compatible with the Charter.[10]

19. Paragraph 10 went on to identify eight rights impacted by the Detention Notices. These were:

    A. section 21 — right to liberty

    B. section 12 — freedom of movement

    C. section 14 — freedom of religion

    D. section 19 — cultural rights

    E. section 16 — freedom of peaceful assembly and association

    F. section 13 — rights to privacy, family and home

    G. section 17 — protection of families and children

    H. section 22 — right to humane treatment when deprived of liberty.[11]

20. Paragraph 12 stated that the Detention Notices were compatible with the human rights in the Charter.[12]

21. There was also Attachment D (12 pages) that detailed DHHS's assessment of human rights issues arising from the Detention Notices,[13] and Attachment C6 (14 pages), which was another memorandum of legal advice, summarising the human rights considerations related to individual Detention Notices.[14]

22. Also, in the bundle was an email from Rowena Orr QC of Counsel to Ms de Witts, dated 28 March 2020, saying that the Notice 'likely amounts to detention' and that the presence of police and military reinforced the idea that people required to stay in hotels were in some sort of 'custodial' setting.[15]

23. A further email from Sarala Fitzgerald of Counsel, dated 28 March 2020, to Ms de Witts referred to the 24-hourly review and what would be required for the purposes of s. 200(6) of the PHW Act. She suggested that, to satisfy this requirement, the authorised officer must ask themselves: 'is the continued detention of this person reasonably necessary to eliminate or reduce a serious risk to public health?' She stated that this was a simple question based on medical advice and need not be time consuming. She then suggested the review could be completed by simply appraising information on a database.[16]

24. For the reason contained in paragraph 4 above, that is, that I have no jurisdiction to rule on compliance or otherwise with respect to the Charter, I go no further on that point. I raise these matters to give an example of how DHHS gave consideration to this Charter right when making decisions as to detention.

A person deprived of liberty must be treated humanely

25. Under s. 22(1) of the Charter, all people deprived of liberty must be treated with humanity and with respect for the inherent dignity of the human person.

26. It could hardly be contentious that the Hotel Quarantine Program deprived people of their liberty. A person in quarantine should not be subject to any hardship or constraint in *addition* to that resulting from the deprivation of their liberty.[17]

27. Self-evidently, those conditions can include the nature of the accommodation itself, facilities for personal hygiene, opportunities for exercise, access to fresh air breaks and availability of medical and general health services. The conditions faced by individuals in quarantine should take into account any particular vulnerabilities of those in detention.

A person has a right to move freely

28. Section 12 of the Charter provides that every person lawfully within Victoria has the right to move freely within Victoria, and to enter and leave it, and has the freedom to choose where to live.

29. Clearly, a person's freedom of movement is restricted where they are required to quarantine within a particular hotel room. Whether or not the restriction is reasonable and proportionate so as to be justifiable under s. 7(2) of the Charter depends upon consideration of all of the circumstances.

A person has the right to freedom of conscience and religion

30. Section 14(1) of the Charter gives every person the right to freedom of thought, conscience, religion and belief, including the freedom to demonstrate his or her religion or belief in worship, observance, practice and teaching, either individually or as part of a community, in public or in private.[18]

31. Self-evidently, the ability of a person in hotel quarantine to participate in a religious life is restricted when they cannot attend face-to-face expressions of their religion. The right to observe or practice their beliefs within their rooms may also be restricted where they are not afforded the opportunity to observe customary dietary regulations.[19]

A person has rights to privacy, family and a home

32. Section 13(a) of the Charter provides that a person has the right to not have his or her privacy, family, home or correspondence unlawfully or arbitrarily interfered with. 'Privacy' is a broad term, which must relate to the autonomy and inherent dignity of the person.[20]

33. The private life of a person who is quarantined within a hotel is limited because it restricts the person's ability to go about their private lives; so, too, is their right to home limited where they are required to live in a hotel room and prevented from living in their home.[21]

34. Other Charter rights, as noted in the summary extract of advices to DHHS, are relevant to the Hotel Quarantine Program, such as:

    A. cultural rights under s. 19

    B. freedom of peaceful assembly and association under s. 16

    C. protection of families and children under s. 13

    D. protection from treatment or punishment in a cruel, inhuman or degrading way under s. 10(b).

12.1.4 Public officials are required to act and make decisions that are compatible with human rights

35. Each public official, including the DCHO, relevant departmental employees and Authorised Officers, is subject to the obligations imposed on public authorities by the Charter.[22]

36. Section 38(1) of the Charter states that it is unlawful for a public authority to act in a way that is incompatible with a human right or, in making a decision, to fail to give proper consideration to a relevant human right. This obligation is not limited to individual decisions relating to individual people; it extends to policy or program design where there is a potential impact on the Charter rights of a class of people.[23]

Are there less restrictive means to achieve the purpose of quarantine?

37. The need for public health measures, including quarantining, to limit the spread of the virus that affected the rights of all Victorians, was not in question before the Inquiry. Compulsory quarantining of people impacts Charter rights. What the Charter requires, among other considerations, is that the limit on rights is reasonable and proportionate. Of critical importance to the proportionality test is the existence of 'any less restrictive means reasonably available to achieve the purpose that the limitation seeks to achieve' at s. 7(2)(e) of the Charter.

38. I accept the evidence of the DCHO that, in contemplating whether the detention orders would be compatible with human rights under the Charter, she considered a number of factors relevant to the purpose of the quarantine program including, by way of summary:

    A. The exceptional circumstances in which the Direction was proposed to be made. That is, there was a continued widespread international outbreak of a viral pandemic for which there was no current vaccine or cure.[24]

    B. The Direction purported to minimise community exposure to COVID-19 and prevent or, at the very least, reduce the risk of the Victorian health system becoming overwhelmed with COVID-19 cases.[25]

    C. It was considered that, on the available medical evidence, it was the 'least restrictive means reasonably available to stem the spread of [COVID-19], particularly since less restrictive measures for international arrivals failing to self-isolate in their homes for 14 days — in clear defiance of previous directions — had caused the further spread of the virus'.[26]

39. Two observations may be made from the decision to give the Direction:

    A. The purpose of the limitation on people's rights (that is, to stop transmission of COVID-19 to the community) and the nature of the rights under the Charter were considered in general terms and without specific consideration to individual needs or circumstances, including health and wellbeing needs. It was understood that this was because the decision was made with respect to a cohort and the threat that was being posed to the rights of all the people of Victoria.

    B. It was understood, on the evidence, that it was not possible or practical, in the circumstances of the initial onslaught of hundreds of people arriving in planes and, potentially, threatening a major spread of the virus, to give proper and individual consideration to less restrictive measures for individual travellers at that time.

Concern about non-compliance with self-isolation directions

40. As I set out in the Interim Report, in particular at Sections 2.7 and 2.8, a key consideration in the decision to direct mandatory hotel quarantining was concern about the levels of non-compliance with the self-isolation orders under the Non-Essential Mass Gatherings and Self-Quarantine following Overseas Travel Directions[27] but, more significantly, those of the Airport Arrivals Direction of 18 March 2020.[28]

41. For clarity, references to 'self-isolation orders', 'home-detention' and 'home quarantine requirements' in this section are used to mean those orders and directions that were issued to returned travellers to isolate at home, as distinct from orders and directions that were applicable to other cohorts of the Victorian community; for example, those required to self-isolate at home due to testing positive for COVID-19 or for being a close contact of a positive case or awaiting the outcome of test results.

42. The Inquiry heard evidence about instances of non-compliance with such orders and directions,[29] but there was no empirical data provided as to the scale of non-compliance. Instead, evidence was provided regarding a lack of confidence in the compliance of returned travellers isolating at home,[30] being that they not only 'stay in their own home, but (that) others do not come within 1.5m of them, and actually further isolated'.[31] This lack of confidence was based on 'a significant amount of public commentary concerning the non-compliance of self-isolation [and] the observation by other jurisdictions and the discussion around AHPPC of significant non-compliance in their own jurisdictions'.[32] Dr van Diemen outlined that 'we had a reasonable amount of evidence, albeit over a short period of time, that people were not adhering to the home quarantine requirements as strictly as we needed them to do'.[33]

43. This evidence led to a view, understandably held by Dr van Diemen at the time she formed her opinion, that returned travellers were not complying with self-isolation orders.[34]

44. Dr van Diemen gave evidence that she had given thought to issuing individualised notices detaining people in their own homes under the threat of a $20,000 fine.[35] However, it appears that this option was not pursued because there was a close to (if not equal) fine associated with existing orders, which did not appear to have deterred a number of people from breaching the order[36] and Dr van Diemen had already formed the view, at that particular time, that she agreed with the requirement for hotel quarantine as opposed to home-based quarantine.[37] Dr van Diemen understood there were a number of people not complying with home-detention, based on intelligence gained through contact tracing.[38]

45. As noted in the Interim Report (at page 74) the former Chief Commissioner of Police, Graham Ashton, gave evidence about Victoria Police's reports of returned travellers' non-compliance with home-quarantine orders. He said:

> … there were regular occasions when people were found not to be home when they were checked upon and that we then had to go through [an] exercise of locating them, working out where in fact they were when they were supposed to be at home. I should add that in many occasions people were isolating but they weren't isolating at the place where the Australian Border Force thought they were going to be, and so we had to adjust records, et cetera, and try and clean the data a lot on where people actually were. But there were levels of non-compliance as well.[39]

46. Despite those identified levels of non-compliance, Mr Ashton could not recall being asked for his view about the sufficiency of home quarantine as a model for dealing with people who were being required to isolate.[40]

12.1.5 Future options: home quarantine model and the Charter

47. I accept the evidence of Dr van Diemen that, in making the mandatory detention orders, she did give serious and proper consideration to her Charter obligations, in the circumstances, and she assessed her obligations with the evidence available to her at that time.

48. While it is accepted there were extraordinary pressures and concerns impacting upon the decision to impose the mandatory Hotel Quarantine Program in the circumstances of March 2020, a more considered and orderly approach to finding measures that are the least restrictive should now be properly undertaken for the next iteration of a quarantine program for returning travellers.

49. I adopt the recommendations made in Section 2 of the Interim Report regarding the option of a home-based quarantine model.

50. Mandatory home quarantine or a hybrid model involving initial reception into a quarantine hotel for a form of 'triage', taking into account all relevant factors for each returned traveller, with increased compliance mechanisms, should be given consideration, consistent with Charter requirements.

51. Such a model may also be, at least, as effective at achieving the objective of containing the virus, balancing the Charter obligations with the need to protect the health and wellbeing of all Victorians.

12.1.6 Recommendations

52. Recommendations 58–69 in Section 2 of the Interim Report apply to this Section. For reference, the recommendations are listed below.

Recommendations 58–69 of the Interim Report

HOME-BASED 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 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 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.

12.2 Psycho-social impacts of quarantine on returned travellers

70. To confine a person within a hotel room for a period of 14 days (even with some breaks) is to significantly interfere with a person's normal life. For those who have not been subject to such quarantine, it may be difficult to imagine the impact such an experience would have on their social and private lives, as well as their physical and mental wellbeing.

71. It should not be forgotten that, while the Hotel Quarantine Program aimed to protect the Victorian community from the risk of COVID-19 virus transmission, at its heart, it involved people whose freedoms were suspended while they had no choice but to remain detained at their assigned hotels.

72. Within the context of such a large and unplanned program, it was always going to be a challenging task to meet the needs of people who had specific requirements or vulnerabilities. The standards and processes for the health and wellbeing of those detained were, therefore, matters that required a commensurate level of care and attention.

73. This section highlights how such a program might — and did — impact the wellbeing of those within it, so that potential psycho-social impacts can be considered and incorporated into any future model of mandatory hotel or facility-based quarantine.

74. More than 20,000 people went through the Hotel Quarantine Program in Victoria.[41] No doubt, the experience of returned travellers in the Hotel Quarantine Program and its impact varied greatly.

75. The Inquiry, of course, did not hear about the experience of every one of those returned travellers or, indeed, even a significant proportion of them. The Inquiry did, however, hear evidence from some returned travellers during its public hearings; moreover, it received information from people who contacted the Intake and Assessment Team to take the opportunity to speak about their experience otherwise than as formal witnesses.

76. The Inquiry heard evidence from Safer Care Victoria, the peak State authority for quality and safety improvement in healthcare.[42] Safer Care Victoria produced two reports that identified significant shortcomings in the health and welfare aspects of the Hotel Quarantine Program, and that recommended better onboarding processes to understand the needs of those undertaking quarantine.[43]

77. The Inquiry heard evidence from those working in various roles across the Program, such as Nurse Jen, who observed that returned travellers 'who had no particular health needs and who were tech-savvy did okay in quarantine'.[44] However, she thought others, particularly those with health concerns — even minor ones — had a more challenging time.[45]

78. Quiet compliance does not necessarily mean the Program did not have an impact on individuals within it. The Inquiry heard evidence on this matter, and the ways in which quarantine might have impacted on returned travellers, from experienced trauma psychologist, Dr Rob Gordon, whose evidence was not challenged.

79. Dr Gordon stated that compliance can be a reflection of our culture and of the confidence or trust most people have in the authorities. According to Dr Gordon, research demonstrates that people will often subject themselves to high levels of stress, for long periods of time, for a variety of reasons personal to them. In other words, compliance does not necessarily reflect a lack of impact on an individual.[46]

80. It was clear from some of the evidence that some returned travellers found the hotel quarantine experience stressful, given the necessary denial of the usual freedoms that returning travellers would otherwise have in their day-to-day lives. The experience of hotel quarantine had a negative emotional and psychological impact in respect of some returned travellers.

Figure 12.2.1: Quotes from returned travellers about their experience in the Hotel Quarantine Program

Returned Traveller 3: Being detained at the hotel was a degrading and dehumanising experience for me. I contacted the Inquiry to share my experience in the hope I can spare other people such needless pain and grief.

Returned Traveller 4: It was honestly the worst 2 weeks of my life!!!

Returned Traveller 5: I wasn't mentally strong enough to deal with hotel quarantine.

Returned Traveller 9: I knew it would be difficult, but I felt that we were being 'incarcerated' and we had 'no rights'.

Returned Traveller 11: I felt like a prisoner, not someone in quarantine. My experience was that hotel quarantine felt like jail: you are locked in your room 24 hours a day, I had one 10-minute fresh air session in 14 days, and I had no choice on what to eat.

Returned Traveller 12: I am now being treated by my GP for the trauma I experienced whilst away and in quarantine and am still trying to deal with the way the general community treats a person who has been COVID positive.

Source: Information provided to the Inquiry via the Intake and Assessment team between 15 July to 3 December 2020. Names of sources have been de-identified for privacy purposes.

12.2.1 A proportion of people in quarantine will be vulnerable and require particular support

81. Dr Gordon gave evidence that it was his understanding that the cohort of returned travellers entering quarantine would reflect the spectrum of people in the Victorian community.[47] From Dr Gordon's experience and research, his evidence was that the population can be split approximately 80-20 in terms of the level of underlying needs and vulnerabilities, and ability to cope in stressful situations.[48] That is, about 20 per cent of the population has various forms of needs, instabilities or personal issues that require a higher level of support than the remaining 80 per cent.[49] These include, for example, mental health problems, disabilities, social disadvantage and other problems, such as a history of loss or illness.[50] The 20 per cent will have experience accessing government services, while the remaining 80 per cent will likely have had little or no contact with support services throughout the course of their lifetime.[51]

82. In the Hotel Quarantine Program context, the cohort changed over time and became more complex, requiring a more nuanced assessment of its health and wellbeing needs.[52] Pam Williams, from the Department of Health and Human Services (DHHS), noted that those returned travellers who initially arrived were mainly business travellers or people returning from an overseas holiday.[53] As time went on, and the Commonwealth repatriated Australian citizens who may have been living overseas, the cohort changed to include 'more families with young children, people with diverse languages and cultures, and [those with] complex medical and mental health issues'.[54]

83. Ms Williams said that if the Commonwealth was more directive in dealings with airlines, it would have assisted with better planning for arrivals, the numbers of travellers and their specific needs, and, especially, the needs of families with young children.[55]

84. Kym Peake, then Secretary of DHHS, gave similar evidence in this regard. She stated that there was little advance notice of the needs of returning travellers or even demographics; flight manifests often did not list children under two years of age and there was little information on unaccompanied minors.[56]

Figure 12.2.2: Narrative from Returned Traveller 5

I needed to get to Australia for family support after leaving my relationship overseas due to family violence.

I had given birth to my daughter two weeks earlier via c-section and was still in severe pain. I was in a wheelchair and carrying a mobility crutch, still recovering. I travelled with my newborn, toddler son as well as my mother.

I was very distressed when I arrived at the airport. I was crying and pleading with the Department of Health and Human Services (DHHS) staff to not make me go into quarantine. I had too many physical problems and mental scarring.

I was told to go to the hotel and just get through the first night, and that an exemption would be processed the next day for me and my family to complete quarantine at home.

On the first night, I called the coronavirus hotline as I had no nappies. The operator advised me to make a Woolworths order which would take 3–4 days to arrive. In the end the nurses got nappies for me, as I needed them urgently. I had come with nothing — I left my whole life in less than a week. The nurses also got me maternity pads and toys for my son.

By 4pm on day two, I had not heard anything. I soon realised no one had started the exemption process for me.

The next day, DHHS told me an exemption had been granted for me to quarantine in a 'Mother Baby Unit'. I contacted this unit and they told me they'd never heard of me and explained they were not able to accommodate a person requiring quarantine. Based on this, my exemption was revoked.

I struggled with this outcome. I felt suicidal. That night, the Crisis Assessment and Treatment (CAT) team had to be called to help me. They spoke to DHHS and finally, an exemption was granted for me and my family to quarantine at home.

Three nurses really helped me while I was in Quarantine, I believe they kept me alive during this time. The nurses did everything for me, the hotel staff, DHHS staff and coronavirus line didn't want to know about me. When I spoke to DHHS on the phone, I felt like a problem.

I wasn't mentally strong enough to deal with hotel quarantine. I was not in a position to be there and things needed to be done differently. After escaping family violence, I found being made to stay in one room very hard, wrong and dehumanising. I had no way to get rid of dirty nappies which piled up. I had no information provided in relation to laundry and there was no way to wash clothes.

In my opinion, the biggest gap in the quarantine program was the lack of assistance for my children. Families were being placed in unsuitable accommodation and it doesn't surprise me that children would get distressed, my son became distressed almost immediately.

> He didn't understand quarantine and he'd been through so much already. I experienced a complete behavioural change with him, and he became very clingy. At least once we were at home, he could run around in the garden and have space.
>
> I understand the need for quarantine, but the cost of this program was too high for some people. For me, the mental impacts were devastating. I had just escaped domestic violence and to be locked up again was very difficult.
>
> Families being quarantined should be placed into serviced apartments with balconies, this would be more appropriate.

Source: Information provided to the Inquiry via the Intake and Assessment team between 15 July to 3 December 2020. Names of sources have been de-identified for privacy purposes.

85. Despite the increase in the Commonwealth's efforts at repatriation, Ms Williams observed there should have been better management of the numbers and the arrival port of incoming travellers on the part of the Australian Border Force and the Commonwealth Department of Foreign Affairs and Trade.[57] Ms Williams gave evidence that those agencies could have been more directive in their dealings with airlines; to that end, she noted that, at times, the Program received flights with up to 40 per cent of arrivals being from other states, many of whom found it difficult to get to their home states and who had to undergo a second period of quarantine.[58]

86. The increasingly diverse cohort of arrivals with varying medical needs added a further layer of complexity for the staff running the Program. A number of travellers who contacted the Inquiry said that their medical conditions were ignored or not taken seriously.

Figure 12.2.3: Narrative from Returned Traveller 6

> My partner and I had returned from overseas. My partner has stage four terminal cancer, so we needed to urgently return home to Brisbane for his chemotherapy. When we arrived at the airport, I told a DHHS officer about my partner's circumstances and asked about getting an exemption from quarantine. They told me to speak to someone from the hotel. We had to wait a long time before we were allowed to get off the bus. My partner was in severe pain and the delay made it worse. We waited for the exemption but never received any response. I ended up contacting the Chief Medical Officer and Minister for Health in Queensland, and the Victorian Minister for Health. I was then told that the exemption was never lodged. Eventually an exemption application was lodged about six days later. I felt like the staff misinformed me.

Source: Information provided to the Inquiry via the Intake and Assessment team between 15 July to 3 December 2020. Names of sources have been de-identified for privacy purposes.

87. Returned Traveller 3 highlighted that dirty air in their hotel room exacerbated their chronic asthma:

> I had three asthma attacks, so had to take a lot of asthma medication. This made my heart race, and the nurses called a doctor. He suggested I needed to go to hospital for steroids. I told them that just having fresh air breaks would assist my breathing. The doctor asked four DHHS officials if I could be given fresh air breaks - they all refused.[59]

88. Meanwhile, Returned Traveller 4 experienced delays in receiving medical attention after falling sick while in quarantine:

> I woke up at 4am with excruciating stomach cramps and diarrhoea. I felt feverish and could not eat or drink. After two phone calls, a doctor came up to my room to see me around 10am, wearing goggles, gloves and a mask. He called an ambulance. Seven hours later an ambulance arrived. I was taken to the Royal Melbourne Hospital and stayed overnight. They did tests and put me on an IV drip. They discharged me the following morning and told me to eat a 'bland diet'. Back at the hotel, I told a nurse that I needed a bland diet. I felt worse the next day so spoke again to the nurse who consulted a doctor. She said my case wasn't an emergency, so wasn't much she could do.[60]

89. Nurse Jen told the Inquiry that she was gravely concerned for the physical wellbeing of one returned traveller who suffered from endometriosis and was in considerable pain. The woman treated her condition with Chinese herbs but was refused access to a kettle to boil water to prepare the medicine by DHHS.[61] Nurse Jen stated:

> I was really concerned. If I ever had a patient in my care like that in a hospital, it would definitely be a medical emergency just to get the pain under control straightaway. In this situation we unfortunately couldn't really do much.'[62]

90. Dr Gordon's evidence was that, in a normal social setting, experience shows when members of the community can meet together, the more functional members of the 80 per cent will play a supportive role towards those who are more vulnerable or struggling to cope. This usually reduces the stress experienced by those in the 20 per cent and also reduces the need for external assistance.[63] Of course, meeting together while in quarantine was not a possibility, so this type of informal support that exists in other emergency scenarios was not possible.

91. Dr Gordon stated, based on previous studies, that the only way to effectively intervene with populations carrying high levels of stress but who have not previously experienced it, is to initiate communication, drawing people into the discussion. Otherwise, those in the 80 per cent will usually not reach out until things get desperate.[64]

92. An example of this can been seen in the evidence of Sue and Ron Erasmus. Ms Erasmus was a registered nurse and Mr Erasmus the CEO of an Indian branch of an Australian business. They returned to Australia with their two children following the sudden death of Mr Erasmus's father in South Africa. Mr Erasmus found quarantine very difficult, as he was not only dealing with grief following the loss of his father, he was continuing to work in his role as CEO and was unable to exercise, which was his usual method to deal with stress. When the situation became too much, Mr Erasmus did reach out to a DHHS staff member about his difficulties and was provided with a number for bereavement counselling. It was a big step for Mr Erasmus to ask for this kind of support. Unfortunately, he stated that, when he did speak with the counsellor, it was clear that information about his personal difficulties had not been shared with her, and Mr Erasmus did not feel cared for or supported. It exacerbated the difficulties he was experiencing in quarantine.[65]

93. Returned Traveller 4 shared their quarantine experience regarding a daily 8.30am welfare call by a nurse and daily fresh air breaks.

> During one welfare check the nurse asked if I had any thoughts of self-harm. I said 'of course I do, I'm locked in a room every day. I am sick and every day has been a fight to get the medical treatment that I need. I am tired of fighting to get appropriate food for my bland diet … I just want to go home.' I got a call later saying my first 'fresh air break' was at 3.15pm. But no one called or came to collect me.[66]

94. Witness Liliana Ratcliff, who, during her own quarantine period expressed ongoing concerns to Hotel Quarantine Program staff about the mental health of returning travellers, said that she told the staff: 'If I was going to commit suicide, I would do it just after their daily call, because I would know that no one would check on me for another 24 hour'.[67]

12.2.2 Potential stressors for some people in quarantine

95. Dr Gordon identified some of the types of stressors that some people placed in quarantine were likely to experience. He described these as the 'key threats' likely to be perceived by returned travellers in the context of a hotel quarantine program: the threat of the virus itself, the threat of isolation and the threat of disruption to lifestyle.[68]

The threat of COVID-19 as a stressor

96. Dr Gordon's evidence was that the threat posed by COVID-19 itself was an abstract one for which most returned travellers would have no firsthand experience.[69] Dr Gordon said that the threat posed by the virus was likely to engender mixed responses.[70] It was possible, he said, that some returned travellers may not take the threat seriously.[71]

97. One example of the threat of the virus itself causing additional anxiety was the evidence of Ms Ratcliff, who experienced quarantine with her two children. Ms Ratcliff was a health professional and familiar with infection control in the hospital setting. She suffered from an auto-immune disease and was especially anxious about getting COVID-19.[72] Her anxiety about contracting the virus was increased because she observed lax infection prevention and control measures throughout her time in the Hotel Quarantine Program. It was Ms Ratcliff's level of understanding about infection prevention and control that increased her anxiety, because she believed the Program was not being run correctly and that those working within it were not adequately trained in infection control. She observed that 'the approach was so different to what she was used to from working in hospitals'.[73]

98. The stress that could be caused by the risk of being infected by COVID-19 were not limited to within the hotel quarantine environment. Indeed, the Inquiry heard evidence of unsafe PPE use and social-distancing practices in the process of transporting returned travellers to their quarantine hotels. Witnessing — and being required to participate in — practices that increased the risk of virus transmission, would doubtlessly have compounded returned travellers' anxiety about being exposed to the COVID-19 virus.

99. The process of transporting returned travellers to their hotels involved travellers being escorted from an area at the back of Melbourne Airport, where there were SkyBuses waiting for them.[74] Those buses were used to transport returned travellers to their hotels.

100. Kaan Ofli, returned traveller, described his experience on the bus used to transport him to his hotel. He recalled his bus as being 'quite full', with approximately 40–50 people on board.[75]

101. There was evidence given to the Inquiry that there was no social distancing observed between passengers.[76] Hugh de Kretser, a returned traveller and Executive Director of the Human Rights Law Centre who was detained with his wife and two children, observed that it was very difficult to maintain physical distancing on the bus from the airport to the hotel, creating unnecessary risks of transmission.[77] He did not remember being asked to wear a mask on the bus,[78] nor were there any instructions around maintaining distance on the bus; however, Kate Hyslop and Ricky Singh, returned travellers, recalled that they were required to wear their masks.[79]

102. Some witnesses reported that, when the bus arrived at a quarantine hotel, security guards carried returned travellers' luggage from the bus and into the hotel. Professor Lindsay Grayson, Professor of Infectious Diseases at Austin Health observed, in the context of security guards assisting in the movement of returned travellers disembarking from those buses, the risk of transmission would be restricted if those guards wore a gown, a mask, eye protection and, if they were going to handle objects that belong to the individuals, they wear gloves, because those objects may be contaminated.[80]

103. Returned Traveller 1 said, however, that they saw security guards handling luggage without wearing gloves or other PPE.[81]

104. Returned travellers were, from the moment they arrived in Victoria, subject to the Hotel Quarantine Program. In chapters 6 and 7 I set out, in detail, why and how the Government was responsible for infection prevention and control measures in the Program. The evidence of Prof. Grayson shows that infection prevention and control measures were necessary to be taken well before returned travellers entered their hotels.

105. Transporting large numbers of potentially infected returned travellers, on buses designed to carry passengers sitting or standing in close proximity to one another, necessarily creates a risk of infection transmission. That is particularly so given what we know about how the COVID-19 virus is transmitted, including by way of surface contamination.

106. It is imperative that proper infection prevention and control measures are adopted on those buses (and also after passengers have alighted) so as to minimise the risk of infection transmission.

107. The conclusions as to what are proper infection prevention and control measures set out in this Final Report — and also in the Interim Report — apply with equal force to transit arrangements. That includes, as a minimum, a need to enforce social distancing, implement cleaning and PPE practices, and reduce the potential for those involved in transporting returned travellers to be exposed to other members of the public.

108. Moreover, where proper infection prevention and control measures are implemented in the transit process — and are also seen to be implemented — it would go a significant way to reducing anxiety that returned passengers may feel about being exposed to the risk of COVID-19 infection.

Isolation as a stressor, and the need for human connection

109. The second threat identified by Dr Gordon was that posed by the isolation of hotel quarantine.[82] Any effective quarantine program necessitates a loss (albeit temporary) of the ordinary and spontaneous social interactions inherent in everyday life. Dr Gordon stated that, in the absence of these interactions and the feedback about one's self that is routinely provided, the hotel quarantine experience had the potential to undermine an individual's internal sense of identity.[83] He explained this would not apply to everyone. Those people who had a strong, stable sense of their own personal identity would be able to manage without constant social feedback. However, individuals who needed that constant feedback to maintain their identity would find its sudden removal disorientating and stressful.[84]

110. Returned Traveller 11 described their experience of isolation in quarantine:

> It is not as easy to sit in a room by yourself, as people think. Being locked up is definitely bad for mental health, but what makes it way worse is the way the system and the staff who run the system treat you — in my 15 interactions with different people, why did only a few people ever follow up? Why couldn't a friend drop something off, yet a taxi was able to?[85]

111. Another returned traveller highlighted that the mental health needs of those in quarantine needed to be better considered:

> The government should have been much more proactive in how they handle the mental health needs of quarantined travellers. It's definitely no picnic or luxury holiday, and for those with existing mental health issues, it can be too much to bear. A more proactive attitude is especially important for men, who are unlikely to reach out for help whilst in distress and much more likely to harm others or themselves. If it were up to me, I'd make it policy that all quarantined travellers receive daily mental health check-ups and daily access to fresh air as a matter of right.[86]

112. In contrast, Returned Traveller 10 shared that they found their quarantine experience more pleasant:

> I coped quite well with the 14 days and felt that the program was run well. I passed the time by discovering WhatsApp, and spending time on my tablet. I was allowed to receive a care package during my detention, which helped. I had friends call me, and I had a lovely view so I could watch the ships come and go and see the traffic on Kings Way.[87]

113. Of the experiences described by returned travellers who contacted the Inquiry, the description of a positive quarantine experience was limited to a small minority. Many returned travellers described feeling isolated, unsupported and punished. I accept that the motivation to contact the Inquiry to report negative experiences may have been a driver, at least in part, for this result. This does not detract from the importance of the information provided, though, in terms of its relevance to improvements to future quarantine programs.

114. One of the nurses working in the Program, Michael Tait, identified the loneliness experienced by some. Mr Tait observed that many people became depressed because they were lonely, in particular the elderly guests, as they were not comfortable using technology to stay connected. As he observed: 'you could tell they were struggling as they just needed some human connection'.[88]

Disruption of lifestyle as a stressor

115. Dr Gordon identified a third threat posed by hotel quarantine; namely, the disruption of lifestyle.[89] He explained that, while regular routines and habits are often taken for granted, disruption to this stable fabric in the context of hotel quarantine can result in an eruption of anxiety and unstable emotional responses.[90] He explained that this disruption of routine is common in disasters and has a destructive influence itself. Because people often do not recognise the importance of routines, or that they even have a routine, losing that stability can lead to a loss of resilience, self-management and understanding.[91]

116. Dr Gordon stated that it is important to bring this loss of routine to the attention of those in quarantine, as they often do not realise that is what they are experiencing. This would enable the returned traveller to identify what was important to them, and to build a routine for themselves for the 14 days of isolation.[92]

117. In addition to the specific potential threats of hotel quarantine, Dr Gordon described the most common effect of a high-stress situation was an increasingly self-centred focus; that is, one's focus becomes solely on the stressor. He described this as an 'adaptive reorganisation to maximise resources' with the result that attention to contextual factors and systems was compromised.[93] What compounds this problem, in the quarantine scenario, is the link between this self-focus and the strong desire for reunification with loved ones.[94]

118. As Dr Gordon described it '... this really is a consequence of the fact that our attachments with our most important people are the fundamental cornerstones of our personality and the most highly-valued aspects of our experience and the very basis for security, comfort and everything we need to counteract the stress'.[95] Accordingly, the separation from loved ones during the quarantine period would, itself, be an added stressor for returned travellers.[96]

119. The Inquiry heard from some returned travellers who shared that they desperately needed contact with their loved ones because they were experiencing grief.

Figure 12.2.4: Narrative from Returned Traveller 3

I am an Australian citizen. I came back to Australia because my father was gravely ill. I was desperate to get home to my family.

I took a COVID-19 test before I left to ensure I wasn't positive. I got a flight to Adelaide and applied for an exemption from quarantine. I wanted to travel on to Melbourne to be close to the hospital and my family. I would never have sought an exemption if I had been COVID positive. In transit I heard from DHHS that my exemption was refused, but it might be possible to quarantine in Melbourne. I had a second COVID-19 test when I arrived in Adelaide, which was also negative.

The officials in SA were understanding of my situation. They supported my request to complete quarantine in Melbourne, liaised with DHHS and told me to book a flight. I was later told DHHS considered that my father's condition was not serious enough to warrant me coming to Melbourne. I was told to cancel my flight.

Not long after this my brother called me to say Dad was not going to make it, and could I come to Melbourne sooner. I was then granted the right to transfer and finish my quarantine in Melbourne.

Sadly, this was too late for me. My father passed away the night before I was allowed to return to Melbourne. I had to watch my father take his last breath over messenger video, while I was alone and distressed in a quarantine hotel in Adelaide.

I feel it was unnecessarily cruel that DHHS did not let me return to Melbourne sooner, and give me the chance to see my Dad one last time.

I was grieving and then I faced further difficulties in my remaining days of quarantine.

Source: Information provided to the Inquiry via the Intake and Assessment team between 15 July to 3 December 2020. Names of sources have been de-identified for privacy purposes.

120. Having identified the potential threats that may be perceived by those in a hotel quarantine scenario, Dr Gordon was able to provide suggestions to assist in the design of a hotel quarantine program that seeks to counteract those potential stressors. In summary, his advice about the fundamental thing to get right is **communication**.[97]

12.2.3 Clear, consistent and accurate information needed

121. A key theme that emerged from the evidence of returned travellers who gave evidence or provided information to the Inquiry was a perceived failure by the authorities to provide clear, consistent and accurate information regarding the operation of the Program, and a lack of clear points of escalation to raise issues or concerns. Returning travellers who gave evidence or contacted the Inquiry variously described receiving information at intake that was inaccurate, requesting and being denied access to relevant policy documents, and information changing without clear explanation.

122. Some returned travellers identified this lack of clear, consistent and accurate messaging as having contributed to feelings of uncertainty, unpredictability and stress.

> We had both tested positive to the virus, but it was not explained to us exactly what this meant, and what would happen next. The whole quarantine situation was extremely stressful for us — separated from our family, and also especially hard due to my father passing away. No one listened to our concerns at the time.[98]

123. Others felt that the language used in documents and the attitude of some staff was cruel and punitive, as highlighted in Figure 12.2.5 below.

Figure 12.2.5: Quotes from returned travellers about use of language in the Hotel Quarantine Program

Returned Traveller 3: I had my birthday during this time and friends and family dropped off gifts and care packages for me. I was required to sign a 'consent for inspection' form. This was harshly worded and written with a tone of intimidation. I was told in a sarcastic and authoritarian tone by a DHHS official that if I didn't sign the form, I would not get my birthday presents. I felt like I was being punished.

Returned Traveller 12: Even the wording of the Detention Notice was harsh. There seemed to be no thought given to the possibility that some of us are already in a fragile state of mind when we land ... I felt like I was being punished for going overseas for a trip of a lifetime.

Source: Information provided to the Inquiry via the Intake and Assessment team between 15 July to 3 December 2020. Names of sources have been de-identified for privacy purposes.

124. The evidence of Dr Gordon assists in analysing and explaining why some returned travellers found the experience of hotel quarantine stressful and difficult. Dr Gordon identified the types of threats that may be experienced by those in hotel quarantine and potential strategies to overcome those threats.

125. Dr Gordon identified the ability to recruit people's confidence and trust as essential to the management of the hotel quarantine scenario. Trust and confidence lead to acceptance and an understanding that what people are being asked to do is necessary, thus leading to cooperation.[99] Dr Gordon explained that the ability to maintain security, trust and confidence of returned travellers will counteract, to some extent, the anxiety, stress and perceived threat they may experience while in quarantine.

126. Some of the returned travellers who contacted the Inquiry described that it was very difficult to get responses from staff and they had to have many conversations, raising the same concerns, before their issues were resolved.

Figure 12.2.6: Quotes from returned travellers regarding issues with communication and processes

Returned Traveller 7: My experience over the two weeks of quarantine was that it seemed like no one knew what was going on. I don't think that the staff knew who was in our room - at least twice during my stay, I got calls from staff asking to speak to my two-year-old daughter. I said, 'I'm happy to give her the phone, but she's 2 years old.'

Returned Traveller 11: I repeatedly asked for drinks to be delivered to my room, but they never got delivered. Staff would promise to follow things up and get back to me, but they only got back to me about 20 per cent of the time.

Returned Traveller 12: There was no clear process, the left and right hand didn't know what they were doing, the incompetence was absurd.

Source: Information provided to the Inquiry via the Intake and Assessment team between 15 July to 3 December 2020. Names of sources have been de-identified for privacy purposes.

127. Indeed, Ms Ratcliff repeatedly raised concerns about infection control at the Stamford Plaza Hotel. As well as using the daily calls from nurses as a means of raising a range of concerns, she also made a complaint to DHHS by email. Ms Ratcliff received an automated reply from DHHS's 'Feedback Management System' on 18 May 2020 but, as at the time of giving evidence to this Inquiry, Ms Ratcliff still had not received a proper response from DHHS.[100]

> I felt that I was brushed off. I believe there should have been proper processes for escalating concerns and complaints.[101]

128. Luke Ashford, who was an Authorised Officer in the Program, stated that '[t]here was no formal procedure for complaints or issues to be raised'.[102]

129. Moreover, there was some evidence that DHHS held a view that the Government helpline ought not proffer advice to detainees that they reach out to parliamentary representatives to raise concerns about their treatment in hotel quarantine.

130. When she appeared before the Inquiry, Merrin Bamert, Director — Emergency Management, DHHS, confirmed that she recalled receiving email correspondence that indicated the helpline run by the Department of Jobs, Precincts and Regions (a 1800-number available to people in quarantine) was saying that people should advocate via their local Members of Parliament.[103] Ms Bamert replied, via email, saying that that was not appropriate at all.[104] Ms Bamert described what she recalled of the complaint that had given rise to the relevant email chain and to explain that it was not appropriate to tell people to ring their local Members because '[t]here should be internal mechanisms' that would allow for a more timely and appropriate response.[105]

131. Ms Bamert was correct that there should be internal mechanisms to enable a timely and proper response to issues and concerns raised by people being held in quarantine. However, internal mechanisms for responding to health and welfare needs and external avenues for escalating concerns are not mutually exclusive.

132. In fact, external oversight (whether by the Ombudsman or by a local Member of Parliament) should operate to strengthen internal processes. The option of complaining to a local Member provides an avenue for people in quarantine to escalate concerns in the event that internal processes are inadequate, either broadly or in a specific respect. Noting the inherent vulnerability of people in mandatory quarantine, it is not 'inappropriate' for people in quarantine to be informed of the full range of options available to them if they have concerns or issues for which they believe they are not getting an adequate response.

133. Dr Gordon stressed that the quarantine program needed to be communicated as being protective against the threat of COVID-19, so that the isolation and disruption is more readily accepted.[106] Returned travellers need to be active participants in discussions and have the opportunity to ask questions.[107] Authorities need to provide clear, repeated information about the situation,[108] as well as channels through which to communicate.[109] As part of this process, the relevant authorities should provide advice on issues returned travellers are likely to experience.[110] Having an understanding about what to expect can greatly lessen the stress of unfamiliarity.

134. Dr Gordon emphasised the importance, in particular, of repetition of information and ensuring the authorities, to the best of their ability, provide consistent information. As Dr Gordon put it:

> I think a very demoralising feature for people who are in any kind of disaster or trauma situation is losing confidence in the clarity and consistency of the authorities, because they are very, very dependent on them, and if they can't feel confident in them, then you see this massive escalation in their level of anxiety. So therefore we come to the notion of regularly repeating all the basic information in varying forms and in varying modalities, speech, written information, stuff on the internet, television, whatever, and just having this circulating through. It's better to bore them than for them to go into this state where they just don't know what's going on.
>
> … With the best intentions, any inconsistency, contradictions or serious failure of coordination has a very profound effect on the confidence and security and therefore the anxiety management of the people concerned. So, I'd say that that would be a really important point to be monitoring and watching. Again, it's about the social psychology of the information management.[111]

135. The evidence of some of the returned travellers who experienced difficulties in the Hotel Quarantine Program demonstrated how communication was vital to ensure trust and confidence in the system. For example, Ms and Mr Erasmus had already been subject to a harsh lockdown in South Africa prior to being able to arrange a mercy flight back into the country, which was a difficult prospect at that time. Due to their challenging personal circumstances, they communicated with the authorities, in advance, to make them aware of some of the issues they were experiencing.[112]

136. However, while they were in quarantine, it became clear that the information was not being shared.[113] This led to the family having to, repeatedly, explain their difficult circumstances, causing re-traumatisation. As they observed: 'Communication was appalling and inconsistent and added to the overall stress … at what was already a difficult time for our family … it really was made so much harder by how disorganised and disjointed the while [sic] process was'.[114]

137. Mr de Kretser, who was detained with his wife and two children, gave evidence about the inconsistency of information being provided to him and his family. Mr de Kretser was aware of the procedure under the PHW Act that required a daily review of each person detained. He asked three different people from DHHS whether his family's detention was being reviewed daily. As he observed: 'One officer seemed surprised by the question and told me we were being detained for 14 days. Another told me that the nurses do the review (presumably referring to the daily nurse welfare check) and another told me that the detention "wasn't really reviewed"'.[115]

Fresh air breaks

138. The importance of fresh air breaks for health and wellbeing is addressed in the Interim Report at page 49, as follows:

> Fresh air breaks are necessary and will need to be factored into not only the 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.[116]

139. In this context, the Interim Report also addressed the need for the facility to be one that can provide a physical environment that facilitates safe access to fresh air and exercise.

140. In relation to information about 'fresh air breaks', availability of fresh air breaks and the impact of not having access to fresh air and exercise breaks for 14 days, the evidence and information obtained by the Inquiry set out in this section speaks to those issues.

141. Mr de Kretser described the information he was provided with to be inconsistent and his family was not given a break from their room until their second last day in quarantine.[117] In fact, when he sought a copy of the policy governing fresh air breaks, Mr de Kretser faced a number of, what he described as, evasive responses from DHHS personnel until eventually he was told to make a Freedom of Information request.[118] Irrespective of the unsatisfactory state of the evidence as to what policies applied at what time, there was at least some form of a fresh air policy in existence when Mr de Kretser asked for it.

142. Ms Hyslop and Mr Singh, who were quarantined in mid-April 2020, received documents upon arrival into Australia, including a letter stating that they were not to leave their rooms.[119] They never left their room and were not told they were allowed fresh air breaks.[120]

143. Ms Ratcliff shared that she and her children had one fresh air break, and chose to not have more, as the fresh air break caused them stress. 'My kids and I only had one walk while in quarantine, despite being offered more fresh air breaks. After the first walk I did not want to go outside again, as I did not feel that safe practices were being observed and the children felt it made them stressed, being watched by four strange men.'[121]

Figure 12.2.7: Narrative from Returned Traveller 4

I got a call ... saying my first 'fresh air break' was at 3.15pm . But no one called or came to collect me. At 3.30pm I called hotel staff. I was frustrated. They booked me another fresh air walk for 7.15pm that night, which went ahead. The walk, and the opportunity to talk with the security guards during the walk, made me feel a lot happier ... I became friends with one security guard who treated me kindly. He and two other security guards I also became friends with arranged extra fresh air breaks for me and escorted me on those breaks. I had a factsheet that said that fresh air breaks are 'weekly'. But because of those three security guards, I usually got two to four fresh air breaks every day. I felt like no one else showed me kindness, except the security guards.

Source: Information provided to the Inquiry via the Intake and Assessment team between 15 July to 3 December 2020. Names of sources have been de-identified for privacy purposes.

Inconsistent information: multiple data sets

144. Mr Tait described inconsistency in DHHS policy with advice constantly changing, often quickly and without explanation. He learned, as a result, not to make any promises to the returned travellers.[122]

145. Mr de Kretser witnessed DHHS staff changing constantly and inconsistent information about policies being given to those staying in the hotel as a result.[123] This experience of staff changing everyday was also observed by Ms and Mr Erasmus, again leading to inconsistent and difficult communication while in quarantine.[124]

146. With better data collection and management systems in place, returned travellers' experiences could have been improved in this regard. Both Ms Bamert and Ms Williams identified that data collection and management were areas requiring improvement.[125] Ms Williams gave evidence that multiple data sets were not adequately harmonised, improvements were slow due to pressures on staff and skill shortages, and that there was the need to develop a tailored technological solution across the whole operation.[126] Ms Bamert similarly recognised the need for improved efficiency in the development and uptake of IT systems, data collection and reporting.[127]

Building trust and acceptance through clear communication

147. Dr Gordon emphasised in his evidence that the key to maintaining management of the quarantine program was fundamentally an exercise in social psychology; that is, recruiting the confidence and trust of those in the system.[128] Dr Gordon explained, as set out above, that returned travellers in hotel quarantine could be expected to perceive three key threats: the threat posed by illness in contracting COVID-19, the threat posed by isolation and the threat posed by disruption of lifestyle.[129] 'Where quarantine is felt as threatening and causes a state of high arousal, the best way to reduce the stress caused by the combination of these three threats is to hold on to the illness as the major threat, and to view the other problems as safety procedures designed to protect from the threat, rather than impositions which are felt as threats in themselves'.[130] Communicating this effectively will motivate adherence and build trust that the measures are necessary.[131] It is much easier to accept personal difficulty and sacrifice if one understands why it is necessary.

148. This ability to build trust and acceptance with returned travellers was compromised due to the difficulty in accessing helpful information; as much can be found from the evidence outlined above. Moreover, Mr de Kretser said that, when planning for his family to return to Australia in May 2020, he found the available information from the Government about hotel quarantine was very poor. He largely relied upon information from Facebook groups set up by returned travellers already in quarantine.[132]

149. Ms Hyslop and Mr Singh shared a similar experience. They conducted research into what to expect of the quarantine program prior to returning to Australia but did not understand how it operated.[133] They agreed that Facebook became a key source of information because they found it was hard to get information from staff.[134]

150. Dr Gordon stressed the importance of the supportive way in which returned travellers need to be communicated with. He explained that 'supportive' in this context means communicating in a way that demonstrates understanding. It is a qualitative feature of communication, not an outcome-based one;[135] in other words, even if a request cannot be met, the person will still feel supported and understand why something cannot be done in the circumstances.

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

> Support is a quality of interpersonal contact. It is [a] 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.[136]

152. Ms Ratcliff spoke of the kindness of the nurses toward her children,[137] which she noted was appreciated at the time and made her feel that the staff were trying to address some of her family's needs.

153. Returned Traveller 5 shared that they felt particularly supported by the nurses:

> Three nurses really helped me while I was in Quarantine, I believe they kept me alive during this time. The nurses did everything for me; the hotel staff, DHHS staff and coronavirus line didn't want to know about me. When I spoke to DHHS on the phone, I felt like a problem.[138]

154. Some returned travellers felt unsupported during their stay in hotel quarantine, leading to additional stress and anxiety. For example, a witness, identified as Returned Traveller 1 was in quarantine with his wife, who was 28 weeks pregnant, as well as two young children, aged two and three. Returned Traveller 1 told the Inquiry about shortcomings in communication, including being given inconsistent information and instructions, and being treated in a way that he felt was unsupportive:

> We were often told by people from the Department that 'you knew what you were getting into'. We were told words to the effect that 'you knew we were being locked in and wouldn't get certain things, like walks every day' and 'no one promised you walks'. Hotel quarantine staff were not always understanding and at times my wife was told words to the effect that 'you're not the first pregnant woman to come here'.[139]

155. Dr Gordon stated that '[o]pportunities for regular, caring, informal unsolicited communication supports a person's sense of identity, as well as providing emotional support and confidence'.[140] 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'.[141]

Creating a sense of community

156. Finally, Dr Gordon identified that creating a sense of community among those in hotel quarantine could assist in bringing down a sense of stress or arousal. As he observed:

> … one of the greatest assets to the containment and processing and therefore bringing arousal down of the situation is to help the whole group that's affected communicate together … that creates a sense of common identity, which counteracts the sense of isolation, which is one of the most damaging factors in the quarantine situation.[142]

157. Communication between those in quarantine should be facilitated in a constructive way,[143] such as through moderated discussion groups.[144] While some returned travellers formed their own groups via social media, Dr Gordon was of the view that it would be more effective to integrate these discussions into the government communication process.[145]

158. Dr Gordon explained the benefits of a sense of community solidarity and support being fostered among the 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.[146]

12.2.4 Safer Care Victoria reports

159. Two Safer Care Victoria reports[147] identified shortcomings in the health and welfare aspects of the Hotel Quarantine Program.
160. Findings in the reports included that there were insufficient staff to conduct the required welfare checks, and that welfare checks were delayed or infrequent.[148]
161. The reports were undertaken at the request of the Secretary of DHHS following two critical incidents that occurred in early April 2020 and which uncovered significant risks to the health and wellbeing of detainees.[149]
162. The reports identified contributing factors relevant to the incidents and made a number of findings that revealed, first, a lack of safe processes in the Program and, second, that extraordinary demands were being placed on all Operation Soteria staff, who were significantly under-resourced for the task.[150]
163. These reports were requested to identify and address any ongoing risks to those who were being detained in hotel quarantine.[151]
164. This was what was found:

KEY FINDINGS AND RECOMMENDATIONS FROM THE SAFER CARE VICTORIA REPORT REGARDING INCIDENT ONE

165. Incident One occurred on 11 April 2020, when a returned traveller was found deceased in their room at the Pan Pacific Hotel, Docklands.[152] The traveller had been detained in quarantine since 3 April 2020.[153] There had not been any indications that the traveller was particularly vulnerable or under significant stress.
166. The Incident One report found that staff were often not able to access all detainee health and welfare information that they needed in order to provide adequate care to detainees, due to the lack of a comprehensive, central, accessible repository for such information,[154] and that detainee health and welfare information was collected in a fragmented manner.[155]
167. The report noted that, at the time, none of the required forms asked about mental health concerns or whether the detainee may wish to speak with someone about any issues of concern regarding their health and welfare.[156]
168. The report also found that there was a lack of specific formal policy about the threshold for escalating concerns about repeated unanswered COVID-19 assessment calls, and a lack of formal procedure for tracking these.[157] In addition, due to workload and delegation challenges, Authorised Officers were sometimes required to prioritise multiple competing demands, resulting in delays in attending to potential health and welfare concerns of returned travellers.[158]

169. The Incident One report made 13 recommendations, including:

A. improved 'onboarding' processes

B. daily health and welfare calls

C. targeted risk assessments

D. improved information in the form of a central repository

E. clear processes for escalation of concerns

F. rapid response surge capacity for staff, such as AOs, if they are overloaded with tasks or demands.[159]

KEY FINDINGS AND RECOMMENDATIONS FROM THE SAFER CARE VICTORIA REPORT REGARDING INCIDENT TWO

170. Incident Two involved the care of a traveller who developed COVID-19 symptoms and deteriorated rapidly, requiring an intensive care unit admission at The Alfred Hospital.[160]

171. The Incident Two report found that on-site clinicians were constrained in their ability to conduct face-to-face clinical assessments due, in part, to an insufficient supply of readily accessible and reliable PPE.[161]

172. The report also found that there was unavailable or unreliable access to clinical equipment for physical examination and clinical monitoring of returned travellers, such that clinical decision-making was being based on incomplete clinical information and assessment.[162] Further, the report found that some staff were unclear on the scope of their role, as well as the delineation of roles and responsibilities within and between teams, which affected care delivery and completion of tasks to address returned traveller health and welfare needs.[163]

173. There was also no clear agreement between the hotel quarantine system and Ambulance Victoria about managing the hospital transfer needs of returned travellers. The report found this contributed to improvised clinical decision-making by frontline staff.[164]

174. Other factors that contributed to the incident included the absence of an accessible, comprehensive, central repository for health and welfare information, and an inability to identify returned travellers with high and/or escalating health and welfare risks because of this. This resulted in the impairment of staff's ability to have good visibility, in a timely manner, of the full clinical picture of unwell returned travellers.[165]

175. Further, the in-room communication system (such as the hotel room telephone) was not able to be used by some returned travellers in order to make calls external to the hotel, and not all returned travellers had access to a functioning mobile phone.[166] The report noted that, while this may not have directly been a contributing factor to the incident, there was an opportunity to make improvements.[167]

176. The Incident Two report made 18 recommendations, including:

A. implement measures to ensure an adequate and reliable on-site supply of PPE that is readily accessible to all staff working in the hotel quarantine system, and policies to ensure appropriate use of PPE by staff

B. development of policies and processes to enable visual telehealth consultations

C. a centralised information system

D. clear role descriptions for all staff and formal communication and handover

E. clear processes and communications regarding escalation of issues

F. implement a formal agreement between all relevant parties in the hotel quarantine system and Ambulance Victoria regarding the ambulance service requirements of returned travellers

G. on arrival, returned travellers should have suitable access to a functioning mobile telephone

for the duration of their mandatory detention.[168]

177. Additionally, in the Incident Two report, 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'.[169]

178. As stated in the Interim Report, 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 was admirable that the hospitality personnel of hotels consistently referred to the people in quarantine as 'guests'.[170]

179. The language used to describe the people in quarantine in a facility is important. It adds 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. The word 'detainee' was derived from the section of the PHW Act that provides the power to issue a Detention Direction mandating people into quarantine.[171]

180. However, inside a quarantine 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.

181. It is not the focus of this section to consider the extent to which, and when, the Safer Care Victoria recommendations were implemented in the Hotel Quarantine Program. I am looking to what the findings and recommendations mean for a future model.

182. Suffice to say, the findings of the two Safer Care Victoria reports highlighted many areas of risk to the welfare of returned travellers in quarantine, and that safeguarding the health and wellbeing of those in quarantine proved to be far more complex than had, perhaps, first been anticipated.

183. The need to focus on health and welfare earlier and better than it was, was the subject of some evidence by Operation Soteria leaders.

12.2.5 Health and welfare were initially not the main focus of DHHS in the Program

184. Jason Helps, the State Controller — Health, gave evidence that the initial welfare arrangements that were put in place for the commencement of the Program had limited understanding of the risks or issues that may arise in the Program.[172] He said that they had no passenger health or demographic information and no experience in how people might react in a quarantine environment, other than to draw on a comparison to what people's needs were in other emergency and crisis situations.[173]

185. Ms Williams held the view that there was an assumption in the Hotel Quarantine Program that detention within the Program could be achieved without undue impact on the health and wellbeing on the detainee.[174] Ms Williams observed that the Program 'was criticised on human rights grounds' for its impact on the mental health and wellbeing of guests.[175] She said, and I agree, that DHHS should have made a more nuanced assessment of the balance between transmission risk and guest health, wellbeing and human rights.[176]

186. In any case, it was Mr Helps's evidence that, around 28 March 2020, the focus on welfare expanded from providing welfare calls to quarantined returned travellers to embedding welfare in the *Operation Soteria Operational Plan* as one of the 'highest priorities' for the Program.[177] This was an appropriate addition to the Operation Soteria plan.

12.2.6 Implications of quarantine on people's health and wellbeing

187. Returned travellers who contacted the Inquiry consistently raised concerns about the conditions of their detention, including access to fresh air, the cleanliness of the hotel rooms, difficulties with dietary requirements, concerns about being infected with the virus due to poor infection control procedures, and poor communication that resulted in confusion as to who was in charge.[178]

188. Indeed, Mr Ofli shared that he and his partner only received enough food for one person. 'It was not until later that we realised we weren't getting enough food because they didn't know I was in the room as well'.[179] He also noted that his specific dietary requirements could not be met. 'I had been eating the food we had been given previously, thinking it was Halal, because my partner had told them that I was Halal in the beginning. It was a shock for us when we realised the meat I had been eating was not Halal'.[180]

Figure 12.2.8: Quotes from returned travellers about dietary issues in quarantine

Returned Traveller 3: The food was unhealthy, and I found the majority of meals to be inedible. I spoke with a woman in charge of the quarantine meals and she encouraged me to order from the in-house menu instead. These meals were very expensive. I felt like this was exploiting a 'captive' market for the hotel to profit from. I was not very hungry anyway, as I was grieving my father.

Returned Traveller 11: When I arrived at the hotel, I hadn't had anything to eat for about 20 hours, and as the hotel wouldn't provide anything simple to eat that I could eat, I ended up not eating for 30 hours. I eventually gave up and ordered Uber Eats.

Source: Information provided to the Inquiry via the Intake and Assessment team between 15 July to 3 December 2020. Names of sources have been de-identified for privacy purposes.

Figure 12.2.9: Quotes from returned travellers about the cleanliness of hotel rooms

Returned Traveller 3: The air in the hotel room was dirty. This was a serious problem for me as I am a chronic asthmatic. I had to change rooms four times due to cigarette smoke and one room not being clean. When I reported that I could still smell that there was a smoker next door to me, I was told by staff that I was ridiculous. I don't blame people for smoking as it is a stressful experience to be quarantined, but for me, it was a health issue because of my asthma.

Returned Traveller 12: After taking 5 hours to get off plane and get to hotel the first thing I needed was to use was the amenities. To my horror when I opened the toilet lid in our room, there were faeces in the toilet and around the lid and seat was filthy. There were a lot of stains in the room also. It made me wonder if any checks had been done on the cleanliness of the rooms to see they were up to standard.

Source: Information provided to the Inquiry via the Intake and Assessment team between 15 July to 3 December 2020. Names of sources have been de-identified for privacy purposes.

189. Issues were likely exacerbated for returned travellers who required a higher level of care due to physical or mental health concerns, or who simply felt unable to cope with being detained. As one returned traveller told the Inquiry:

> Many of us returning to Australia are doing so out of necessity. We are returning to a dying relative or a death in the family. Others have lost their jobs, homes and residency rights and visas in a country they adopted as their home. Many of us are already in a fragile state of mind when we land and this harsh, corrections model is inappropriate for returning citizens who have not committed a crime other than return to their homeland in a time of crisis.[181]

12.2.7 Exemptions and temporary leave arrangements as a means to promote welfare

190. DHHS did make efforts to cater to the needs of returned travellers. In its submissions, the department gave examples of having done so,[182] such as:

    A. Dr Finn Romanes, Deputy Public Health Commander, being responsible for a *Physical Distancing Policy*, which included policies and procedures to address the health and wellbeing of people in quarantine, and included content regarding welfare checks.[183]

    B. Dr Romanes' evidence about an *Interim Healthcare and Welfare Mandatory Quarantine Plan*, which included an initial assessment of welfare, a welfare check requirement and protocols regarding smoking, fresh air breaks and exercise, nutrition and food safety, care packages and safety, and family violence risks.[184] However, Dr Romanes could not say, with certainty, whether all of the measures in that Plan were adopted by Operation Soteria.[185]

    C. Consideration of human rights, consistent with the Charter.[186]

191. Efforts were also made to provide for the health and wellbeing needs of returned travellers through the process of considering and granting exemptions from the requirement to quarantine in a hotel setting.

192. Dr van Diemen gave evidence that the detention directions applied to all returned travellers and that exceptional circumstances were required for people seeking not to be ordered into hotel quarantine.[187] Dr van Diemen and Chief Health Officer, Professor Brett Sutton, agreed with each other that exemptions should be granted in limited circumstances.[188] Exemptions from the requirement to quarantine were initially granted for the following reasons:

    A. attending a medical facility to receive medical care

    B. where it was reasonably necessary for physical or mental health

    C. on compassionate grounds

    D. in case of emergencies.[189]

193. By mid-May 2020, the categories for which exemptions could be granted by the Enforcement and Compliance Commander expanded to include:

E. unaccompanied minors in transit to another state

F. unaccompanied minors where a parent or guardian does not agree to come into the hotel

G. foreign diplomats coming into the country

H. people with a terminal illness

I. people whose health and welfare cannot be accommodated in a hotel environment (mental health or requirements for in-facility health treatment)

J. people who are transiting directly to another country (and who do not need to travel domestically first)

K. air crew including medevac crew

L. maritime workers who have come off a boat and would be leaving by boat, depending on their particular movements

M. maritime workers who have come off a plane and would be leaving by boat within the quarantine period, depending on their particular movements.[190]

194. For those categories, exemptions could be granted (on certain conditions) for non-complex cases without the need for Dr van Diemen to approve those exemptions.

195. The *Physical Distancing Plan* in place allowed for applications for permission to leave in certain circumstances, including in 'instances where a person has a reasonably necessary requirement for physical or mental health or compassionate grounds to leave the room, as per the Detention Notice'.[191]

196. Authorised Officers were to make decisions as to exemptions and temporary leave applications. Dr van Diemen said that Authorised Officers were required to balance the needs of the person and public health risk. In this context, Dr van Diemen referred to the *Physical Distancing Plan*, which provided that:

> If the person needs immediate medical care, public health risks need to be managed appropriately, but the expectation is that the leave would automatically be granted. This would be more nuanced and complex when the request is made on compassionate grounds where there is a question about how public health risks might be managed. However, again, human rights need to be considered closely.[192]

197. DHHS said that more than 439 temporary leave permits were granted to allow people to take leave from quarantine for compassionate reasons.[193]

198. Ms Peake gave evidence that there were '440-odd exemptions that were provided to people so that they could complete their quarantine program in an alternative setting, and often that was on the basis of input of the assessment of either the mental health nurses or the CART team, that someone with complex needs, that this setting wasn't appropriate for them'.[194]

199. That this happened 'often' was not borne out by the evidence. Material from DHHS's answer to questions put to Ms Peake showed that a total of 426 individuals were granted an exemption. Of those exemptions, 269 were for travellers in transit; that was, travellers continuing to a further international or interstate destination, with only 56 granted on medical or compassionate grounds.[195] Therefore, around 13 per cent of exemptions granted were related to a person's welfare.

200. I consider that exemptions could and likely should have been granted in more situations with proper regard having been given to the welfare needs of returned travellers. That would be especially so in circumstances where it was inappropriate for a returned traveller to be confined in a hotel room because of their needs, whether they be mental health needs, physical needs or needs arising from their family situation, and in situations where the returned traveller could demonstrate that they could safely and reliably quarantine in their own home or some other suitable residential premises.

12.2.8 Conclusions

201. 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.[196] These needs created many problems for those in quarantine, 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.[197]

202. In some instances, the manner in which these needs were handled increased the risk of transmission,[198] detrimentally affected the health and wellbeing of people detained in quarantine and created considerable strain on those working in the Program.

203. The health and wellbeing needs of returned travellers include the need to not be unnecessarily exposed to a risk of infection while being transported from the airport to the quarantine hotel. It is necessary that proper infection prevention and control measures be implemented with respect to the transit of returned travellers to their hotels, just as those measures are required to be implemented in hotels.

204. In order to address health and wellbeing issues, the health, wellbeing and needs of those in quarantine must be a central feature of a future quarantine program.

205. In the Hotel Quarantine Program, expert advice should have been obtained in order to understand and account for the risks that this type of quarantine arrangement posed to people and to provide guidance to the Program on how to best manage them. Such expertise could have spoken to the challenging behaviours that would likely be encountered as a result of the deprivation of liberty involved in the Program, and the measures that were needed to proactively account for them and other health and welfare issues.

206. The fact that such advice was not obtained is likely to be attributable to several factors: the speed with which the Program had to be set up, that there was no developed plan or experience for holding people in mass quarantine facilities, and what I have found to be a disproportionate focus by those designing and implementing the Hotel Quarantine Program on logistics, when health should have been given greater attention. What this evidence showed was that there was some, but in my view insufficient, attention given to the mental health and overall wellbeing of returned passengers.

207. There were areas where there were shortcomings or systemic gaps in meeting the health and human needs of those in quarantine. These can be summarised from this section as follows:

   A. not initially understanding or adequately addressing the fact that:

      I. being detained in quarantine in a hotel room for 14 days would be a very difficult and stressful experience for some

      II. a percentage of the people held in quarantine would have significant health needs, either physical or mental, or both, and would need particular support

      III. having no access to fresh air or exercise would be extremely difficult for some people

B. that the information provided by airlines and/or Commonwealth officials to allow the State to make proper preparations to accommodate people's health and wellbeing needs was limited and inadequate

C. that the State had no control of the numbers arriving at short or no notice, which made the health and wellbeing aspects of the Program very difficult to address adequately

D. transport arrangements on arrival at airports created an immediate stressor for some people as PPE was not consistently available or worn and buses were reported by some to be crowded

E. that clear, consistent and accurate information was necessary but not available or it was difficult to find or it was in a language that was not accessible

F. that the system for acquiring and maintaining information on people in quarantine was inadequate

G. that there was no clear and consistent and communicated process for people to raise issues and concerns about health and wellbeing and to receive a timely response

H. that the process of access to applications for leave and/or exemptions was not clear or consistent.

208. The difficulties this posed were then not sufficiently revisited over time. This was particularly the case in the areas of communication and the degree of responsiveness when those in quarantine attempted to resolve issues. There was a distinct lack of consistent, easily accessible and transparent information available to people detained in the Program regarding the circumstances of their detention and the policies that applied to it.

209. I accept that efforts were made to keep all returning travellers safe and comfortable and to offer appropriate support to all of them. But meeting the health and wellbeing needs of a range of returned travellers is a complex and nuanced task that needs proper attention. Those responsible for the welfare of those in quarantine must be continuously mindful of performing their roles in a way that does not impose additional stressors beyond those already imposed by reason of a highly stressful and unusual situation.

12.2.9 Recommendations

Transitioning into quarantine facilities

80. The Quarantine Governing Body (called COVID-19 Quarantine Victoria) should ensure proper infection prevention and control measures are applied in the transit of returned travellers to their quarantine facility, in the same manner as those measures are applied at hotels. Those measures should include proper social distancing, cleaning and PPE practices.

81. To further reduce the risk of transmission during transit, the Quarantine Governing Body should require that:

A. buses used to transport returned travellers to quarantine facilities must be used only for that purpose and not to provide non-quarantine related transport services to members of the public

B. every effort be made to ensure that drivers of buses used to transport returned travellers to quarantine facilities are not permitted to work in other forms of employment (or to drive buses for any other purpose), consistent with Recommendation 22.

Recommendations 2–6, 37 and 40–57 of the Interim Report have been adopted for the purposes of this Report and apply directly to this chapter. I have set out these recommendations below.

Recommendations 2–6, 37 and 40–57 of the Interim Report

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).

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 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.

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 I set out at paragraph 21 of Section 1 of my Interim Report).

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 HQI0210_P Transcript of Press Conference by the Hon. Daniel Andrews MP on 27 March 2020, 2.
2 *Charter of Human Rights and Responsibilities Act 2006* (Vic) (Charter) s. 1(2)(a).
3 Ibid s. 1(2)(c).
4 Ibid s. 7(2).
5 Ibid s. 7(2)(a)–(e).
6 Victorian Equal Opportunity & Human Rights Commission, 'Right to life' (Web Page) <https://www.humanrights.vic.gov.au/for-individuals/right-to-life/>; Case of Osman v The United Kingdom (1998) 29 EHRR 235, 30
7 *Charter of Human Rights and Responsibilities Act 2006* (Vic) s. 38.
8 Submission 03 Department of Health and Human Services, 66–67 [357].
9 Exhibit HQI0226_RP Bundle of notices and advices tendered by DHHS, DHS.0001.0004.1702.
10 Ibid DHS.0001.0004.1703.
11 Ibid.
12 Ibid.
13 Ibid DHS.0001.0011.0658.
14 Ibid DHS.0001.0004.1872.
15 Ibid DHS.0001.0103.0008.
16 Ibid DHS.0001.0104.0094.
17 Human Rights Committee, General Comment No.21: Article 10 (Humane Treatment of Persons Deprived of Their Liberty), 44th sess, UN Doc HRI/ GEN/1/Rev.9 (10 April 1992) 1 [3] <https://www.refworld.org/docid/453883fb11.html>.
18 Charter s. 14(1)(b).
19 Human Rights Committee, General Comment No. 22: Article 18 (Freedom of Thought, Conscience or Religion), 48th session, UN Doc CCPR/C/21/Rev.1/Add.4 (30 July 1993) 1 [4] <https://www.refworld.org/docid/453883fb22.html>.
20 *Kracke v Mental Health Review Board (General)* (2009) 29 VAR 1; [2009] VCAT 646 [619]–[620].
21 See eg *Director of Housing v Sudi* (2010) 33 VAR 139, [34].
22 See Charter s. 4 for the definition of a 'public authority' and s. 6(2)(c) with respect to the Charter applying to public authorities.
23 *Certain Children v Minister for Families and Children & Ors (No 2)* [2017] VSC 251 [190].
24 Exhibit HQI0226_RP Bundle of notices and advices tendered by DHHS, DHS.0001.0004.1873 [10].
25 Ibid [11].
26 Ibid [12].
27 See 'Direction from Chief Health Officer in accordance with emergency powers arising from declared state of emergency, Part 2 - Self-Quarantine Following Overseas Travel', Exhibit HQI0155_RP Annexures to witness statement of Prof. Brett Sutton, DHS.5000.0055.3881–3882.
28 See 'Direction from Deputy Chief Health Officer (Communicable Disease) in accordance with emergency powers arising from declared state of emergency — Airport Arrivals, (Airport Arrivals Direction) <http://www.gazette.vic.gov.au/gazette/Gazettes2020/GG2020S135.pdf#page=1>.
29 Exhibit HQI0218_P Witness statement of the Hon. Daniel Andrews MP, 5 [23].
30 Transcript of day 15 hearing 10 September 2020, 1230.
31 Ibid 1228.
32 Ibid 1230.
33 Transcript of day 18 hearing 16 September 2020, 1537.
34 Transcript of day 15 hearing 10 September, 1230–1231.
35 Transcript of day 18 hearing 16 September 2020, 1538.
36 Ibid; Transcript of day 15 hearing 10 September 1230–1231.
37 Transcript of day 18 hearing 16 September 2020, 1538; Transcript of day 15 hearing 10 September 2020, 1230–1231.
38 Transcript of day 18 hearing 16 September 2020, 1540.
39 Transcript of day 19 hearing 17 September 2020, 1681.
40 Ibid.
41 Exhibit HQI0135_RP Witness statement of Ms Merrin Bamert, 26 [92].
42 Exhibit HQI0116_RP Witness statement of Prof. Euan Wallace AM, 2 [7].
43 Exhibit HQI0117_RP Annexures to the first witness statement of Prof. Euan Wallace AM, DHS.0001.0002.0068–0076, DHS.0001.0002.0042–0053.

44 Exhibit HQI0009_RP Witness statement of 'Nurse Jen', 7 [56].
45 Ibid.
46 Transcript of day 20 hearing 18 September 2020, 1742.
47 Exhibit HQI0176_RP Witness statement of Dr Rob Gordon, 7 [28].
48 Ibid 7 [29].
49 Ibid.
50 Ibid.
51 Ibid 7 [29]–[30].
52 Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 5 [15].
53 Ibid.
54 Ibid.
55 Ibid.
56 Exhibit HQI0186_RP First witness statement of Ms Kym Peake, 37 [185].
57 Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 38 [100].
58 Ibid.
59 'Returned Traveller 3', Information provided to the Inquiry via the Intake and Assessment team between 15 July to 3 December 2020.
60 'Returned Traveller 4', Information provided to the Inquiry via the Intake and Assessment team between 15 July to 3 December 2020.
61 Exhibit HQI0009_RP Witness statement of 'Nurse Jen', 9 [76]–[77]; Transcript of day 5 hearing 20 August 2020, 144.
62 Transcript of day 5 hearing 20 August 2020, 144.
63 Exhibit HQI0176_P Witness statement of Dr Rob Gordon, 8 [31].
64 Transcript of day 20 hearing 18 September 2020, 1737.
65 Exhibit HQI0019_P Witness statement of Ms Sue and Mr Ron Erasmus, 4 [23]–[24].
66 'Returned traveller 4', Information provided to the Inquiry via the Intake and Assessment team between 15 July to 4 December 2020.
67 Exhibit HQI0020_P Witness statement of Ms Liliana Ratcliff, 8 [62].
68 Exhibit HQI0176_P Witness statement of Dr Rob Gordon, 8–9 [35].
69 Ibid 9 [36].
70 Ibid 9 [35.1]; Transcript of day 20 hearing 18 September 2020, 1731–1733.
71 Exhibit HQI0176_P Witness statement of Dr Rob Gordon, 9-10 [36]–[38].
72 Exhibit HQI0020_P Witness statement of Ms Liliana Ratcliff, 1 [3], 15 [56]–[57].
73 Ibid 11 [87].
74 Exhibit HQI0018_P Joint Witness Statement of Ms Kate Hyslop and Mr Ricky Singh, 1 [5]; Exhibit HQI0016_P Witness statement of Mr Hugh de Kretser, 4 [23]; Exhibit HQI0020_P Witness statement of Ms Liliana Ratcliff, 2 [14]–[15]; Exhibit HQI0027_P Witness statement of Mr Kaan Ofli, 1 [6].
75 Exhibit HQI0027_P Witness statement of Mr Kaan Ofli, 1 [6].
76 Exhibit HQI0018_P Joint Witness statement of Ms Kate Hyslop and Mr Ricky Singh, 1 [5].
77 Exhibit HQI0016_P Witness statement of Mr Hugh de Kretser, 4 [23].
78 Ibid.
79 Exhibit HQI0018_P Joint Witness statement of Ms Kate Hyslop and Mr Ricky Singh, 1 [5].
80 Transcript of day 3 hearing 17 August 2020, 65.
81 Transcript of day 5 hearing 20 August 2020, 162.
82 Exhibit HQI0176_P Witness statement of Dr Rob Gordon, 9 [35.2].
83 Transcript of day 20 hearing 18 September 2020, 1730.
84 Ibid; Exhibit HQI0176_P Witness statement of Dr Rob Gordon, 10 [40]–[41].
85 'Returned Traveller 11', Information provided to the Inquiry via the Intake and Assessment team between 15 July to 3 December 2020.
86 'Returned Traveller 13', Information provided to the Inquiry via the Intake and Assessment team between 15 July to 3 December 2020.
87 'Returned traveller 10', Information provided to the Inquiry via the Intake and Assessment team between 15 July to 3 December 2020.
88 Exhibit HQI0014_RP Witness statement of Mr Michael Tait, 9 [73].
89 Exhibit HQI0176_RP Witness statement of Dr Rob Gordon, 9 [35.3].
90 Transcript of day 20 hearing 18 September 2020, 1731.
91 Ibid.
92 Ibid.
93 Ibid 1725.

94 Exhibit HQI0176_P Witness statement of Dr Rob Gordon, 6 [20]–[21].
95 Transcript of day 20 hearing 18 September 2020, 1725.
96 Ibid; Exhibit HQI0176_P Witness statement of Dr Rob Gordon, 6 [21].
97 See Transcript of day 20 hearing 18 September 2020, 1741.
98 'Returned traveller 12', Information provided to the Inquiry via the Intake and Assessment team between 15 July to 3 December 2020.
99 Transcript of day 20 hearing 18 September 2020, 1726.
100 Exhibit HQI0020_P Witness statement of Ms Liliana Ratcliff, 1 [89].
101 Ibid 1 [88].
102 Exhibit HQI0023_P Witness statement of Mr Luke Ashford, 6 [38].
103 Transcript of day 16 hearing 11 September 2020, 1314.
104 Ibid.
105 Ibid 1315.
106 Exhibit HQI0176_P Witness statement of Dr Rob Gordon, 11 [45].
107 Ibid 15 [62].
108 Ibid 17 [66.1].
109 Ibid 17 [66.3].
110 Ibid 17 [66.5].
111 Transcript of day 20 hearing 18 September 2020, 1739.
112 Exhibit HQI0019_P Joint witness statement of Ms Sue and Mr Ron Erasmus, 1; Transcript of day 6 hearing 20 August 2020, 227–230.
113 Exhibit HQI0019_P Joint witness statement of Ms Sue and Mr Ron Erasmus, 3 [19]–[22].
114 Ibid 8 [46]–[47].
115 Exhibit HQI0016_P Witness statement of Mr Hugh de Kretser, 8 [53].
116 Board of Inquiry into the COVID-19 Hotel Quarantine Program (Interim Report, 6 November 2020), 49 [140].
117 Ibid.
118 Ibid 2 [10].
119 Exhibit HQI0018_P Joint witness statement of Ms Kate Hyslop and Mr Ricky Singh, 1–2 [6].
120 Ibid 2 [9].
121 Exhibit HQI0020_P Witness statement of Ms Liliana Ratcliffe, 7 [55].
122 Exhibit HQI0014_RP Witness statement of Mr Michael Tait, 7 [61].
123 Exhibit HQI0016_P Witness statement of Mr Hugh de Kretser, 2 [10].
124 Exhibit HQI0019_P Joint witness statement of Ms Sue and Mr Ron Erasmus, 4 [21]–[22].
125 Exhibit HQI0135_RP Witness statement of Ms Merrin Bamert, 23 [73]; Exhibit HQI0130_RP Witness Statement of Ms Pam Williams, 40 [107].
126 Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 40 [107].
127 Exhibit HQI0135_RP Witness statement of Ms Merrin Bamert, 23 [73].
128 Transcript of day 20 hearing 18 September 2020, 1726.
129 Exhibit HQI0176_P Witness statement of Dr Rob Gordon, 8–9 [35].
130 Ibid 11 [44].
131 Transcript of Day 20 hearing 18 September 2020, 1729.
132 Exhibit HQI0016_P Witness statement of Mr Hugh de Kretser, 2 [10], 3 [15]–4 [21].
133 Exhibit HQI0018_P Joint witness statement of Ms Kate Hyslop and Mr Ricky Singh, 1 [4].
134 Ibid 2 [13].
135 Transcript of day 20 hearing 18 September 2020, 1735.
136 Exhibit HQI0176_P Witness statement of Dr Rob Gordon, 14–15 [56].
137 Exhibit HQI0020_P Witness statement of Ms Liliana Ratcliff, 9 [67].
138 'Returned traveller 5', Information provided to the Inquiry via the Intake and Assessment team between 15 July to 3 December 2020.
139 Exhibit HQI0013_RP Witness statement of 'Returned traveller 1', 7 [61].
140 Exhibit HQI0176_P Witness statement of Dr Rob Gordon, 15 [60].
141 Ibid 15 [60.1].
142 Transcript of day 20 hearing 18 September 2020, 1728.
143 Exhibit HQI0176_P Witness statement of Dr Rob Gordon, 8 [33].
144 Ibid 15 [59].
145 Transcript of day 20 hearing 18 September 2020, 1736–1737.
146 Exhibit HQI0176_P Witness statement of Dr Rob Gordon, 15 [58].
147 Exhibit HQI0117_RP Annexures to the first witness statement of Prof. Euan Wallace AM, DHS.0001.0002.0068–0076, DHS.0001.0002.0042–0053.

148 Ibid DHS.0001.0002.0068, DHS.0001.0002.0045–0046.
149 Ibid DHS.0001.0002.0058.
150 Ibid DHS.0001.0002.0068-DHS.0001.0002.0073; DHS.0001.0002.0042–0048.
151 Ibid DHS.0001.0002.0058.
152 Ibid DHS.0001.0002.0062.
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154 Ibid DHS.0001.0002.0069.
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161 Ibid DHS.0001.0002.0042.
162 Ibid DHS.0001.0002.0043.
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164 Ibid DHS.0001.0002.0050.
165 Ibid DHS.0001.0002.0042–0050.
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167 Ibid DHS.0001.0002.0053.
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171 *Public Health and Wellbeing Act 2008* (Vic) s. 200.
172 Exhibit HQI0164_RP Witness statement of Mr Jason Helps, 28 [125].
173 Ibid 28 [126].
174 Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 36 [94].
175 Ibid.
176 Ibid 36–37 [93]–[94].
177 Exhibit HQI0164_RP Witness statement of Mr Jason Helps, 29 [130].
178 Board of Inquiry into the COVID-19 Hotel Quarantine Program (Interim Report, 6 November 2020), 54 [171].
179 Exhibit HQI0027_P Witness Statement of Mr Kaan Ofli, 2 [11].
180 Ibid 2 [13].
181 'Returned Traveller 3', Information provided to the Inquiry via the Intake and Assessment team between 15 July to 3 December 2020.
182 Submission 03 Department of Health and Human Services, 59–64 [329]–[344].
183 Exhibit HQI0113_P Witness statement of Dr Finn Romanes, 9 [46].
184 Ibid 10 [50].
185 Ibid 10 [51].
186 Submission 03 Department of Health and Human Services, 67 [359]–[361].
187 Exhibit HQI0160 Witness statement of Dr Annaliese van Diemen, 8–9 [40].
188 Ibid 9 [42].
189 Ibid 9 [44].
190 Ibid 12 [55].
191 Ibid 10 [47].
192 Ibid 10 [49].
193 Submission 03 Department of Health and Human Services, 69 [372].
194 Transcript of day 23 hearing 23 September 2020, 2039.
195 Exhibit HQI0228_RP Letter from MinterEllison dated 25 September 2020, Responsive to questions posed to Ms Kym Peake, 2.
196 Submission 03 Department of Health and Human Services, 59–64 [329]–[344].
197 Exhibit HQI0162_P Witness statement of Ms Andrea Spiteri, 15 [59]; Submission 03 Department of Health and Human Services, 60 [330].
198 Exhibit HQI0191_RP Initial response to the Board of Inquiry from DHHS, 8; Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 8–9 [22(c)]; Exhibit HQI0075_P Witness statement of Mr Noel Cleaves, 14 [76(a)–(b)]; Transcript of day 13 hearing 4 September 2020, 912–13.