CHAPTER 3

The state of pandemic planning in Australia and Victoria and the envisaged use of quarantining

1. Any proper analysis of the decision to adopt a mandatory quarantine program for all international arrivals, to commence within a period of some 36 hours, cannot be divorced from an understanding of Victoria's planning for, and readiness to undertake, such a program.

2. The possibility of an epidemic or pandemic, particularly with a highly contagious viral infection, had been recognised for decades both in Victoria and nationally. Since 1999, state and territory governments and the Australian Government had developed and refined a series of plans to guide Australia's response to an influenza pandemic.[1]

3. The *Commonwealth Government's Australian Health Management Plan for Pandemic Influenza* (the Commonwealth Pandemic Plan) is intended to provide overarching guidance and a framework for a nationally consistent approach to managing an influenza pandemic.[2] The guidance provided in the Commonwealth Pandemic Plan is reflected in state and territory pandemic plans, which are tailored to local contexts.[3] In Victoria, the relevant plans are the *Victorian Health Management Plan for Pandemic Influenza 2014* (the Victorian Pandemic Plan)[4] and the *Victorian Action Plan for Influenza Pandemic 2015*.[5] Plans at both levels of government (Commonwealth and State) sit within a complex framework of emergency management strategies, plans and guidelines.

4. Professor Lindsay Grayson, Director of Infectious Diseases and Microbiology at Austin Health, gave evidence that most pandemic planning had focused on strategies aimed at influenza, given the history of the Spanish Flu a century ago and more recent outbreaks of avian influenza (H5N1) and swine flu (H1N1). However, despite that focus, Prof. Grayson stated that the principles and operational framework of these influenza pandemic plans were known to be applicable to other respiratory viral infections, including COVID-19.[6]

5. Given the existence of pandemic plans at the Victorian and Commonwealth level, a question before the Inquiry was whether, prior to the announcement and establishment of the Hotel Quarantine Program in Victoria, there was planning for a mass quarantine program that could have informed this Program.

6. In short, there was not. That was despite a review of the Commonwealth's response to the (H1N1) pandemic, published in 2011, recommending an examination of the policy on quarantine and isolation. This matter is examined in further detail in the context of the Commonwealth and Victorian pandemic plans.

3.1 The Commonwealth Pandemic Plan

7. The Commonwealth Pandemic Plan describes pandemics as unpredictable and presenting a significant risk to Australia.[7] The report states that pandemics have the potential to cause high levels of disease and death and disrupt the community, both socially and economically.[8] The Commonwealth Pandemic Plan, which was developed in consultation with states, territories and health sector stakeholders, outlines Australia's strategy to manage an influenza pandemic and minimise its impact on the health of Australians and the health system.[9] To support the management of an influenza pandemic, the Commonwealth Pandemic Plan seeks to:

    A. clarify the roles and responsibilities within the health sector of the Australian Government and state and territory governments

    B. identify areas where national guidance and coordination will be provided and how this will be achieved

    C. support decision-makers to respond in a manner that is flexible, informed and proportionate to the circumstances at the time.[10]

8. The Commonwealth Pandemic Plan recognises that the operational aspects of public health responses sit with state and territory governments. Some examples of the operational aspects of a public health response include implementing social distancing measures as per national recommendations and local risk assessment, implementing infection control guidelines and healthcare safety and quality standards, and undertaking contact tracing.[11]

9. The Commonwealth Pandemic Plan also sets out an ethical framework to guide health sector responses and actions taken under it. Some principles or values to be taken into account include providing care in an equitable manner, ensuring that the rights of the individual are upheld as much as possible and ensuring that measures taken are proportionate to the threat.[12]

10. Given states and territories have operational responsibility for public health responses, the Commonwealth Pandemic Plan notes that the majority of operational detail will be found in state and territory plans.[13] The Victorian plans are considered below.

Context and legal framework for the Commonwealth Pandemic Plan

11. The Commonwealth Pandemic Plan sits under the *Emergency Response Plan for Communicable Disease Incidents of National Significance*, which is one of four plans under the *Australian National Health Emergency Response Arrangements*. It also supports the *Emergency Response Plan for Communicable Disease Incidents of National Significance: National Arrangements.*[14]

12. The Commonwealth Pandemic Plan sets out measures to respond to an influenza pandemic, some of which rely on the exercise of coercive powers conferred by statute onto the Commonwealth Government. It identifies the following statutes as relevant to supporting pandemic actions:[15]

    A. The *Biosecurity Act 2015* (Cth) — which authorises activities used to prevent the introduction and spread of target diseases into Australia.

    B. The *National Health Security Act 2007* (Cth) — which authorises the exchange of public health surveillance information (including personal information) between the Australian Government, states and territories and the World Health Organization.

C. The International Health Regulations 2005 (incorporated into Australian law through the *Biosecurity Act 2015* (Cth) and the *National Health Security Act 2007* (Cth)) — which commits Australia and other signatory countries to take action to prevent, protect against, control and provide a public health response to the international spread of disease. As a signatory, Australia has a range of obligations, including reporting and maintaining certain core capacities at designated points of entry.

13. Those statutes are part of the suite of legislation available to the Commonwealth to support pandemic response activities. In addition, state and territory governments have powers under their respective jurisdiction's legislation to implement biosecurity arrangements within their borders, and which complement Commonwealth Government biosecurity arrangements. States and territories have a broad range of public health and emergency response powers available under legislation for responding to public health emergencies. Further detail on relevant legislation in Victoria is provided at paragraph 40.

Isolation, quarantine and mandatory detention for returned travellers in the Commonwealth Pandemic Plan

14. The Commonwealth Pandemic Plan does not provide specific guidance for a program of mandatory detention or quarantine for returned travellers. It does not refer to a mass program of mandatory quarantine to the scale of the Hotel Quarantine Program.

15. It does, however, provide guidance and analysis regarding *voluntary* isolation of ill travellers who do not require hospitalisation, and possible quarantine of contacts of ill travellers at the border (though this option is not recommended).[16]

Voluntary isolation of ill travellers: hotel quarantine seen as 'problematic'

16. The objective and rationale for voluntary isolation of ill travellers, as outlined by the Commonwealth Pandemic Plan, is to reduce exposure to the disease by managing the entry of ill travellers at the border.[17]

17. It states that returning Australians may isolate at home, but other arrangements would be required for other travellers.[18] The Commonwealth Pandemic Plan also states that voluntary isolation should commence when notified of sustained human-to-human transmission of a novel virus and that it must be used early to be effective in limiting entry of the disease into the community.[19]

18. The Plan considers voluntary self-isolation experiences during the SARS outbreak and the pandemic (H1N1) in 2009. It notes that compliance with self-isolation during the outbreak was high in most countries.[20] Notwithstanding that, the Commonwealth Pandemic Plan identifies that isolation may be difficult to enforce, self-regulated isolation may not be complied with and support for isolated cases is resource intensive.[21]

19. The Commonwealth Pandemic Plan identifies that the use of hotels to quarantine returned travellers is **problematic** (emphasis added), though it does not go so far as to say why this is so. Costs are noted as high if travellers are isolated in hotels; this is attributed to accommodation, food, servicing, medical support, security, entertainment and a support system to monitor people isolated.[22]

20. Voluntary self-isolation of cases more broadly (cases not limited to travellers) is recommended as a measure, particularly as the clinical severity of the disease increases. The Commonwealth Pandemic Plan states it is to be used in conjunction with infection control measures to reduce the risk of transmission to household contacts. Voluntary self-isolation is said to be most likely to influence the course of the pandemic when clinical severity is high and transmissibility is low.[23]

21. In the case of COVID-19, Prof. Grayson stated that COVID-19 is considered to be 'highly infectious, particularly as it can be transmitted before the onset of symptoms and because those who are infectious may be entirely asymptomatic or have only trivial symptoms'.[24] The nature of COVID-19 is discussed in detail in Chapter 2.

Quarantine of contacts not recommended

22. The Commonwealth Pandemic Plan does not recommend quarantining contacts of ill travellers at the border[25] in the context of pandemic influenza.

23. That is because, according to that Plan, quarantining contacts has minor effectiveness, imposes a significant burden on health and other systems, and places high costs and significant imposts on travellers and services. The Commonwealth Pandemic Plan states that extensive infrastructure would be needed, including databases, information and surveillance hotlines, and staff, to enforce quarantine.[26]

24. The Plan states that it would be highly complex to arrange and maintain a quarantine program, and that ethical issues may arise from confining individuals, as well as stress arising as a result of confinement. Notwithstanding this point, the Commonwealth Pandemic Plan provides that, if quarantining contacts of ill travellers at the border is to be used as a response strategy, the agency controlling the health response should commence its operation when it is 'notified of sustained human-to-human transmission of a novel virus. It must be used early to be effective…'[27]

25. Voluntary quarantine of contacts more broadly (cases not limited to travellers) is recommended as a measure, particularly where consequences of infection are high.[28]

26. Overall, the Commonwealth Pandemic Plan notes that the effectiveness of isolation and quarantine depends on a number of factors. Specifically, as the Plan deals with voluntary isolation and quarantine, it considers that factors influencing its effectiveness include perception and understanding of risk associated with infection and illness, and financial considerations.[29] It also states that early and transparent communication to the public is an important component of implementation.[30]

27. While these factors are relevant in the context of a voluntary program, they are obviously important in a program of mandatory quarantine with respect to both those placed into mandatory quarantine and those working at quarantine sites.

Updates to the Commonwealth Pandemic Plan following the Review of Australia's Health Sector Response to the (H1N1) Pandemic 2009

28. The most recent version of the Commonwealth Pandemic Plan was updated on 21 August 2019.[31] The Commonwealth Department of Health notes that this version of the Plan incorporates minor amendments, such as incorporation of the decommissioned 'Fluborderplan' throughout the document, and updated references to legislation, terminology and committee names.[32]

29. Prior to the most recent update, the Plan went through a significant update in 2014 following the Commonwealth Department of Health and Ageing's *Review of Australia's Health Sector Response to Pandemic (H1N1) 2009*, which was published in 2011.[33]

30. This review recommended a substantial change to the approach of the Commonwealth Pandemic Plan. Some of the key aspects of the new approach included:

    A. wherever possible, using existing systems and governance mechanisms, particularly those for seasonal influenza, as the basis of the response

    B. applying a flexible approach, which can be scaled and varied to meet the needs experienced at the time

    C. making decisions based on available evidence

    D. linking with emergency response arrangements

    E. emphasising communication activities as a key tool in management of the response

    F. provision of detailed guidance on the collection of national surveillance data.[34]

Recommendations from previous reviews regarding quarantine and isolation

31. What was of particular interest in the *Review of Australia's Health Sector Response to the (H1N1) Pandemic 2009* was the recommendation for an examination of the policy on quarantine and isolation, including management, support systems and communication.[35]

32. This was because the Australian response to the (H1N1) outbreak in 2009 identified that quarantining non-residents arriving in Australia was an issue, as:

    A. many hotels refused to provide accommodation to individuals under quarantine

    B. the purpose of voluntary quarantine was not well understood, was inconvenient, unappealing and difficult to enforce

    C. policy and operational plans for managing people in quarantine had not been finalised (at the state, territory and national level) when the pandemic emerged

    D. information provided to people in quarantine was insufficient and conflicting, and support was slow to be provided to them.[36]

33. The review found:

> The roles and responsibilities of all governments for the management of people in quarantine, both at home and in other accommodation, during a pandemic should be clarified. A set of nationally consistent principles could form the basis for jurisdictions to develop operating guidelines, including plans for accommodating potentially infected people in future pandemics and better systems to support people in quarantine.[37]

34. Professor Brett Sutton, Victoria's Chief Health Officer, gave evidence that no work had been done, nationally or in any jurisdiction of Australia, to implement this recommendation since it was made in 2011.[38] The implications of this work not being undertaken are discussed further at paragraphs 53–55.

3.2 The Victorian Pandemic Plan

35. The Victorian Health Management Plan for Pandemic Influenza (the Victorian Pandemic Plan) is the local reflection, and replicates much, of the Commonwealth Pandemic Plan.[39] The stated aim of the Victorian Pandemic Plan is to provide an effective health response framework to minimise transmissibility, morbidity and mortality associated with an influenza pandemic and its impacts on the health sector and community.[40]

36. The Victorian Pandemic Plan describes activities needed to reduce the impact of an influenza pandemic in Victoria, including:

    A. surveillance systems to rapidly and efficiently identify the emergence of new strains of influenza in the Victorian community

    B. timely implementation of measures seeking to limit or prevent the transmission of pandemic influenza in the various stages of a pandemic

    C. continuing surveillance to monitor the status of the outbreak

    D. maximising the use of resources

    E. public health strategies to best meet the needs of the current situation based on the best surveillance data

    F. informing staffing needs and requirements

    G. implementing policies on the use of personal protective equipment (PPE) and antivirals

    H. communicating accurate, consistent and comprehensive information about the situation to the general public, the media, our partners in the health sector and other key stakeholders.[41]

37. The *Victorian Action Plan for Influenza Pandemic 2015* (Action Plan) is the Emergency Management Victoria pandemic plan. It articulates Victoria's strategic approach to reducing the social and economic impacts and consequences of pandemic influenza on communities.[42] It is, effectively, a plan to help manage the operations of government departments and other organisations in a pandemic.

38. The Action Plan is stated to help departments and organisations complete or review their pandemic influenza plans. It sets out:

    A. Victorian arrangements for pandemic influenza planning and response

    B. key agencies and their roles and responsibilities

    C. relevant governance structures

    D. incident response guidance for departments and agencies.[43]

39. In February 2020, with the onset of COVID-19 infections in Victoria, the Department of Health and Human Services (DHHS) developed the *COVID-19 Pandemic Plan for the Victorian Health Sector*.[44] This plan, which was published on 10 March 2020, set out a four-stage response to COVID-19 for the health sector that included initial containment, targeted action, peak action and stand down and recovery.[45]

Legal framework and relationship of the Victorian Pandemic Plan and the Action Plan with other plans

40. As with the Commonwealth Pandemic Plan, State Acts and Regulations authorise actions under the Victorian Pandemic Plan and the Action Plan. In addition to the national legislation set out at paragraph 12, the key pieces of Victorian legislation available to support pandemic actions in Victoria include:

    A. the *Public Health and Wellbeing Act 2008* (Vic) and *Public Health and Wellbeing Regulations 2009* — which aim to protect the health and wellbeing of the population and establish provisions for managing infectious diseases

    B. the *Emergency Management Act 1986* (Vic) — which authorises authorities to take control of specific aspects of an emergency when declared by the Premier

    C. the *Emergency Management Act 2013* (Vic) — which implements a series of reforms such as establishing the State Crisis and Resilience Council, Emergency Management Victoria and the Emergency Management Commissioner.[46]

41. The Victorian Pandemic Plan is also guided by the same ethical framework established under the Commonwealth Pandemic Plan to guide health sector responses and actions taken.[47]

42. The Victorian Pandemic Plan and the Action Plan interact. They relate to a specific type of pandemic. Victoria's pandemic response arrangements, more generally, involve the following key plans (in addition to the Commonwealth Pandemic Plan):[48]

    A. the State Emergency Response Plan (SERP) as contained in the Emergency Management Manual Victoria. The State Emergency Response Plan describes the arrangements for controlling a response to specified types of emergencies, and the roles of the agencies who control and support the control of that response. The Emergency Management Manual Victoria also sets out the arrangements for emergency management in Victoria more generally[49]

    B. the State Health Emergency Response Plan (SHERP) — a sub-plan of the State Emergency Response Plan that outlines the arrangements for coordinating a health response to health emergency incidents that go beyond day-to-day business arrangements.[50] The details of the Victorian emergency management framework, its use and how it worked in the Hotel Quarantine Program are discussed in detail in Chapter 8.

Isolation, quarantine and mandatory detention for returned travellers in the Victorian Pandemic Plan

43. As is the case with the Commonwealth Pandemic Plan, the Victorian Pandemic Plan does not provide specific guidance for a program of mandatory detention or quarantine for returned travellers, nor does it refer to a mass program of mandatory quarantine to the scale of the Hotel Quarantine Program.

44. The Victorian Pandemic Plan states, consistent with the Commonwealth Pandemic Plan, that voluntary isolation of ill travellers and voluntary quarantine of contacts can assist to control the transmission of disease into the community.[51]

45. It provides that, voluntary and home-based isolation should be considered as part of the preparedness, initial and targeted-response stages.[52] The Plan states that in the targeted response stage, benefits will be reassessed contingent on evidence as to the transmissibility of the virus and severity of the illness. The Victorian Pandemic Plan also refers to the Commonwealth Pandemic Plan for further details on isolation and quarantine.[53]

46. The *COVID-19 Pandemic Plan for the Victorian Health Sector* also does not envisage the involuntary, large scale detention of people arriving from interstate or overseas. As with the Victorian Pandemic Plan, its focus, with regard to isolation or quarantine, is on the *voluntary* isolation of people in their own homes.[54]

47. Notably, it states the following under the heading of Quarantine:

> Quarantine refers to home isolation of well people who are deemed at risk of COVID-19 due to travel location or contact with a case. As the COVID-19 response has progressed there has been varying requirements for returned travellers to quarantine after being in a high-risk location.[55]

Updates to the Victorian Pandemic Plan, consideration of a mass quarantine program and applicability to a coronavirus with pandemic potential

48. The Victorian Pandemic Plan was prepared in 2007 and updated in 2014 in line with the Commonwealth Pandemic Plan, and in response to lessons learned from the (H1N1) pandemic, based on the *Review of Australia's Health Sector Response to Pandemic (H1N1) 2009*.[56]

49. As noted at paragraphs 31 to 34, the review recommended that an examination of the policy on quarantine and isolation, including management, support systems and communication, be undertaken.[57] Prof. Sutton gave evidence to the Inquiry that this work had not been undertaken, either nationally or at the state or territory level. When questioned on this matter by Counsel Assisting the Inquiry, Prof. Sutton agreed that had this work been undertaken, it would have been very useful for establishing the Hotel Quarantine Program in a pandemic situation.[58]

50. Dr Annaliese van Diemen's (Deputy Chief Health Officer for Victoria) evidence was that she had never turned her mind to the concept of a large-scale quarantine program for returned travellers prior to late March 2020.[59] Before this point in time, and as illustrated by the evidence in the preceding paragraphs of this section, pandemic plans considered isolation or quarantine in the context of a home-based program for cases or contacts.[60]

51. It was only following the announcement of a quarantine program by National Cabinet and during subsequent conversations about implementing the decision did Dr van Diemen consider the concept of a mandatory, mass quarantine program.[61]

52. In a similar vein, not surprisingly, Ms Kym Peake, the then Secretary of DHHS since November 2015, gave evidence that, prior to late March 2020, she had not turned her mind to such a concept and only did so for the very first time following National Cabinet's announcement.[62] Ms Peake stated that, in her view, the Commonwealth Constitution envisages that quarantine will primarily sit as a responsibility of the Commonwealth Government.[63] As such, as at March 2020, it was not 'on the radar' for DHHS in Victoria that there would be a mass quarantine program required at a state level.[64]

53. Notwithstanding the Commonwealth's (H1N1) review in 2011 noting that the roles and responsibilities of all governments for the management of people in quarantine during a pandemic should be clarified,[65] this recommendation had not been addressed by the Commonwealth, which provided the model for the states and territories to adopt.[66] (See Recommendation 70 below.)

54. Despite updates having been made recently to the Victorian Pandemic Plan (and the Commonwealth Pandemic Plan) to reflect lessons learned from the (H1N1) pandemic, a key recommendation to review the policy on quarantine and isolation (Recommendation 13)[67] was left unaddressed. Evidence provided by Prof. Sutton provides some insight as to why this may have been the case.

55. During his evidence, Prof. Sutton stated that, in his view (with the benefit of hindsight), it was an issue that the pandemic plans prior to the COVID-19 pandemic gave insufficient consideration of the pandemic potential of a coronavirus and no explicit consideration of a program of quarantine to keep a jurisdiction entirely free of the virus.[68]

56. Prof. Sutton noted that it was always an assumption that a pandemic influenza (the basis of the Commonwealth plans) would reach every country and the purpose of quarantine was to minimise the peak of the pandemic and the resulting pressures on the health system.[69] Prof. Sutton stated that, following what happened in Wuhan, and reflecting that the COVID-19 pandemic had the greatest severity seen since the Spanish Flu, the impetus was for a quarantine program that would keep the virus out of the community to the fullest extent possible. Prof. Sutton's evidence, in this regard, was that prior pandemic planning was directed to minimising transmission, rather than eliminating transmission via a system of quarantine.[70]

No 'off-the-shelf' plan for mass quarantining of international arrivals

57. Significantly, for Victoria, this left the State with no pre-planned structure or arrangements for mass quarantining of international arrivals.

58. During the course of the hearings, several witnesses gave evidence about the fact there was no 'off-the-shelf' plan for mass quarantine and that, accordingly, after the announcement of National Cabinet on 27 March 2020, the Hotel Quarantine Program needed to be stood up in a mere 36 hours.[71] This meant that decisions were made under enormous pressure and plans for a complex system were developed in haste. Detail on the establishment of the Hotel Quarantine Program within this short timeframe is dealt with in Chapters 4 and 5 of this report.

Pandemic planning exercises

59. Under the *Emergency Management Act 2013* (Vic), major health emergencies and biosecurity emergencies (unless linked to an act of terrorism) are defined as a 'Class 2' emergency.[72]

60. According to the evidence of Ms Peake, Class 2 emergencies have been comparatively rare in Victoria.[73] Ms Peake stated that DHHS 'regularly undertakes emergency incident exercises where the emergency management regime and the State Health Emergency Response Plan are performed'.[74] The evidence of DHHS witnesses was that such exercises are undertaken on a regular basis and often include other agencies.[75]

61. According to Prof. Sutton, pandemic planning exercises are an opportunity to test the efficacy of the arrangements and to practice performing the roles, activities and deliverables of each person and agency with responsibilities.[76]

62. The Inquiry has heard evidence of exercises that featured infectious disease scenarios. While it may be so that it is not possible to predict the exact nature, scale and type of an infectious disease emergency and to rehearse a response to that emergency, Prof. Sutton stated that these exercises, nevertheless, have the benefit of testing the efficacy of response arrangements, practising the performance of allocated roles and to engage all areas and agencies in doing so.[77]

63. The evidence as to the most recent exercises undertaken in relation to an infectious disease pandemic included:

    A. 'Exercise Teapot' — undertaken in September 2019 and led by the Health Protection Branch and Emergency Management Branch in DHHS, with representatives from more than 16 agencies.[78] This was described as a discussion exercise that explored a complex multiagency emergency involving widespread outbreaks including of Middle Eastern Respiratory Syndrome coronavirus.[79]

    B. 'Exercise Alchemy' — undertaken in August 2018 and led by Emergency Management Victoria.[80] The stated purpose of this exercise was to assess state-level communications processes during a biosecurity emergency that transitioned to a pandemic emergency.[81]

64. Feedback from Exercise Alchemy identified that the role and function of any team or structure needed to be clearly defined and practical given that Class 2 emergencies have unique challenges.[82] In the context of the Hotel Quarantine Program, given the time constraints and lack of an overarching plan for mass, mandatory quarantine, the lessons from Exercise Alchemy were not applied when they should have been. The implementation of the Hotel Quarantine Program is discussed further in chapters 5 and 8.

65. Whereas Ms Peake and Prof. Sutton gave evidence that emergency incident exercises specifically related to infectious disease pandemics are undertaken regularly, there were views expressed by doctors outside DHHS about not being sufficiently included in pandemic planning exercises for the medical profession more broadly. Dr Nathan Pinskier, director of Onsite Doctor Pty Ltd, which was engaged to assist with the provision of medical services and support to returned travellers in the Hotel Quarantine Program,[83] raised questions about pandemic planning exercises across the health sector more broadly.

66. Dr Pinskier is a Melbourne-based GP with nearly 40 years of involvement in primary health, tertiary care, digital health, accreditation, medical deputising services and practice management.[84] Dr Pinskier stated that, in the course of his professional life, the occurrence of a pandemic had never been discussed at any of the professional forums he had attended across Australia, other than a 'zombie apocalypse' workshop he attended in October 2014 that dealt broadly with the issue of a pandemic.[85]

67. Based on this experience, Dr Pinskier concluded that 'given the lack of ongoing systemic planning, no-one was remotely prepared for the pandemic and when it did arise the response was, in consequence, cobbled together in an ad hoc manner'.[86]

68. Dr Julian Rait, President of the Australian Medical Association (AMA) gave evidence in the form of a statement to the Inquiry[87] in which he, too, raised concerns about the level of engagement from DHHS with the medical profession more broadly in the context of emergency medicine. This subject is outside the Terms of Reference of this Inquiry. Nevertheless, given the evidence of such an experienced GP who was engaged in the Hotel Quarantine Program in his professional capacity and the concerns and issues expressed by Dr Rait as the President of the AMA, I consider that the issues raised by Dr Pinksier and Dr Rait as to the engagement of DHHS with the medical profession and the medical profession's ability to collaborate with DHHS and be a source of potential resources to DHHS in public health emergencies, should be the subject of follow up by DHHS (see Recommendation 71).

3.3 Conclusions

69. The Commonwealth Pandemic Plan describes pandemics as unpredictable and presenting a significant risk to Australia and having the potential to cause high levels of disease and death and disrupt the community, both socially and economically. The Commonwealth Pandemic Plan, which was developed in consultation with states and territories, outlines Australia's strategy to manage an influenza pandemic and minimise its impact on the health of Australians and the health system.

70. The Plan is intended to provide overarching guidance and a framework for a nationally consistent approach to managing an influenza pandemic. The guidance provided in the Commonwealth Pandemic Plan, consistent with this intention, is reflected in Victoria's relevant plans. It is the responsibility of the states and territories for the majority of the operational detail to be in their plans.

71. The Commonwealth Pandemic Plan does not provide any specific guidance for a program of mandatory detention or quarantine for returned travellers. It does not refer to a mass program of mandatory quarantine.

72. It does provide guidance and analysis regarding *voluntary* isolation of ill travellers who do not require hospitalisation, and possible quarantine of contacts of ill travellers at the border (though this option is not recommended).

73. The Plan considered voluntary self-isolation experiences during the SARS outbreak and the pandemic (H1N1) in 2009. It notes that compliance with self-isolation during the outbreak was high in most countries. Notwithstanding that, the Commonwealth Pandemic Plan identifies that isolation may be difficult to enforce, self-regulated isolation may not be complied with, and support for isolated cases is resource intensive.

74. The Commonwealth Pandemic Plan specifically identifies that the use of hotels to quarantine returned travellers is **problematic** (emphasis added), though it does not go so far as to say why this is so. Costs are noted as high if travellers are isolated in hotels, attributable to the costs of accommodation, food, servicing, medical support, security, entertainment and a support system to monitor people isolated.[88]

75. The Plan states that it would be highly complex to arrange and maintain a quarantine program, and that ethical issues may arise from confining individuals, as well as stress arising as a result of confinement. Notwithstanding this point, the Commonwealth Pandemic Plan provides that, if quarantining contacts of ill travellers at the border is to be used as a response strategy, the agency controlling the health response should commence its operation when it is 'notified of sustained human-to-human transmission of a novel virus and that it must be used early to be effective.

76. Voluntary quarantine of contacts more broadly (cases not limited to travellers) is recommended as a measure, particularly where consequences of infection are high.

77. The Commonwealth Pandemic Plan notes that the effectiveness of isolation and quarantine depends on a number of factors. Specifically, as the Plan deals with voluntary isolation and quarantine, it considers that factors influencing its effectiveness include perception and understanding of risk associated with infection and illness, and financial considerations.

78. It is clear that both the State and Commonwealth governments were aware, prior to 2020, of the possibility of a pandemic and its potentially devastating consequences.

79. However, none of the existing Commonwealth or State pandemic plans contained plans for mandatory, mass quarantine. Indeed, the concept of hotel quarantine was considered problematic and thus, no plans existed in the overarching Commonwealth plans for hotel quarantining.

80. Similarly, as of 27 March 2020, when the National Cabinet announced the mass quarantining of returning travellers, Victoria had no plan for large-scale mandatory quarantine of people arriving into the State via international points of entry.

81. Prior pandemic planning was directed at minimising transmission (for example, via voluntary isolation or quarantine at home), and not an elimination strategy. Prof. Sutton accepted that:

> One of the issues in both the Australian Health Management Plan for Pandemic Influenza and the Victorian plan reflecting it is that there probably wasn't sufficient consideration of coronavirus as a virus of pandemic potential, nor was there such explicit consideration of a program of quarantine essentially for the purpose of keeping a jurisdiction entirely free of the virus.[89]

82. While this Inquiry has no remit or jurisdiction to examine any action or inaction by the Commonwealth, given the role of the Commonwealth through the Commonwealth Pandemic Plan and the lead that it provides to the states and territories, it would be unfair to judge Victoria's lack of planning for a mandatory quarantining program given the Commonwealth, itself, had neither recommended nor developed such a plan.

83. Significantly, the Commonwealth undertook a review of its health sector response in the wake of the (H1N1) pandemic in 2009. The Commonwealth's *Review of Australia's Health Sector Response to Pandemic (H1N1) 2009* recommended that the roles and responsibilities of all governments for the management of people in quarantine, both at home and in other accommodation, during a pandemic should be clarified. The review further recommended that a set of nationally consistent principles could form the basis for jurisdictions to develop operating guidelines, including plans for accommodating potentially infected people in future pandemics and better systems to support people in quarantine. Further, this review recommended an examination of the policy on quarantine and isolation, including management, support systems and communication.[90]

84. Despite the Commonwealth Pandemic Plan and the Victorian Pandemic Plan being updated following the *Review of Australia's Health Sector Response to Pandemic (H1N1) 2009* to ensure evidence-based decision-making; use of existing governance mechanisms; a scalable and flexible approach and to emphasise communication activities, an important piece of work regarding the policy on quarantine and isolation, including management, support systems and communication and the roles and responsibilities of all governments for the management of people in quarantine during a pandemic to be clarified, the evidence to the Inquiry is that this work was not undertaken.

85. Had the work proposed by the review been undertaken, there would likely have been, at least, a set of guiding principles and a framework to support the establishment of the Hotel Quarantine Program, thus avoiding the program needing to be set up in an ad hoc manner during a pandemic.

86. Just two weeks before the National Cabinet agreement to mass quarantining, Victoria published its 10 March 2020 *COVID-19 Pandemic Plan for the Victorian Health Sector*. It did not envisage the involuntary detention of people arriving in from overseas. As with the Victorian Pandemic Plan, its focus with regard to isolation or quarantine was on the *voluntary* isolation of people in their own homes.

87. The lack of a plan for mandatory mass quarantining meant that the Hotel Quarantine Program was conceived and implemented 'from scratch' to be operational within 36 hours from concept to operation. This placed incredible strain on the resources of the State and, more specifically, on those Departments and people required to give effect to the decision of the National Cabinet. This was a most unsatisfactory situation from which to develop such a complex and high-risk program.

88. Given the future movement of people in and out of Victoria from across the nation, it is in Victoria's interests to advocate for nationally cohesive and detailed quarantine plans as previously recommended in the wake of the *Review of Australia's Health Sector Response to Pandemic (H1N1) 2009* as to clarity of roles and responsibilities between different levels of government, management and support systems and communication. Recommendations 2, 3, 4, 5, 49 and 59 identify and address specific issues of liaison and communication as between the State and Commonwealth agencies. Recommendation 70 addresses this issue as between Victoria and the Commonwealth.

PANDEMIC PLANNING EXERCISES

89. The evidence shows emergency incident exercises, specifically related to infectious disease pandemics, are undertaken regularly. These exercises consider associated public health and emergency management plans and are undertaken within DHHS and with other agencies.

90. 'Exercise Alchemy' in August 2018 identified that the role and function of any team or structure needed to be clearly defined and practical, given that Class 2 emergencies have unique challenges. The need for clarity in roles and structure was a valuable result from the exercise which was an opportunity to address this issue. Given the conclusions from this Inquiry, it should be given due focus when developing future emergency response activities. (See Recommendation 72 and see also Chapter 8 for issues more generally as to role clarity).

91. There was a perceived gap in terms of provision of pandemic planning across the broader health sector. There can be no doubt that there is a role for the broader health sector to play in health emergency planning. DHHS should review its pandemic planning processes and activities so as to consider an appropriate level of involvement from the broader health sector (see Recommendation 73).

3.4 Recommendations

70. The Victorian Government, through the various national structures available to the Premier, the Minister for Health, the Secretary to DHHS and the Chief Health Officer, advocates for necessary action to be taken to address the recommendations from the *Review of Australia's Health Sector Response to Pandemic (H1N1) 2009* as to clarity on roles and responsibilities between different levels of government, management, support systems and communication and policy on quarantine and isolation.

71. The Secretary of DHHS engages with the appropriate representative bodies from the medical profession with a view to developing agreed plans as to the availability of medical expertise and resources in the event of a public health emergency and the need for future surge demands.

72. The Secretary of DHHS ensures that future pandemic planning exercises should specifically address the need for clarity of roles, structures and accountabilities, to ensure the necessary detailed focus and preparedness as to the importance of these issues is widely understood and well-rehearsed.

73. The Secretary of DHHS, in consultation with representative bodies from the broader health sector, reviews the range of participants currently invited to pandemic planning exercises to assess how the range of representative participants could be expanded to include the broader health sector.

Endnotes

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