CHAPTER 13

Victoria's Quarantine Program: future options

13.1 Introduction

1. This Inquiry has investigated why the Hotel Quarantine Program was established and how it was managed. It has identified failings in the Program's design and administration, including with respect to where focus, responsibility and accountability lay. Fundamentally, this Inquiry has highlighted that the Hotel Quarantine Program was administered without the focus on infection prevention and control that was needed to properly contain the COVID-19 virus and reduce the chance of its spread into the community.
2. This Inquiry has not been solely about identifying deficiencies or finding fault. To do so would be to miss opportunities for strengthening a quarantine model for international arrivals into Victoria. The Inquiry heard evidence from some witnesses about not just what went wrong, but also, what could have been done better. Where deficiencies have been identified throughout the course of the Inquiry, it has given rise to lessons that can be learned. This Inquiry has been about identifying not just what the Hotel Quarantine Program was but, also, what it could or should be in the future. It has accordingly given rise to 81 recommendations.
3. Those 81 recommendations include the ones I made in the Inquiry's Interim Report, as to options for future quarantine for international arrivals. Those recommendations set out two models that would operate concurrently: the first being a facility-based model and the second being a home-based model.[1] Those models were proposed having taken into account, and in response to, the issues that were raised during the Inquiry.
4. The Interim Report and attached recommendations deal, first, with a facility-based model. Many aspects of the facility-based model apply generally to both components of this future program.

13.2 A facility-based quarantine model for the future

5. The way forward from the Hotel Quarantine Program is the development of a future model for quarantine that has, at a minimum, certain key features. I have described those features in the Interim Report[2] but, for completeness, provide a general overview of those features here.

There should be clarity of roles and in the governance structure for the program

6. First, there should be a governance structure that sits across the entire Program with clear lines of accountability and with clarity of roles throughout that structure.[3] Built into that governance structure should be a framework for supporting decision-making that is informed by appropriate expertise and oversight.[4]

7. Within that governance structure, overall accountability should lie with one Responsible Minister and one responsible agency[5] — which I called the 'Quarantine Governing Body' — accountable to that Minister.

8. With clarity of roles comes a need to set clear expectations as to what is required from all personnel operating at the facility, with appropriate monitoring and oversight of those personnel.[6]

On-site management and role clarity

9. Second, and related to the first feature, is the need for clear definition of roles at the on-site leadership level and throughout the facility.

10. At the operational level, there should be one position that holds — and is clearly seen to hold — authority on-site for the overall operation of the quarantine facility.[7] I have called that role the 'Site Manager'. The Site Manager should report to the Quarantine Governing Body.[8] It should be filled by a person with expertise in managing complex healthcare facilities.[9]

11. Every person working at the quarantine facility needs to understand their role and responsibilities, how their role relates to the roles of others and who on-site has ultimate authority to control the site.[10]

Facilities need to be staffed with an appropriate mix of on-site personnel

12. Third, there ought to be a suitable mix of personnel engaged on-site so as to meet the objectives of a facility-based quarantine program.[11] Just as the overarching objective of a quarantine program should be to prevent the transmission of COVID-19 from international arrivals entering the community,[12] the objective of protecting the safety of those placed within the Program, and those working within the Program, should also be paramount.[13]

13. There should be a focus on infection prevention and control, and infection prevention and control measures should be both proactive and reactive, with infection prevention and control experts embedded within each facility.[14]

14. A dedicated contact tracing unit should be embedded in each facility,[15] along with COVID-19 testers, food service providers, cleaners, and compliance, enforcement and security personnel.[16] Facilities should be staffed with clinical personnel (including healthcare workers) who can meet the mental and physical health needs of returned travellers.[17]

Facilities should be staffed with security services provided by an appropriate cohort, with Victoria Police involved

15. Fourth, on-site security personnel should be directly employed by the Quarantine Governing Body and be bound by the Code of Conduct for Victorian Public Sector Employees.[18] Those providing security services should have skills in supervision, communication, de-escalation, conflict management and maintaining professional boundaries.[19]

16. Victoria Police should have a 24/7 presence in facilities.[20] Victoria Police members should be supported by appropriate safety measures, training and instructions.[21] Their role should be to control access, entry and exit points, maintain a presence in the facility foyer and to patrol floors.[22]

A dedicated mix of personnel is necessary

17. Fifth, employment conditions are important to reduce the risk of transmission between the facility and elsewhere in the community. Those conditions should require that personnel in a facility, wherever possible, be limited to working at that facility.[23] That applies to clinical and non-clinical personnel.[24]

18. To reduce the potential for personnel to work across multiple sites or to continue to work even if symptomatic (so as to not absent themselves and risk their wage), personnel should be salaried and appropriately remunerated.[25] Their terms of employment should contain sick-leave entitlements in the event they receive a positive COVID-19 diagnosis or are otherwise required to self-isolate.[26] Personnel should be financially supported to encourage self-isolation where they show symptoms or are otherwise at risk of contracting COVID-19.[27] Following self-isolation, personnel should be permitted to return to work after having received a negative swab result.[28]

19. There should be ways to control the number of returning travellers at any one time so as to properly and consistently manage personnel levels and not become reliant on the need to build a 'surge capacity' of additional personnel.[29]

There should be an appropriate focus on training and the building of an infection prevention and control culture

20. Sixth, each person within a facility should be appropriately trained in infection control requirements, PPE usage, physical distancing and hand hygiene.[30] They must have a thorough understanding of the range of COVID-19 symptoms, as well as the need to self-isolate if they show symptoms.[31] They must also have a clear understanding of their responsibilities with respect to contact tracing, should contacts need to be identified, tested and isolated.[32]

21. The Site Manager should continually reinforce, supervise and monitor this training, understanding and practice.[33]

22. The approach to infection prevention and control should be a collaborative one, focusing on education, auditing personnel and processes, and ensuring clear and apparent lines of escalation.[34]

23. The workplace infection prevention and control culture should be enhanced through the adoption of a range of measures, such as health screenings, changing PPE after arrival, leaving uniforms and equipment at facilities, decontamination procedures, briefings upon entry and assessment of rules relating to movement within and around common facilities.[35]

24. To protect against the risk of transmission, it should remain a presumption at all facilities (whether or not COVID-positive cases are cohorted in one facility) that those in quarantine are infected until it is known that they are not infected.[36]

25. Cleaning is particularly important to infection prevention and control measures. It requires experts to train and direct cleaning personnel, both with respect to areas to be cleaned, the standard to which areas must be cleaned and the products and methods used to properly clean those areas.[37]

26. A culture of safety is important. It should be actively fostered and reinforced.[38]

PPE should be made available and properly used

27. Seventh, appropriate PPE should be made available,[39] together with up-to-date advice on its proper use.[40] The use of PPE should be subject to monitoring and supervision.[41]

28. All personnel must receive training on how to properly use PPE,[42] with personnel being tested on their ability to properly use PPE before being permitted to work in the facility.[43] Those providing training must be experienced in the use of PPE.[44] PPE training should be delivered (at least, in part) in person, with physical supervision and instruction; remote or online training is not sufficient. [45]

Implementing audits and rapid responses to issues in order to serve continuous improvement

29. Eighth, there should be regular and independent compliance audits to ensure best practice is maintained.[46] In particular, cleaning practices should be regularly audited using industry-standard swab tests of surfaces.[47]

30. Concerns identified (through audit or otherwise) should be responded to quickly and effectively.[48] As part of internal governance procedures, a risk register should be maintained and reviewed, and provided to safety auditors.[49]

Make efforts to manage the influx of returned passengers and their health and welfare needs

31. Ninth, the number of returned travellers should be managed by reference to available facilities. Efforts should be made to control the number of returned travellers at any given time.[50] There must be appropriate engagement with, and cooperation between, Commonwealth and State officials to achieve a more manageable procedure for arrivals.[51]

32. That engagement is not only to determine the number of new arrivals but to also determine the demographics of the returning cohort and to identify any complexities or particular health and wellbeing requirements of those returning.[52] Officials should proactively seek information about the returning travellers.[53] The quality of that information is important: it should be accurate, detailed and current.[54]

33. The health, wellbeing and needs of those in quarantine must be a central feature of a future quarantine program.[55]

34. Each returning traveller should be assessed to determine and understand, as completely as possible, their individual needs and risk factors.[56] Steps should be taken to address any communication needs for people being mandated into quarantine, such as language barriers or physical impairments that necessitate additional supports.[57]

35. Clinical equipment to service the needs of returned travellers should be made available on-site, and their availability and use should be based on medical advice.[58]

36. There is a need for a consistent, appropriate and safe method for medical, nursing and healthcare personnel to maintain daily health and welfare checks on people in quarantine.[59] Consideration should be given to using technology to maximise care without unnecessarily exposing personnel to risk of exposure to the virus.[60]

37. Where people require high levels of monitoring or care, they should be placed in a hospital or other suitable equivalent and dedicated health facility, not a quarantine facility.[61]

Proper information collection, storage and sharing of processes and practices is necessary

38. Tenth, it is important to collect, share and use information to provide for the welfare of returned travellers.

39. Once travellers are placed into quarantine, their information should be stored on a real-time information sharing and tracking system that is accessible by all staff with a role in providing services, care and support to returned travellers.[62]

40. To assist in their care and support, information about returned travellers should be stored on an electronic record[63] with the functionality to alert personnel of key activities, such as welfare or symptoms checks, and whether they have been missed.[64]

41. The maintenance of such records will assist with communication between personnel at a facility. There should be formal processes to ensure proper and thorough handover occurs within, and between, teams.[65]

The program should include testing for returned travellers

42. Eleventh, accepting that the 14-day quarantine period has a rational evidentiary basis,[66] COVID-19 testing is nevertheless critical to identify people who have contracted the disease but are asymptomatic (or have minor symptoms) before their discharge from the quarantine program.[67]

There should be provision for exemptions from quarantine

43. Twelfth, there must be a process for allowing temporary, partial or complete exemptions from quarantine,[68] which must be made known to people to enable requests for exemptions to be made.[69] The criteria for assessing requests for exemptions should also be made known.[70] Exemptions should be assessed using guidance material anchored in advice regarding risk of infection and wellbeing issues, together with legal advice regarding the application of the *Public Health and Wellbeing Act 2008* and *Charter of Human Rights and Responsibilities Act 2006*.[71]

44. Decisions to allow temporary exemptions should be made promptly, and subject to conditions to manage the risk of transmission of COVID-19, where necessary.[72] These conditions should be clearly communicated to the international arrivals and recorded on the traveller's file.[73]

Safe transport arrangements need to be implemented where necessary

45. Thirteenth, where travel is required, it must be safe. A range of travel options might exist; the most appropriate will differ depending on individual circumstances.[74] It is for this reason that there should be an effective triage process in place to determine safe modes of transport for a relevant traveller, which includes the need for those making that assessment to have the appropriate skills and training.[75]

The facility must be safe and suitable to provide for the maintenance of health and wellbeing

46. Fourteenth, the selection of an appropriate facility should take into account a number of factors, such as its proximity to a hospital,[76] commuting distance for adequate numbers of appropriately skilled personnel[77] and adaptability for proper implementation of infection prevention and control requirements and physical separation of people and zones.[78]
47. When considering a facility to stand up, special consideration should be given to the physical environment for accommodating children and their particular needs.[79] There should also be additional supports for those with nicotine, drug or alcohol dependency issues.[80]
48. The facility should accommodate safe access to fresh air for all those in quarantine.[81] Fresh air breaks are important for health and wellbeing of people in quarantine. They should all have the same opportunity for fresh air and exercise breaks each day.[82]
49. Access to fresh air should be supplemented by a robust and appropriately developed process for safely facilitating such breaks.[83] The process should provide clear instructions to those conducting fresh air breaks and clearly communicate to people in quarantine what to expect from those breaks.[84]
50. In the case of emergencies, the facility should have an emergency evacuation plan. Each Site Manager must develop an emergency evacuation plan for the facility that is well understood and regularly rehearsed by all personnel.[85] The plan must address safe evacuation practices in a manner consistent with minimising the risk of infection to guests, personnel and the community.[86]

It is critical to promote access to information and provide for various communication channels

51. Fifteenth, effective and supportive communication is important to reduce stress for people in quarantine. It is important to provide people in quarantine with information about how the COVID-19 virus works and what people need to do to protect themselves against it.[87] By communicating the link between the virus and arrangements in place to reduce its spread, compliance with — and trust in — the program should increase.[88]
52. Personnel within the facility should practice 'supportive communication' and be trained in it, where appropriate.[89]
53. People in quarantine may also need to make complaints about their experiences. Each facility should have a process for those people to give feedback, communicate and (if necessary) escalate unaddressed or inadequately addressed concerns about their needs.[90]

54. Communication between people in quarantine should be encouraged.[91] Developing a sense of community solidarity and support is a way to manage fears and reduce a sense of solitary exposure.[92] Technology may be used to safely disseminate information and foster a sense of community, such as through social media and moderated online discussion groups.[93]

55. When referring to people in quarantine, it is necessary to use consistent and neutral terms in a way that promotes a positive culture within a facility: for example, 'resident' is a preferable descriptor to 'detainee'.[94]

56. When people exit the quarantine program, it is important that there is a framework within which they can debrief, or reflect upon, their experience.[95] This provides an opportunity for the Site Manager to be made aware of issues and respond to them, and to promote continuous improvement.[96]

Endnotes

1 Board of Inquiry into the COVID-19 Hotel Quarantine Program (Interim Report, 6 November 2020) 24 [5] <https://www.quarantineinquiry.vic.gov.au/reports>.
2 Ibid 29–62.
3 Ibid 29 [10].
4 Ibid 29 [12].
5 Ibid.
6 Ibid 29 [15].
7 Ibid.
8 Ibid 29 [16].
9 Ibid.
10 Ibid 29–30 [17]–[19].
11 Ibid 30 [20].
12 Ibid 27 [4], citing Ms Melissa Skilbeck, Deputy Secretary Regulation, Health Protection and Emergency Management, DHHS: Exhibit HQI0125_RP Witness statement of Ms Melissa Skilbeck, 6 [34].
13 Board of Inquiry into the COVID-19 Hotel Quarantine Program (Interim Report, 6 November 2020) 27 [5] <https://www.quarantineinquiry.vic.gov.au/reports>.
14 Ibid 18 [24], 30 [20], 57 [21], [24].
15 Ibid 19 [38], 34 [39]–[41].
16 Ibid 30 [21].
17 Ibid.
18 Ibid 32 [25].
19 Ibid.
20 Ibid 32 [28].
21 Ibid 32 [26]–[27].
22 Ibid.
23 Ibid 33 [29].
24 Ibid.
25 Ibid 33 [31].
26 Ibid 33 [32].
27 Ibid 36 [52].
28 Ibid.
29 Ibid 33 [34].
30 Ibid 34 [36].
31 Ibid 34 [38].
32 Ibid 37 [53].
33 Ibid 34 [38].
34 Ibid 35 [43].
35 Ibid 36 [48].
36 Ibid 40 [76].
37 Ibid 39 [67].
38 Ibid 35 [42].
39 Ibid 37 [55].
40 Ibid 37 [56].
41 Ibid 38 [61].
42 Ibid 37 [57].
43 Ibid 37 [60].
44 Ibid 37 [58].
45 Ibid 37 [59].
46 Ibid 38 [63].
47 Ibid 39 [68].
48 Ibid 38 [63].
49 Ibid 38 [65].
50 Ibid 39 [70].
51 Ibid 39 [72].
52 Ibid 40 [77].

53 Ibid 40 [78].
54 Ibid 40 [78], [80].
55 Ibid 46 [116].
56 Ibid 40 [77].
57 Ibid 52 [163].
58 Ibid 19 [36].
59 Ibid 47 [122].
60 Ibid 48 [125].
61 Ibid 47 [121].
62 Ibid 41 [87].
63 Ibid 42 [90].
64 Ibid 43 [91].
65 Ibid 43 [93].
66 Ibid 43 [97].
67 Ibid 44 [98].
68 Ibid 44 [102].
69 Ibid.
70 Ibid.
71 Ibid 44 [101].
72 Ibid 44 [103].
73 Ibid.
74 Ibid 44 [104].
75 Ibid 45 [107].
76 Ibid 48 [131].
77 Ibid 48 [132].
78 Ibid 48 [133], 49 [134].
79 Ibid 49 [135].
80 Ibid 49 [136].
81 Ibid 49 [137].
82 Ibid 49 [139].
83 Ibid 49 [140].
84 Ibid.
85 Ibid 45 [110].
86 Ibid.
87 Ibid 50 [142].
88 Ibid.
89 Ibid 50 [146]–[147].
90 Ibid 51 [151]–[152].
91 Ibid 52 [158].
92 Ibid 51 [156].
93 Ibid 52 [159]–[160].
94 Ibid 53 [168].
95 Ibid 53 [169].
96 Ibid 54 [172].