CHAPTER 7

Use of hotels and cleaners

Section 1 — The decision to use hotels and the terms of their contracts

7.1 Decision to 'stand up' hotels for the Hotel Quarantine Program

1. Following the National Cabinet meeting on 27 March 2020, Prime Minister, the Hon. Scott Morrison MP, held a press conference to announce the decision that had been made. He stated that all international arrivals were to be quarantined in 'designated facilities'.[1] This generic description — designated facilities — was accompanied by an express example, namely 'such as a hotel'.[2]
2. The evidence of the Premier was that, after the decision of National Cabinet, he thought it most likely the designated facilities in Victoria would be hotels.[3] In his view, and as he described it, hotels were the most logical facilities to use for the Program.[4]
3. However, the Premier explained, in his evidence, that he did not consider the matter of hotels to have been settled at that early stage (namely, on 27 March 2020).[5] His evidence was that, in his view, the issue was not settled until the following day.[6]

The Secretary to the Department of Premier and Cabinet set the hotel procurement process in motion

4. I have described in Chapter 5, at paragraphs 29 to 37, the telephone call from Chris Eccles AO, Secretary to the Department of Premier and Cabinet (DPC), to Simon Phemister, Secretary to the Department of Jobs, Precincts and Regions (DJPR), tasking his Department to source hotels to implement the National Cabinet decision.
5. That call, particularly following the discussion I set out below, set in motion a significant logistical and procurement process that resulted in DJPR entering into formal agreements with 29 hotels in respect of the Program.[7]
6. To get a sense of whether it was achievable to have hotel stock available for the commencement of the Hotel Quarantine Program, Mr Phemister and Mr Eccles had discussed how far advanced DJPR was with respect to contracting hotels.[8]

7. Mr Phemister was confident that around 5,000 rooms would be available 36 hours after the call.[9] As a result of that call, Mr Phemister understood that he would start to put together an 'end-to-end' program of work to support the operation;[10] that is, from the moment someone was seated on an aeroplane to exiting the hotel after their two-week stay, and everything in between,[11] although I note Mr Eccles did not purport to commission DJPR to undertake the whole Program.[12]

8. Mr Phemister saw this call as 'effectively a head-start' for DJPR to commence work on the Program, including acquiring hotel stock.[13] Mr Eccles stated that it was likely that he advised the Premier and the Premier's Chief of Staff, Lissie Ratcliff, of what he was doing when stepping out of the National Cabinet meeting to telephone Mr Phemister.[14] However, there was nothing in the evidence to suggest that Mr Eccles was instructed or directed to place that call. In fact, it was the evidence of Mr Eccles that it was he who decided to place this call to Mr Phemister.[15] During the course of his press conference at about 3.00pm that afternoon, on 27 March 2020,[16] the Premier stated that returning travellers would be quarantined at hotels and that '5,000 rooms [were] basically on standby now'.[17]

9. Ultimately, only 20 of those hotels were actually used as part of the Hotel Quarantine Program.[18] However, it was that call as between these two departmental heads that commenced the hotel procurement process.

10. Although it was the evidence of Mr Eccles that it was his decision to call Mr Phemister and get the hotel procurement going, and that he was not directed by the Premier to do this, equally, by the following day, the Premier had embraced the proposal to use hotels.

7.2 Procurement of hotels

11. Following his call with Mr Eccles on the afternoon of 27 March 2020, Mr Phemister spoke with Unni Menon, Executive Director, Aviation Strategy and Services, at DJPR.[19] Mr Phemister requested that Mr Menon begin work immediately so as to ascertain the availability of hotels for use in the Hotel Quarantine Program. This included determining the capacity of hotels to provide meals, security services and cleaning services.[20]

12. Since around 22 March 2020, Mr Menon had been leading DJPR's efforts to assist DHHS in identifying and securing hotel stock for vulnerable persons requiring accommodation in order to self-isolate.[21] As part of these efforts, Mr Menon had run an 'expression of interest' processes through the Victorian Tourism Industry Council, the Australian Hotel Association and the Accommodation Association of Australia.[22] Consequently, by 27 March 2020, Mr Menon had a significant amount of information about which hotels across Victoria were available and willing to participate in the Program.

13. In order to identify appropriate accommodation for the purposes of the Hotel Quarantine Program, Mr Menon and his team speedily commenced work to review the information obtained through the earlier expression of interest processes.[23] Mr Menon's team sought feedback from the State Control Centre (SCC) team as to their preference from a mandatory quarantine perspective; he said SCC feedback was a preference for hotels to be located within the CBD.[24] Mr Menon understood the reason given for hotels in the Melbourne CBD was their proximity to major testing centres, major hospitals and to be confined in a geographical area for security and safety.[25]

14. Mr Menon and his team began by contacting various hotels in the Melbourne CBD in order to ascertain the security, cleaning and catering capacity of each.[26]

15. Meanwhile, having already spoken to Mr Menon, Mr Phemister convened a meeting with Rob Holland, Director, Office of the Secretary; Cameron Nolan, Executive Director, Priority Projects Unit; and Claire Febey, Executive Director, Priority Projects Unit at DJPR.[27] Ms Febey was made project lead.[28] At that stage, based on his understanding of the discussion with Mr Eccles, Mr Phemister believed that DJPR had lead responsibility for delivering the Hotel Quarantine Program. He believed, at the time, that other departments would hold responsibility for components of the Program within their areas of expertise, but that DJPR would 'bring it all together'.[29]

16. Early in the morning on 28 March 2020, Mr Menon circulated the spreadsheet he had created the day before, setting out the hotels that were available in the short term, as well as their cleaning, catering and security arrangements.[30] Around that time, the template for the contractual agreement for the provision of accommodation was drafted and provided to Mr Menon for completion.[31]

17. It appears that Mr Menon then sent an email to Mr Phemister requesting authorisation to execute the contracts with hotels.[32] Mr Phemister replied that afternoon to convey his approval.[33] Mr Menon was, thereby, able to execute the formal agreements with hotels on behalf of DJPR, which he did.[34]

18. Thus, it was that DJPR made the initial decisions about which hotel sites to use. According to Mr Menon, these decisions were informed by feedback from the team within the SCC, the views of key personnel within DJPR and discussions with the various hotels.[35] It was by this process the first hotels were selected and implemented within the Program.[36] It does not appear on the evidence that DHHS was specifically engaged in hotel selection at that stage. Notwithstanding the evidence of Mr Phemister that DHHS was consulted, Mr Menon did not identify any DHHS consultation at that point. State Controller — Health at the Department of Health and Human Services (DHHS), Jason Helps, in outlining to Ms Febey that a transition to DHHS must happen, stated that it would be 'now be vital' that DHHS made the operational decisions about which hotels to use and when.[37]

Change of 'lead agency'

19. On the morning of 28 March 2020, Mr Eccles informed Mr Phemister that Emergency Management Commissioner Andrew Crisp would have the responsibility for coordinating the Hotel Quarantine Program and that DHHS would be the control agency in respect of the program.[38] It was agreed that DJPR should transition various roles and functions over to DHHS.[39] (See chapters 5 and 8 for more detail).

20. DJPR's position was that, upon DHHS becoming control agency, its role was as support agency effectively working under the direction of, and managing contracts to assist, DHHS as the department in control of the Program. DHHS maintained that it was not in charge of the overall Program and had responsibility only for those parts of the Program that related to the health and wellbeing of those in detention. Throughout the Inquiry and in closing submissions, DHHS, through its witnesses up to and including the former Minister Jenny Mikakos, maintained a description of its role as one of 'shared accountability'. The impact of this is discussed at length in Chapter 8.

21. By Sunday 29 March 2020, Mr Helps emailed Ms Febey of DJPR to confirm his desire that DJPR 'continue to provide the valuable work in procurement of hotels', but went on to confirm that DHHS was the **control agency** (emphasis added).[40]

22. Mr Menon and his team, thereafter, sought and relied upon the specific requirements and preferences expressed by DHHS representatives, as well as any feedback that had been received from the relevant DJPR personnel.[41] According to Mr Menon, the views of DHHS on this matter were critical.[42] He stated that DHHS had the ultimate call regarding the selection or renewal of hotels for use in the Program.[43]

23. Some witnesses for DHHS appeared to have taken a different view as to its role in the selection of hotels. Merrin Bamert, the then Deputy Commander — Hotels at DHHS, gave evidence that, following her initial concerns about suitability of hotels, DHHS was able to have 'more input' regarding future contractual engagements, including by providing a checklist of 'must-haves' for contractual engagements and 'trying to encourage the selection of hotels with fresh air options where possible'.[44] While Ms Bamert's evidence indicated that DHHS had input into these decisions, it did not indicate that DHHS had ultimate responsibility. Indeed, DHHS submitted that selection of hotels was a matter for DJPR 'as the entity with responsibility and knowledge of the relevant hotels and their suitability'.[45]

24. The one exception to this was the Brady Hotel, which was selected to replace Rydges and to accommodate COVID-positive guests. DHHS selected and contracted the Brady Hotel, without the involvement of DJPR,[46] with it ultimately being stood up on 17 June 2020.[47]

25. Mr Menon explained his understanding of the criteria applied by DHHS in determining whether a hotel was appropriate for use in the Program. This included room types and configurations, access to natural ventilation (windows or balconies), whether there were controlled areas for recreation, layout for check-in/out and access to lifts.[48]

26. Mr Menon also gave evidence that he was not aware of any specific documentation from DHHS concerning assessment of prospective hotels from an infection control point of view prior to giving approval to engage them.[49]

Hotels as quarantine facilities

27. The starting point on the issue of the selection of hotels was that there were no specific quarantine facilities able to be identified in Victoria at the time of the National Cabinet decision. The evidence of Pam Williams, DHHS COVID-19 Accommodation Commander, was that there were no apparent viable alternatives to the use of hotels for the purposes of the Hotel Quarantine Program. Ms Williams explained that 'there are no specific quarantine facilities that we could have accessed'.[50] According to Ms Williams, while the Commonwealth had some designated quarantine facilities, Victoria did not have any such purpose-built facilities.[51]

28. Hotels provided the necessary capacity and availability given the then expected scale of the Program. While precise numbers of returning travellers were not known at that early stage, the evidence of the Premier was that he had been informed that thousands of rooms would be required.[52]

29. As a result of the limitations that had been placed on travel and tourism due to the COVID-19 pandemic, the Premier knew that there were many hotel rooms available at that time,[53] thus, they would be generally available for occupation by those to be quarantined pursuant to the Program.

30. The use of hotels was also seen by the Premier as providing a significant financial and employment boost to the State's pandemic-affected economy; specifically, a direct injection of work into the hotel and tourism sectors. As the Premier stated, in his press conference on 27 March 2020, and is described more fully in Chapter 5, the Hotel Quarantine Program was, in addition to being an appropriate health response, 'also … about working for Victoria and re-purposing people who have perhaps had their hours cut'.[54]

31. It appeared that the suitability of hotels as quarantine facilities was considered mainly from a point of view of expediency, rather than their capability to minimise against the risk of infection transmission.

32. Hotels, it was said, could contain returned travellers within specific hotel rooms with access to their own bathroom, which could provide a measure against cross-contamination and the proliferation of infection.[55]

33. But, as the Program unfolded, there were aspects of hotel facilities that provided challenges for infection prevention and control:

    A. the carpets and soft furnishings that made people in quarantine more comfortable may also have made it more difficult to clean surfaces[56]

    B. structurally, hotels were not designed for infection prevention and control; they do not typically have features, such as wide corridors and oversized lifts, that allow for physical distancing[57]

    C. handwashing stations and clinical waste disposal facilities were not readily available in a hotel environment[58]

    D. ventilation and air flow within hotels were not designed with a focus on infection prevention and control.[59]

34. Despite efforts being made to source hotels with natural ventilation (windows/balconies), controlled areas for recreation and an appropriate layout for check-in/out and access to lifts, many of the hotels used in the Hotel Quarantine Program did not present as having suitable areas for access to fresh air without guests coming into contact with others. As Ms Williams observed, '[t]he fresh air breaks were difficult to implement safely and without transmission risk due to the limitations of many of the hotels (many did not have balconies, rooftops, or open areas that could be sectioned off from the public to reduce flight and transmission risk)'.[60]

35. Ms Williams described what adaptations were made to ameliorate some of the challenges presented by the hotel environment in order to reduce transmission risks and support specific infection-control measures:

> [M]odifications were made to the physical set up of the hotels to reduce transmission risk. Hotel lobbies were cordoned off to encourage swift movement through the spaces. Hotels were encouraged to remove or limit soft furnishings. Lifts were assigned to 'clean' and 'dirty' purposes to reduce cross-infection. Staff on-site were separated into specific zones to prevent cross-infection.[61]

36. While such measures were conducive to reducing the risk of transmission, the physical features of hotels presented corresponding difficulties for the ability of staff to meet the health and wellbeing needs of those who were in quarantine. Hotels are set up so as to give guests privacy, and when those facilities are also used to ensure that potentially contaminated people do not come into contact with others, many guests may spend much, if not all, of their quarantine period without ever being seen by another person. The impact of this aspect of hotel quarantine on people's health and wellbeing is discussed in Chapter 12.2.

7.3 Contracts with hotels

37. As explained above, contracts were executed by DJPR with each participating hotel. Pursuant to those contracts (which were in substantially the same terms), the primary service that hotels were contracted to provide was the supply of rooms and meals to accommodate returned travellers.

38. The precise number of rooms to be supplied for the purposes of the Program varied between different hotels and at different times. Contractual arrangements were made with some hotels to supply the entire hotel for the Program, while others only agreed to supply a certain number of rooms or floors.[62]

39. The decision as to whether a hotel would be contracted to provide the entire property or whether only certain floors or rooms depended on a number of factors, including the hotel's availability, the incoming demographics of returning travellers and the projected or anticipated demand in terms of hotel stock.[63]

40. In addition to accommodation, the hotels were vested with other responsibilities under the terms of the contracts. These responsibilities included catering, certain cleaning, the provision of PPE for staff and general training in the use of PPE. Aspects of the contractual responsibilities of hotels were problematic and became the subject of some attention during the Inquiry. The hotels' contractual responsibilities are discussed below in this chapter.

Catering

41. With respect to catering, under clause 2.1(o), hotels were required to:

> Provide three reasonable meals a day to each of the Department's Nominees. The preparation and service of food must be done in accordance with recommended health standards including in relation to COVID-19.[64]

42. The evidence before the Inquiry was that there were a range of complaints from those in quarantine about the food provided by some of the hotels. These complaints included food quality, accommodation of dietary and religious requirements or preferences, religious requirements, quantity, the nutritional value of meals and a lack of variation in the food provided.[65]

43. Witness Liliana Ratcliff noted that '[W]e were given the same breakfast each day. The other meals were mostly curries and pies. Once, we were given a salad, but otherwise there were very few vegetables only mushroom or pumpkin soup'. She further commented that '[I]t was possible to order Uber Eats. I started ordering food for me and my kids, because it was a way that we could have some control over a small part of our lives while we were in quarantine. From a mental health perspective, it was good for us to have that autonomy — to eat when we were hungry and to choose what we wanted to have'.[66]

44. In some instances, the frustration expressed by witnesses was that, despite being asked about dietary requirements and giving this information on several occasions, the hotel catering was not apparently responsive to the information provided.[67]

45. In response to this evidence, the hoteliers who gave evidence explained that they were mostly in circumstances where they were receiving large groups of people at very short notice with little or no information about dietary requirements being provided to them and, consequently, had little time to make the necessary arrangements for the incoming group.[68] According to some witnesses before the Inquiry, this issue of catering was a matter that had an impact on people's sense of wellbeing.[69] This matter is discussed further in Chapter 12.2 on psycho-social impacts of quarantine.

Figure 7.1: Quotes from returned travellers about their experience with food and dietary requirements in the Hotel Quarantine Program

Returned Traveller 3: 'The food at the [hotel] lacked nutrition and meals were mostly very unhealthy. One lunch consisted of a meat pie and a very greasy potato cake. Breakfasts were particularly calorie laden and unhealthy, an unwise choice given that 'detainees' had no opportunity to exercise it off. After a few days, having found that the majority of meals to be inedible, I called the kitchen, and it was suggested that I purchase off the in-house dining menu — for me it seemed so wrong that and indeed deliberate that the hotel would serve inadequate and unhealthy meals, in the hope of forcing 'detainees' to order from their alternative menu at inflated prices'.

Returned Traveller 6: 'We were very tired after a long flight home. There was no food or drink in our hotel room. I was unable to order any food from room service and no one was answering my calls. I asked the security guards for help, but they said they couldn't help. I kept ringing hotel staff. Eventually a hotel staff member came and gave us food and drink. He told me they were too busy to respond to all calls quickly'.

Returned Traveller 11: 'I have no medical proof of my eating disorder so could not get an exemption to serve quarantine at home. So, I was very hungry and stuck. I resorted to having one meal a day by ordering my own Uber Eats or other delivery service meal. This was expensive so I could only do this once a day'.

Returned Traveller 12: 'I have issues with certain foods due to medical complaints. By the look of the meals they would not have cost more than $5 and were visually not appetising. I felt annoyed that some guests got the option to order meals and get reimbursed while the rest of us had to eat slops. One lunch was 3/4 tray of cold boiled rice and 1/3 cup if that of mushrooms in curry. Surely a fresh sandwich would be better. We were given bananas that were old and black'.

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.

7.4 Contractual responsibility for risk management, worker safety and PPE

46. It was not contentious at any time during the Inquiry that training in how to work safely in the quarantine environment, including the provision and proper use of PPE, was a key element of infection prevention and control. What was contentious was who should provide that training, who did provide that training, what that training was, what that training should have been and the sufficiency of 'episodic' training sessions without the on-site embedded supervision and oversight of those with infection control expertise.

47. The form of contract prepared by DJPR made the hotel operators generally responsible for their staff training in workplace health and safety, risk management and the provision of PPE. The presence of such provisions was an acknowledgment of the central importance of infection prevention and control inside the quarantine hotels, and that worker safety on-site was an issue that needed to be addressed with training and the provision of PPE.

48. Specifically, a standard clause (usually clause 2.1(h)) provided that hotels must:

> … be responsible for, ensuring that before its officers, employees, agents, contractors and sub-contractors perform the Services, they receive:
>
> I. adequate training in security, workplace health and safety, customer service and risk management; and
>
> II. are provided with personal protective equipment in accordance with the relevant public health standards, including but not limited to in relation to COVID-19.[70]

49. Managers from a sample of hotels from the Program did not take issue with the contractual provisions contained in 2.1(h). Each of the hotel managers who gave evidence stated that they largely sourced their own information and support around specialist infection-control training and provision, and the use of PPE.[71] The evidence established that each hotel, prior to its participation in the Program, had prepared for operating in a COVID-19 environment. Several hotels had quite detailed and structured policies and procedures in place around COVID-19 safe practices, which they used to train staff for the purposes of this Program.[72]

50. For example, Stephen Ferrigno, General Manager at the Four Points by Sheraton Melbourne Docklands, gave evidence that its staff were required to do online training courses, including with respect to social distancing, hand sanitising, the use of PPE, public space cleanliness and cleaning, and what to do with a presumed or confirmed COVID-19 case on the property.[73] They were also tasked to complete the Australian Government Infection Control online training course.[74] Ram Mandyam, General Manager at the Travelodge Docklands, gave evidence of policies that covered self-isolation, sanitisation, use of PPE and signage.[75] Shaun D'Cruz, Executive Manager of Crown Melbourne Hotels, gave evidence of its staff being trained around social distancing and the use of PPE.[76]

51. The PPE that each hotel provided to its staff varied. The evidence from the sample of hotels that gave evidence was that, generally, each supplied its own PPE to staff as per the hotel's contractual obligations. Each of the hoteliers who gave evidence said that different levels of PPE were provided to hotel staff depending on the nature of contact that staff might have with guests.[77] At Travelodge, for example, the evidence was that the hotel provided staff with gloves, masks (N-95 and surgical), hairnets, sanitiser and PPE training.[78]

52. At Crown, 'standard PPE' was supplied by DJPR to Crown staff, while all other PPE was supplied by Crown.[79] PPE was stationed throughout the hotel at various locations.[80] Staff were directed by Crown to wear standard PPE when working in designated areas.[81] This changed to wearing masks at all times after the Victorian Government announced additional restrictions.[82] All training on the use of PPE was provided by hotel management rather than people with expertise in infection prevention and control.[83]

53. At the Four Points by Sheraton, the hotel initially provided staff with masks, gloves and safety glasses.[84] About 4–6 weeks into the Program, DHHS made PPE available for the Sheraton staff.[85] The hotel provided online and in-person training by managers and supervisors in relation to the use of PPE to staff. At some time after the Program commenced, the hotel was provided with documents from DHHS and DJPR in relation to the use of PPE. Again, the application of the training was supervised by hotel management and not by people who had expertise in infection prevention and control.[86]

54. Understandably, the hotels that agreed to participate in the Hotel Quarantine Program were keen to have the business when the pandemic had such drastic impacts on the tourism industry. It was unsurprising they accepted obligations under their contracts to provide 'adequate training', 'workplace health and safety', 'risk management' and 'personal protective equipment in accordance with the relevant public health standard, including but not limited to COVID-19'. Given the consequences of any failure to discharge these obligations, it was an entirely different matter as to whether it was prudent for the Government to allocate this obligation to hoteliers in the first place.

Infection prevention and control in hotels: the ever-present risk of cross-infection

55. Self-evidently, the risk of infectious outbreaks as between those in quarantine, and to those working in the quarantine hotels, was an ever-present one on-site. Consequently, infection prevention and control (IPC) for those in quarantine and those working on the sites was an essential component of what the Hotel Quarantine Program was required to deliver.

56. IPC encompasses a wide range of issues in the context of hotels as quarantine facilities, including:

    A. training for hotel workers, including in how to work safely by understanding the risks of infection and how to mitigate against those risks by engaging in practices such as maintaining safe distances, hand sanitising, understanding high-touch area risks and coughing and sneezing requirements

    B. provision and use of PPE

    C. cleaning requirements including methods and standards.

What expertise was available to hotels for IPC?

57. It was uncontentious that IPC was a recognised area of expertise. In the context of the COVID-19 pandemic, even those with such expertise have explained that understanding the nature and transmission of the virus was, and remains, a constantly evolving process.

58. DHHS accepted that it was its responsibility to provide guidance and advice on IPC issues, and asserted that it did do so.[87]

59. More particularly, it was the position of DHHS that it was its role to provide the advice and guidance to DJPR and that DJPR was then responsible for passing it on and managing or overseeing compliance. DHHS took the position that it did not hold or manage the contracts with hotels and did not see it as its role to implement that advice and guidance and ensure it was done to the requisite standard.

60. DJPR's position was that although it held the contracts with the hotels, DJPR looked to DHHS for the necessary expertise and guidance in this area. This impasse made its contribution to what became a Gordian knot that developed in the early days of the Hotel Quarantine Program (See Chapter 8 for more detail).

61. At the time the Hotel Quarantine Program was set up, DHHS had one infection and prevention control consultant (IPC Consultant) at its disposal for the State of Victoria. That IPC Consultant stated that she had no formal role in the Hotel Quarantine Program.[88] The IPC Consultant's evidence was that she was not engaged with the Program,[89] had no knowledge of what PPE was provided to people working in hotel quarantine[90] and did not provide training at hotels about PPE, cleaning or other aspects of IPC other than providing guidance or advice or reviewing training materials from time to time.[91]

62. By early April 2020, the need for staff with IPC expertise was identified by DHHS as requests for assistance grew across the State.[92] In early April 2020, the IPC Cell commenced with the IPC Consultant, two additional part-time consultants and an administrative assistant.[93] By mid-April 2020, the team had expanded to include an IPC Cell Strategy, Policy & Planning Lead and two more part-time IPC practitioners.[94] The number of IPC staff in the DHHS IPC Cell fluctuated thereafter.[95]

63. Suffice to say, the evidence was that this very small team was handling general COVID-19 enquiries from across the State, rather than specifically focusing on the Hotel Quarantine Program. This would account for the slow and non-specific response that the Public Health Team inside DHHS was able to provide as the Hotel Quarantine Program commenced and developed.

64. The IPC Consultant explained that she answered questions from those working in the Hotel Quarantine Program from time to time in response to requests: 'Often this advice was also provided as state-wide advice, that was then available to those managing the Hotel Quarantine Program'.[96]

65. Her evidence was to the effect that various instances of 'one-off' training in the use of PPE were delivered at hotel sites for security staff in June.[97]

66. On the suggestion of the IPC Consultant, DHHS engaged an outside consultant to provide IPC advice. As a result, Infection Prevention Australia was engaged in early April 2020.[98]

67. There was no evidence before the Inquiry to suggest DHHS played a role in training hotel staff in infection prevention and control in any uniform, systematic or coordinated way. There were some examples of ad hoc training, like a short tutorial on infection prevention for all hotel staff at the Rydges on 11 April 2020, organised by DHHS.[99] No doubt, having such an inadequate capacity to provide that infection prevention control expertise from inside DHHS made its contribution to the lack of any cohesive approach to infection prevention and control in hotels.

Section 2 — Hotel cleaning contracts, oversight and vulnerabilities

7.5 The cleaning of quarantine hotels

The importance of cleaning

68. Cleaning was a critical element of infection prevention and control within the Hotel Quarantine Program and an important means of achieving the Program's key objective: to contain the further spread of COVID-19 among the people in quarantine and those working in and at the hotels.

What was understood by 29 March 2020 about modes of transmission of the virus?

69. Cleaning requirements in the Hotel Quarantine Program needed to be informed by what was understood about modes of COVID-19 transmission. I have dealt with the evidence as to what is currently known about how the COVID-19 virus is transmitted in Chapter 2, but in the context of cleaning, the evidence about fomites was particularly relevant and worthy of briefly revisiting here.

70. As noted in Chapter 2, Professor Lindsay Grayson, Professor of Infectious Diseases at Austin Health, explained that the SARS-CoV-2 virus 'can be transmitted through droplets, aerosols and fomites'.[100] Prof. Grayson provided the following explanation of fomite transmission:

> Fomites are surfaces or objects (including hands) which may become contaminated and serve as an intermediary vehicle for transmission. There are studies demonstrating that SARS-CoV-2 may survive on certain surfaces outside of the body (such as plastic, cardboard and stainless steel) for up to 72 hours. Were a person to come into contact with a surface containing droplets or aerosol which contain the virus, those particles and the virus could subsequently be transmitted to that person's body by exposure to their mucous membranes. For example, an infected person may cough on a door handle, which is then touched by another person. Should that second person then touch their mouth, there is transmission from the infected person to the second person.[101]

71. In respect of the possibility of fomite transmission, as of 1 May 2020, Dr Simon Crouch, Senior Medical Advisor, Communicable Diseases Section at DHHS and Deputy Public Health Commander for Case, Contact and Outbreak Management, held the view that:

> … while fomite transmission from surfaces (as opposed to people's hands or objects) was possible, there was not significant evidence of it happening in outbreak settings in Victoria prior to that date and I did not consider it a significant source of transmission for local outbreaks.[102]

72. Indeed, it was only when considering the Rydges outbreak, in late May 2020, that Dr Crouch first considered fomite transmission as a likely source of transmission.[103] He acknowledged, in light of the growing experience of the outbreaks that have since been managed, 'it does appear that fomite transmission plays a larger role than I would have given it credit at that point'.[104]

73. It appeared, however, that others within DHHS were of a different view at an earlier stage as to the risk posed by fomite transmission. When asked as to her knowledge of the ways in which COVID-19 could be transmitted as of 1 May 2020, Dr Sarah McGuinness, an academic infectious diseases physician who was, at the time, Outbreaks Lead at DHHS, stated that her understanding would have reflected the World Health Organization (WHO) material current at the time.[105] In particular, Dr McGuinness made reference to the WHO guidance titled *Modes of transmission of virus causing COVID-19: implications for IPC precaution recommendations: scientific brief, 29 March 2020*.[106]

74. That guidance provides as follows:

> According to current evidence, the COVID-19 virus is primarily transmitted between people through respiratory droplets and contact routes. Transmission may also occur through fomites in the immediate environment around the infected person. Therefore transmission of the COVID-19 virus can occur by direct contact with infected people and indirect contact with surfaces in the immediate environment or with objects used on the infected person.[107]

75. That same document also emphasised:

> The utmost importance of environmental cleaning and disinfection, among other infection prevention measures.[108]

76. Dr McGuinness was involved in drafting and updating DHHS's publication *Coronavirus disease 2019 (COVID-19), Case and contact management guidelines for health services and general practitioners*.[109] The version of this document that was available on 1 May 2020 (version 20, dated 25 April 2020) contained the following explanation about the mode of transmission for COVID-19:

> The mode or modes of transmission of COVID-19 are not yet fully understood, although based on the nature of other coronavirus infections, transmission is likely through droplet and contact. There were cases with a strong history of exposure to the Hua Nan Seafood Wholesale Market in Wuhan City, China where live animals are sold. However, the mechanism by which transmission occurred in these cases, whether through respiratory secretions after coughing or sneezing, or direct physical contact with the patient or via fomites after contamination of the environment by the patient, is unknown.

> Person to person transmission has now occurred worldwide and the WHO declared a pandemic on 11 March 2020. As a result, droplet and contact precautions are recommended.[110]

77. While the above section does not refer to airborne transmission, another section of that document states that '[a]irborne and contact precautions are now recommended in specific circumstances when undertaking aerosol generating procedures'.[111]

78. Dr McGuinness stated that the document was consistent with the WHO position and, together, these documents reflected her understanding of the modes of transmission as of 1 May 2020.[112] As noted above, Dr McGuinness confirmed that the WHO guidance from late March 2020 was her source material as of 1 May 2020, among others.[113]

7.6 Contracts for cleaning of quarantine hotels

79. When, on behalf of DJPR, Mr Menon initially emailed hotels to gauge their interest in providing accommodation services as part of the Hotel Quarantine Program, he indicated that responsibility for cleaning of rooms would vary, depending on whether a particular room had been occupied by a person who was known to have tested positive for COVID-19:

> Please note while we expect that cleaning of the rooms will be the responsibility of the hotel (in accordance with the Agreement), if there is a confirmed case of COVID-19 in any of the guests nominated by the department, the department will organise for cleaners to provide an industrial clean of the relevant rooms upon the departure of that guest.[114]

80. This responsibility was borne out in the contractual arrangements. Under the contracts entered into between the State (through DJPR) and hotels, primary responsibility for cleaning rooms fell to hotels participating in the program. As per clause 2.1(d), hotels were generally required to:

> … ensure that each Room is thoroughly cleaned and disinfected at minimum:
>
> i. prior to the commencement of each Department's Nominee's stay; and
>
> ii. as soon as practicable following the conclusion of each Department Nominee's stay, to a standard consistent with the most recent recommended public health standards in respect of COVID-19.[115]

81. As noted above, that general requirement was subject to an exception in respect of rooms that had been used to accommodate a person in quarantine who was known to have tested positive for COVID-19. A further part of clause 2.1 (usually 2.1(e)) provided that hotels must:

> … if there is a confirmed case of COVID-19 in any of the Department's Nominees, allow the Department's representatives to enter the Supplier's premises in order to undertake specialised cleaning of the relevant Room. For the avoidance of doubt, these specialised cleaning services will be at the cost of the Department.[116]

82. In these instances, rooms that had accommodated COVID-positive guests were dealt with by commercial cleaning providers. Those cleaners performed what was variously referred to as an 'industrial', 'commercial' or 'specialised' clean.[117]

83. Each hotel used its own contracted cleaners/housekeepers (as per their regular operation) for the cleaning of rooms and common areas around the hotel. Evidence to the Inquiry was that some hotels provided training to their staff in relation to social distancing, the use of PPE and sanitisation.[118] Mr Ferrigno of the Four Points by Sheraton Melbourne Docklands, noted that staff were required to undertake specific COVID-19 cleaning training, including training on public space cleanliness and high touch cleaning, and touchless transactions.[119]

84. The regular hotel cleaners only cleaned rooms after the guests had departed (that is, there was no cleaning during the 14-day quarantine period).[120] During the quarantine period, essential cleaning items were required to be provided to guest rooms upon request (noting that no cleaning services were otherwise provided during this time).[121]

85. However, one returned traveller told the Intake and Assessment Team that he asked for a toilet brush and toilet cleaner during his stay. After three failed responses (he was offered dishwashing liquid, antiseptic wipes and then hair conditioner), he was advised that they had run out of cleaning equipment.[122]

86. Representatives of the hotels who gave evidence at the hearings said they used subcontractors for their regular cleaning services. There was no evidence that these sub-contracted hotel cleaners were trained in any specific infection control procedures.[123]

7.7 Procurement of commercial cleaning companies for 'specialised cleaning'

87. DJPR was responsible for procuring and contracting the specialised commercial cleaning providers to perform COVID-positive cleans at quarantine hotels.[124]

88. Rachaele May, Executive Director of Emergency Coordination and Resilience at DJPR, began substantively performing the procurement role after taking over from Ms Febey in mid-April.[125]

89. Ms May was provided with the relevant quotes and sought to progress procurement.[126] As a preliminary step, she liaised with DHHS in an effort to understand its requirements in relation to the provision of commercial cleaning services.[127]

90. Ms May gave evidence that she understood that DHHS did not have specific requirements about which cleaning contractor(s) were to be engaged.[128] As to methods and standards for cleaning, DJPR was advised by DHHS to direct the commercial cleaning contractors engaged to the relevant cleaning protocol,[129] which, at that time, was *Cleaning and disinfecting to reduce COVID-19 transmission, Tips for non-healthcare settings* (Cleaning Protocol).[130]

91. One of the cleaning services that had provided a quote to DJPR was IKON Services Australia Pty Ltd (IKON), a commercial company that provides infectious cleaning services to a range of clients.[131] In his evidence to the Inquiry, Michael Girgis, General Manager of IKON, said that he first became aware on 11 April 2020 that IKON had been requested to provide a quote for infectious cleaning services in respect of the Hotel Quarantine Program. It was Mr Girgis' understanding that DJPR had initiated this contact and requested a quote.[132]

92. On 13 April 2020, Ms May had a discussion with Mr Helps to express the view that IKON satisfied the requirements of the Cleaning Protocol and explained that rooms at the Crown hotels needed to be cleaned urgently so that further arrivals could be allocated later in the week. Mr Helps agreed with her assessment and advised Ms May to proceed and engage IKON.[133]

93. Ms May approved the engagement of IKON and instructed that a contract be drafted for IKON's consideration.[134] Due to the urgency of the engagement, IKON commenced providing commercial cleaning services in the Program before having seen a contract. DJPR did, however, provide IKON with a copy of the Cleaning Protocol, in accordance with the direction from DHHS.[135]

94. IKON was the only actual provider of commercial cleaning services to the Program prior to the outbreak at Rydges Hotel.[136]

95. Mr Girgis gave evidence that his company provided specialised cleaning services including sanitising and disinfecting of rooms, and the use of a 'fogging' machine to ensure surfaces were free of bacteria and germs.[137] IKON used chlorine-based chemical (that is, bleach) to fog the rooms and a bleach and disinfectant to clean hard surfaces.[138] Rubbish and cutlery were removed in bio-waste bags. As requested, and on an ad hoc basis, IKON would also remove and bag linen from within those rooms.[139]

96. Ms May understood that commercial cleaning service providers were in high demand at the time due to the COVID-19 pandemic. Of the five cleaning companies that were subsequently contacted by DJPR, only AHS Hospitality Pty Ltd (AHS) and AMC Commercial Cleaning (AMC) were available. After satisfying herself that the cleaning proposals of AHS and AMC met the requirements of the Cleaning Protocol, Ms May engaged both companies.[140]

97. Ms May explained that IKON, AHS and AMC were each selected for the provision of commercial cleaning at the hotel quarantine sites because they satisfied the requirements prescribed by DHHS and they were available.[141]

98. The cleaning standards with which commercial cleaning contractors were required to comply also changed over time,[142] as did the contractual terms addressing cleaning methods and standards, each of which varied between contractors, depending on the time of their engagement by DJPR.[143]

Auditing of 'specialised cleaning'

99. The relevant commercial cleaning contracts imposed reporting obligations on the cleaners, but the form of those obligations also varied between different contractors. IKON was required to keep a record of the commercial cleaning it undertook, while AHS and AMC were required to provide DJPR with a report at the completion of each clean, attaching a cleaning certificate.[144]

100. Mr Girgis described that, when other infectious cleans are undertaken by IKON, their client would (in every case) engage a separate organisation to conduct 'swab tests'. He explained that this is done as a form of auditing or checking to ensure the clean had been effective in eliminating pathogens. Mr Girgis did not believe such a 'swabbing' process occurred in respect of IKON's work in the Hotel Quarantine Program.[145]

7.8 Cleaning standards and expert advice

101. As is clear, DJPR entered into the contracts with the hotels and the specialised commercial cleaning contractors. However, DJPR possessed no special expertise in infection control sufficient for it to direct or supervise the general hotel cleaners or the commercial cleaning contractors or assess the quality of their work.[146] Rather, DJPR asked DHHS to provide advice and guidance regarding infection prevention and control and appropriate cleaning methods so that DJPR could relay that information to the hotels and commercial cleaning contractors.

102. DHHS considered that DJPR was responsible for procuring commercial cleaning services.[147] Ms Williams saw DHHS's role as providing advice to cleaning contractors, but through DJPR as a conduit, on the basis that DJPR was the contract manager.[148]

103. DHHS submitted that it provided the following by way of cleaning advice:

    A. First, its consultant prepared cleaning advice, *Cleaning and disinfecting to reduce COVID-19 transmission: Tips for non-healthcare settings* (March Cleaning Advice), which was publicly available on 20 March 2020.[149] (This advice was not specifically for hotels nor people working in a quarantine facility but, rather, a general advice that had been prepared for state-wide use. It was amended on 22 March 2020.)

    B. Second, on 8 April 2020, DHHS emailed DJPR about cleaning requirements for rooms; specifically, those rooms that had been occupied by COVID-19 cases.[150] That email also provided the March Cleaning Advice and a document apparently directed to medical practitioners and those operating in a medical setting entitled, *COVID-19 Case and Contact Management Guidelines for Health Services and General Practitioners* (CCOM Guidelines).

    C. Third, in response to requests for advice from DJPR, DHHS advised DJPR to refer cleaners to the March Cleaning Advice.[151]

    D. Fourth, on 16 June 2020, DHHS issued a document, *Hotel Quarantine Response—Advice for cleaning requirements for hotels who are accommodating quarantined, close contacts and confirmed COVID-19 guests—Updated* (June Cleaning Advice).[152]

104. The June Cleaning Advice was the first comprehensive, situation-specific cleaning advice tailored to the Hotel Quarantine Program environment. It was provided to DJPR on 17 June 2020 and DJPR directed it be provided to the cleaning contractors.[153] It is unclear whether the June Cleaning Advice was also provided to the hotel cleaners.

105. Ms May gave evidence that she considered DHHS was ultimately responsible for the cleaning function.[154] She did so on the basis that DHHS was the control agency, the only department with expertise in infection control and the only Department with a consistent site presence at hotels within the Program. Ms May saw DJPR's practical role to be responsible for procuring commercial cleaning contracts 'in accordance with the directions of DHHS', managing issues that were drawn to her attention directly with contractors, liaising with DHHS and commercial cleaning contractors and escalating issues for DHHS for resolution.[155]

106. DJPR submitted that it had difficulties in getting DHHS to provide cleaning protocols tailored to the Hotel Quarantine Program environment and to respond to multiple and repeated escalations seeking tailored information and responses to specific questions about cleaning.[156]

107. DHHS submitted that the June Cleaning Advice, provided to DJPR in mid-June, was essentially and substantially the same as that contained in the March Cleaning Advice.[157]

108. In early April 2020, DJPR requested detailed advice from DHHS in relation to the general standard of cleaning for the hotels. Apart from a link to the generically available information referred to in paragraph 103, no further information was provided at that stage.[158] By mid-April, DJPR confirmed with DHHS that the Cleaning Protocol for the commercial contractors represented the standards expected of the cleaners in relation to cleaning COVID-19 positive rooms.[159]

109. As set out at paragraph 104, on 17 June 2020, Ms May directed that the June Cleaning Advice be sent to the three commercial cleaning companies that DJPR had engaged at that time. IKON, AHS and AMC and the contractors were instructed that it must be followed.[160] On 28 June 2020, after the outbreaks at Rydges and the Stamford, DHHS reissued this second cleaning protocol, responding to comments and feedback from the hotels and others.[161] Two days later, DHHS assumed control of all service contracts under the Program.[162]

110. At the time of the outbreak at the Rydges Hotel in Carlton, there was no cleaning protocol specific for the Hotel Quarantine Program. DHHS was still relying on the generic cleaning advice issued on 20 March 2020 in relation to non-healthcare settings. The Program-specific cleaning protocol issued by DHHS on 16 June 2020, following agitation for such by DJPR, was released on the day the outbreak at the Stamford was identified.[163]

111. The evidence demonstrates that DJPR was frustrated that DHHS did not provide tailored cleaning advice and protocols for the Hotel Quarantine Program in the initial phase of the operation. DJPR saw this as a concern and a problem that needed to be addressed.[164] In contrast, DHHS submitted that the March Cleaning Advice was applicable to the hotel environment and was sufficient and appropriate for the purposes of the program. DHHS did not share the same concern as DJPR. It should have.[165]

112. DHHS submitted that it provided advice to DJPR about the standard of cleaning required, based on public health advice, and expected DJPR to be responsible for passing on that information to the hotels and cleaners.[166]

113. As a result of the ad hoc nature of the information DJPR had received from DHHS around cleaning protocols, DJPR sought to consolidate all the information into one document for DHHS to consider. DHHS asked the Infection Control Consultant to review the document and also asked Ms May to approve the document. On 13 June 2020, Ms May declined, as DHHS was the control agency with responsibility for infection control and she did not consider herself to have the relevant expertise in infection control.[167]

114. Given the scarcity of IPC expertise inside DHHS, it did not have the necessary capacity to provide advice tailored to the needs of quarantine hotels. I note here that the provision of expert advice and guidance is a separate issue to on site supervision and oversight which is discussed in more detail in Chapter 8.

Protocol for cleaning of common areas

115. Initially, those doing general cleaning in the quarantine hotels were responsible for the cleaning of common areas, including lobbies, corridors and lifts. However, after the outbreak at the Rydges, and at the direction of DHHS, a different cleaning protocol was introduced. As a result, commercial cleaning contractors took over common areas and high touchpoint cleaning.[168] From that time, those doing general cleaning in the quarantine hotels were responsible for cleaning only 'back of house' common areas.[169]

Oversight of specialised cleaning in quarantine hotels — cleaning as an infection control measure

116. DJPR, as the contracting agency, performed the role of arranging and scheduling the attendance of commercial cleaning contractors at the various hotel sites. It also provided directions as to the expected cleaning standards (as determined by DHHS). The DJPR site manager at each hotel would take requests from hotels for cleaning of vacated COVID-positive rooms, except in respect of Rydges (where there was no DJPR site presence). The DJPR site manager, or a member of the DJPR support team, would then arrange cleans directly with a representative of the commercial cleaning contractor.[170]

117. There was evidence from DHHS witnesses that it did not accept its department as having responsibility in respect of the management and direction of cleaning contractors.[171] However, other evidence indicated that DHHS did play a role in the management and direction of commercial cleaning contractors, not only in relation to the creation of the policy documents as to the cleaning standards required but also, at least in the case of the Rydges Hotel on 12 April 2020, in the provision of training on cleaning standards.[172]

118. DHHS's evidence was that it was not responsible for supervising cleaning as part of IPC measures. Kym Peake, the then Secretary to DHHS, gave evidence that public health advice, including with respect to cleaning, would be translated into policies and guidelines by those at the Emergency Operations Centre.[173] Dr Annaliese van Diemen, Public Health Commander (and therefore having a formal position within Operation Soteria), gave evidence that, although her team had responsibility for the availability of IPC advice and guidance in hotels, it was not accountable for determining whether it was appropriately implemented.[174]

119. That DHHS did not proactively take an oversight and implementation role in respect of appropriate IPC cleaning was especially significant. DHHS took the view that its role was to provide policies to DJPR as the contractors with hotels and cleaning companies and that it was for DJPR to oversee the implementation of those contracts. DHHS accepted that it was the department vested with specific public health expertise and knowledge, including, critically, in relation to the ways in which the virus could be transmitted.[175] Given the centrality of appropriate cleaning to any effective system of infection control, this created vulnerabilities within the program. Chapter 9 provides further details as to how inappropriate cleaning practices at the Rydges likely contributed to the outbreak.

Infection prevention and control and on-site supervision

120. In Chapter 2 of this Report, a number of conclusions drawn from the scientific evidence presented to the Inquiry were set out in relation to the fundamental safety features required to underpin any efficacious quarantine program. One of those fundamental safety features is expert advice, input and ongoing supervision and oversight of IPC.

121. Consistent with the evidence to the Inquiry, it was uncontroversial that IPC, including cleaning services, was a crucial aspect of a successful quarantine program.

122. Prof. Grayson described quarantine environments as 'self-evidently dangerous spaces' and emphasised that 'the rigour and processes in place need to reflect and reinforce this'.[176] Prof. Grayson highlighted the importance of on-site supervision of IPC measures. He was discussing the use of PPE but noted it was applicable to any safety training for infection control:

> Inherent in PPE training (or indeed any safety training) is a regular objective system of monitoring to ensure adherence, resolve any practice questions and to provide constructive feedback to users. Thus, an ongoing 'system of supervision' should be established for infection control regimens to regularly reinforce the importance of adherence to the appropriate procedures and standards, and to ensure that adequate protections are maintained, even when one may be tired or distracted. People must understand the potential danger of infection in order to appreciate the importance of adhering to the training.[177]

123. The evidence demonstrated that this type of rigorous monitoring and training was not occurring within the hotels. DHHS, through consultants, provided mostly policy advice and some ad hoc training and site visits; not the rigorous supervision recommended by Prof. Grayson.

124. DHHS submitted that it employed an IPC consultant to conduct on-site reviews and report on IPC and PPE issues.[178] Further, it was submitted DHHS developed written guidance in relation to the use of PPE at quarantine hotels (which was provided to nursing staff, security guards and Authorised Officers on site at quarantine hotels).[179] Infection prevention measures were reinforced by the use of posters at hotels about infection prevention and PPE use (including donning and doffing of PPE).[180] The IPC consultant for DHHS gave evidence that she was involved in developing documents, upon request, that were used in the program, but was not involved in the implementation of the procedures and was unable to comment on their effectiveness.[181]

125. This approach demonstrates that IPC measures were not sufficiently monitored within the hotels. As Prof. Grayson stated:

> Infection control regimens in the hospital are regularly reinforced to staff through weekly CEO-led webinar presentations with the Infectious Diseases Department about COVID-19 infection control measures, direct monitoring of adherence by the Nurse Unit Manager on each clinical area, regular visits to wards by infection control staff to observe behaviour, widely displayed infection control signage throughout the hospital and biannual re-credentialing in hand hygiene. **As has been well published, educational signage alone has only limited value in reinforcing behaviour, unless they are updated frequently, since they quickly become ignored. In addition, if the signs are only in English, they may not be fully understood by people where English is not their first language**.[182] (emphasis added)

126. There were no IPC stationed at the hotel sites to give guidance, oversight or supervision on the range of risks to which hotel staff would be exposed and what they needed to do to mitigate those risks. That was a deficiency in the model.

127. Putting to one side the efficacy of the policies that were provided, the lack of an on-site presence with expertise in IPC, supervising, monitoring and overseeing the implementation of those policies was a demonstrable systemic flaw given the highly infectious nature of this virus and its risks of transmission, including by indirect surface (fomite) contact. This issue has been addressed in recommendations in Section 1 of the Interim Report and adopted as part of this Final Report at pages 38–49.

7.9 Vulnerabilities were created by the arrangements with hotels and commercial cleaning companies

128. While many within DHHS saw DJPR's support role as being of great assistance,[183] the allocation of the contracting function to DJPR had the unintended effect of reducing the access of contractors to direct, timely and authoritative guidance and advice on cleaning practices.

129. Perhaps of more significance, DHHS held the view that as DJPR was the contracting department, it (DHHS) did not have any obligations in relation to the direction and management of contractors, even in respect of infection prevention and control.[184] That was so, despite the fact that DHHS had health and infection control responsibility in Operation Soteria, and that the cleaning (whether it was undertaken by hotels or commercial cleaners) was a clear component of any proper system of infection control.[185]

130. DHHS submitted that Operation Soteria, and specifically the COVID-19 Accommodation Commander (a role held within DJPR), was responsible for 'operationalizing [sic] the public health policies in each hotel'.[186] DHHS also submitted that 'contracts between DJPR and hotels allocated responsibilities between them with respect to standard cleaning and for the commercial cleaning of COVID positive guest rooms'.[187] The difficulty with the first part of that submission rests on the use of the word 'operationalising'. Its ordinary usage seems to be 'putting into effect', which carries an implication beyond sending through a piece of advice or a policy.

131. The requirements referred to in paragraph 130 were set out in clause 2.1 of the agreements with hotels. Under clause 2.1(d), the responsibility was on hotels to identify the most recent recommended public health standards in respect of COVID-19 for the cleaning of rooms used to accommodate people who were not known to have tested positive for COVID-19.[188] The onus was clearly on the hotels to identify those standards, for themselves, without guidance from DJPR or DHHS. The onus was clearly — and was clearly intended to be — on contractors to determine the standards. As Mr Menon said, '… first and foremost, it was the responsibility of the supplier to actually avail themselves of that relevant information'.[189]

132. Similarly the agreements provided, at clause 2.1(h), that hotels:

> … will be responsible for, ensuring that before its officers, employees, agents, contractors and sub-contractors perform the Services [which included cleaning] they receive:
>
> i. adequate training in security, workplace health and safety, customer service and risk management; and
>
> ii. are provided with personal protective equipment in accordance with the relevant public health standards, including but not limited to in relation to COVID-19.[190]

133. As such, in respect of staff training, PPE supply and the cleaning of non-COVID guest rooms, hotel providers were largely left to determine these issues without guidance.

134. In respect of the training requirements within the commercial cleaning contracts, Ms May said that she asked for an approach to be taken in the commercial cleaning contracts similar to that adopted in the agreements for security services,[191] that is, commercial cleaners would agree to provide their own training. [192]

135. While the evidence shows, overwhelmingly, that all those working within the program acted in good faith and with good intentions, these providers simply did not have the expertise to adequately fulfil these obligations. That was evidenced and known to DHHS, certainly, following the outbreaks at the Rydges and Stamford Plaza hotels, where reviews found evidence of poor cleaning practices as well as poor training and education among some on-site personnel.[193]

136. That most unsatisfactory situation led to DJPR with contract management responsibility but no expertise in IPC. DHHS led Operation Soteria. DHHS promulgated the relevant cleaning standards, which meant that DJPR was effectively acting as a conduit between DHHS and the cleaning providers as far as cleaning standards were concerned.[194] Like the situation that arose with the hotels, and indeed with security services providers discussed in Chapter 6, that made the administration of those contracts unwieldy and unnecessarily complicated, and not a safe system of IPC.

137. Consistent with DJPR's contractual arrangements with security services providers, so, too, did the contracts with hotels and cleaning companies effectively impose the primary responsibilities for infection prevention and control on those private providers. That included obligations with respect to cleaning, staff training and the supply of PPE.[195] These were significant responsibilities to outsource, especially in the context of a government-led quarantine program.[196]

138. By requiring all returned passengers to be detained in a hotel setting, the Government thereby concentrated, within the Program, a large number of potential carriers of the virus. The Government had a corresponding responsibility to take appropriate action to ensure the safest systems were in place to address the risk that accompanies the creation of suspected or known hot spots.

139. The Premier explained that he was, by the time he gave evidence, aware that the contracts signed by the hotels and cleaning companies sought to put the onus on those private operators to be responsible for IPC training and implementation. When it was put by Counsel Assisting, Ms Ellyard, that 'issues of infection control were too important to be left entirely to private contractors' the Premier answered: '... given what's at stake, given the seriousness and the infectivity of this virus ... I think that is a fair statement'.[197]

140. This is, perhaps, an unsurprising concession. Given the focus of the Program and the engagement of contractors who were not specialised in the areas of IPC, shifting of a burden created, in part, by the Government to the contractors was inappropriate and ought not have occurred.

141. At odds with this concession from the Premier, DHHS submitted that the risks were not created or carried by the Hotel Quarantine Program but, rather, risks arose from COVID-19 itself and the entry into Victoria of travellers potentially infected with COVID-19.[198] What was required was a choice, it was submitted, as to how best to deal with the risk.[199]

142. DHHS otherwise did not make submissions as to the contractual apportionment of responsibility for infection prevention and control measures, save to say that it considered the PPE and training requirements in the hotel contracts were 'reasonable and prudent' and consistent with hotels' pre-existing legal obligations.[200]

143. The DHHS submission did not recognise that if the Government mandates potentially infected people into the quarantine facility that it has created to avoid community transmission, it had then accepted the responsibility to take all necessary actions to keep the people in quarantine safe and minimise the risk of cross infection or community transmission out of the quarantine facility. Neither did the submission grapple with a reasonable and legitimate expectation of the Victorian community that its government, when faced with the threat of a highly contagious virus, would take whatever action it considered necessary to address it and then accept responsibility for the actions it took.

144. It was not unreasonable to impose a range of contractual obligations on a private contractor but, in circumstances where the Government is compelling people into a facility that carries such obvious risks, whatever other obligations exist, it too retained an obligation to maintain the highest standards of safety in that facility. Whatever the reason for those contractual provisions, it did not absolve the Government of its duty to ensure that appropriate safeguards were in place.

7.10 Conclusions

Decision to 'stand up' hotels for the Hotel Quarantine Program

145. Once the decision had been taken to adopt a universal quarantine program for all international arrivals, within some 36 hours the decision to use hotels as the designated facilities for the purpose of Victoria's quarantine program was an obvious enough choice. Hotels were stood up because they were available, could be stood up quickly, would accommodate large numbers of returned travellers and would provide economic benefits. Even if afforded careful prior contemplation, hotels presented as the only readily available option in the absence of a purpose-built quarantine facility.

146. But that is not to make a virtue of necessity. Hotels were not designed as 'quarantine facilities'. The physical limitations of hotels, together with the highly infectious nature of the virus and the state of knowledge about transmission, meant that constant attention on all of the necessary IPC measures was needed to run the Program with a minimum of risk to both the people in quarantine and those working in the Program.

Procurement of hotels; contracting of hotels

147. It was beyond doubt that the organisation of the hotels and the cleaning companies involved a significant logistical undertaking. DJPR entered formal agreements with 29 hotels (only 20 hotels were ultimately used for the Program).[201] It engaged three professional cleaning companies for specialised cleaning, initially only for those rooms that had been used by people who were known to be COVID-positive.[202]

148. There is no controversy that those contracts between the State and the hotels and cleaning companies were prepared and executed, on behalf of the State, by DJPR.[203] DJPR maintained the obligation of contract management throughout the period from March 2020 until July 2020, at which time primary control of the Hotel Quarantine Program transferred to the DJCS.[204]

149. Putting to one side the question of who had overall responsibility for the Program (which is discussed in detail at Chapter 8), while DJPR engaged the hotels and the contract cleaners (and established those contractual relationships between those services and the State), many aspects of the way in which those contracts were to be performed required substantive input from DHHS, specifically in the form of policies directed to IPC measures.[205]

150. In practical effect, this meant that, while DJPR had responsibility for management of the contracts, in a number of important respects, especially in relation to IPC measures, direction and management of those contractors was based on advice from DHHS. This resulted in a situation where those responsible for ensuring compliance with the contracts (DJPR) were not the ones with sufficient expertise to understand whether the contracts were being performed as they should. This was an unnecessarily complicated and unwieldy situation and not a safe system of infection prevention and control.

151. Important information directed to IPC — the cornerstone of this program — was merely transferred to the contractors via DJPR; as a result, its import may have been diluted or, even, lost.

152. Additionally, this contractual framework complicated and obscured what was the necessary and appropriate, albeit apparently lacking, 'ongoing supervision and oversight'[206] by DHHS of the operational aspects of the Hotel Quarantine Program.

153. Insofar as those aspects were being delivered, or at least were intended to be delivered, by the hotels and cleaners who had been engaged, it was apparent that the Public Health Team and the IPC expertise available to DHHS had little direct insight into how the Program was being administered and, indeed, no oversight.[207] At most, DHHS submitted that 'the Public Health Team had responsibility for the availability of IPC and PPE advice and guidance'.[208]

154. A number of witnesses (including Ms Peake and former Minister Mikakos) accepted that, while they were grateful to DJPR for establishing the contracts with hotels and cleaning providers that furnished the Program with the necessary facilities and ancillary – but no less necessary – cleaning professionals at an early stage, there was no legal or practical preclusion from the management of those contracts being transferred to DHHS after the establishment of those agreements and while the Program continued to run under the various iterations of Operation Soteria, with DHHS the designated control agency.[209]

155. The impact of fragmenting responsibilities in this way as between DJPR, DHHS and the private contractors added to or increased the vulnerabilities inherent within the Hotel Quarantine Program. The provision of policy advice and guidance on IPC measures, such as proper cleaning standards and methods, to DJPR, a department with no expertise in the area and, therefore, no ability to oversee the correct implementation of these requirements, was not a safe way to minimise the risk of infectious outbreaks in hotel quarantine sites.

156. Apparently, with a realisation as to the unwieldy nature of the Program, subsequently, from 3 July 2020, DHHS assumed responsibility for both the selection and contracting of all hotels in the Program.[210] Existing agreements with hotels were amended to reflect this transfer of responsibility from DJPR to DHHS on 3 July 2020.[211]

157. At a much earlier stage in the Program, DHHS and DJPR should have arranged for the transfer of responsibility for the administration of contracts to DHHS. This would have brought the department with public health expertise into a direct role in administering essential components of the Program and would have provided clear lines of accountability, responsibility and supervision of roles. It would also have meant those with the requisite public health expertise could be fully embedded in the operation of the Program, including the necessary on-site supervision. Importantly, given it was an unplanned and untested Program with high risks, one agency overseeing the Program would also have likely embedded a proper, ongoing review of the Program in its operation.

158. Decisions to contract with hotels were made with reliance on DHHS's requirements as to what hotels were suitable; despite this, DJPR (Mr Menon) did not receive any specific documents from DHHS regarding whether hotels were assessed from an infection control point of view. The key consideration for such an assessment should have been the extent to which infection control measures could be successfully implemented.

Infection prevention and control in hotels: the ever-present risk of cross-infection

159. IPC measures are essential to a quarantine program. It is necessary to have those with the expertise in IPC deliver that training. And nothing short of constant reinforcement, supervision and oversight from those with the necessary expertise is what is required in such a highly infectious environment.

160. There were no IPC experts stationed at the hotel sites to give guidance, oversight or supervision on the range of risks to which hotel staff would be exposed and what they needed to do to mitigate those risks.

161. DHHS witnesses have made clear that knowledge about the virus and its modes of transmission was evolving.[212] Dr Crouch gave evidence that:

> The understanding of COVID-19 continues to develop. As this has happened, so too has my understanding of the virus and its modes of transmission. I am not convinced that we yet fully understand how it is transmitted.

162. Given what Dr Crouch stated, it made it even more unsatisfactory that hoteliers were contracted to provide their own PPE, training and infection prevention and control. It was a wholly inadequate situation.

The importance of cleaning

163. There was inadequate focus in the design and implementation of the Hotel Quarantine Program on the need for specialised and rigorous cleaning to address the risk of virus transmission through environmental contact. Given that the guidance from the WHO in March 2020, specifically identified fomite transmission as a recognised method by which infection might occur, the Program should have been informed by the development of proper and authoritative guidance that dealt specifically with rigorous 'environmental cleaning and disinfection'.

164. This was especially so given the movement of people in and out of the hotels; those in quarantine and the workers and staff and personnel on-site.

Procurement of commercial cleaning companies for 'specialised cleaning'

165. The requirement that hotels undertake specialised cleans of COVID-positive rooms was flawed. It was based on a presumption that it would be known, upon rooms being vacated, which people in quarantine were COVID-positive and which people were not. Having regard to the symptomology of COVID-19 (see Chapter 2), because of the possibility that people infected with COVID-19 might be asymptomatic or might experience only mild symptoms that they may not recognise or may not report, and because testing was not initially universal nor ever compulsory, it was reasonably possible that a person's COVID-positive status might not have been discovered. In such a case, a room that had held a person, potentially, at least, with COVID-19, would be cleaned by hotel staff or subcontractors rather than specialised cleaners.

166. Irrespective of the contracting arrangements and who carried out the cleaning, it was imperative that proper auditing checks were conducted with due care, particularly given the known risk of environmental transmission.[213] There is no evidence this was done.

Figure 7.2: Quotes from returned travellers regarding the cleanliness of their hotel rooms

Returned Traveller 3: 'I opened the fridge and found a hair and a piece of left-over container or carton. I was immediately concerned that the room had not been deep cleaned. I became anxious at the cleanliness standards of the hotel'.

Returned Traveller 12: 'There were a lot of stains in the room … 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.

Cleaning standards and quality control

167. There was no comprehensive, specific cleaning advice tailored to the Hotel Quarantine Program until the June Cleaning Advice was developed. Until then, DHHS relied on the March Cleaning Advice but, even then, it was only provided to DJPR some 12 days after the Hotel Quarantine Program was announced.

168. It was necessary for advice that dealt specifically with hotels in the quarantine environment to have been provided early. It could not have been expected that DJPR officials engaging cleaning contractors had sufficient IPC knowledge to know whether generic guidance was appropriate in that specific context. Where DJPR had made requests of DHHS for tailored hotel quarantine advice and policies, those requests were reasonable.

169. The consequences of the 'split' DHHS and DJPR arrangement included delays in providing proper cleaning advice and services, hampering the ability of those within hotels to deal quickly with issues as they arose.

Oversight of specialised cleaning in quarantine hotels

170. Putting to one side the efficacy of the policies that were provided, as has already been noted, the lack of on-site presence of those with expertise in IPC, supervising, monitoring and overseeing the implementation of those policies was a systemic flaw given the highly infectious nature of this virus and its risks of transmission, including by surface (fomite) contact.

171. DHHS took over the management of all cleaning contracts (other than in relation to the Brady) in quarantine hotels from 1 July 2020.[214] Had DHHS taken over that contracting function earlier, it would likely have been more proactive in directing and managing hotels and cleaners in relation to IPC practices. The demarcation of roles that existed resulted in a diffusion of responsibility and led to an absence of appropriate oversight and leadership within the Program in respect of this central tenet of IPC.

172. From the outset of the Program, there should have been a fuller implementation of processes that adequately identified the known risks of transmission. Whether this arose due to the contractual arrangements or the division of responsibilities between DHHS as control agency and DJPR as the contracting party, or for some other reason, it is clear that this was an aspect of the program that was inadequate.

173. Further, the expertise to ensure proper IPC standards were embedded in the Program and maintained did not lie with the contracting agency. This was a structural problem that permeated the Program. DHHS should have been responsible for ensuring implementation of its own standards.

Vulnerabilities were created by the arrangements with hotels and commercial cleaning companies

174. Chapter 6 sets out that it was not appropriate for the Government to place contractual responsibility for IPC on security services providers. I come to the same conclusion with respect to contracts with hotels and commercial cleaners, and I repeat those reasons here with respect to hotel and cleaning contracts.

175. That is, contracts entered into by DJPR on behalf of the State allocated to hotels and cleaners key responsibilities for worker safety, including the need to provide PPE and to manage IPC.

176. DJPR submitted that it was reasonable and appropriate for contractors to have responsibility for matters within their control, noting that under the *Occupational Health and Safety Act 2004* (Vic), contractors have a positive duty to control risks.[215] DJPR went further to submit that it would be inappropriate for the State to seek to assume contractors' own obligations with respect to their workforces because:

    A. obligations on contractors provide an extra layer of protection for workers[216]

    B. the State and contractors exercise a different level of control over relevant workers and workplaces: here, DJPR submits that contractors have particular roles with respect to on-site supervision arrangements, communication, disciplinary action and counselling[217]

    C. it is appropriate for the State to limit its risk through contracts[218]

    D. it was appropriate to require contractors to source their own PPE given the State's concern that it would be unable to source sufficient PPE.[219]

177. DJPR submitted that its contracts did not purport to transfer to contractors, or diminish the State's IPC responsibilities, nor did the State seek to contract out of its obligations under the *Occupational Health and Safety Act 2004* (Vic).[220]

178. As I have said, earlier in Chapter 6, in the context of private security, this Inquiry is not the proper venue for rulings and findings with respect to duties owed by these contractors at employment, contract or tort law. Suffice to say, it was not appropriate for the Government to seek to impose the risk of transmission of COVID-19 onto the hotel and cleaning providers in the way in which these contracts purported to do. The Hotel Quarantine Program was not just a workplace or a private arrangement between employer and employee, or contractor and principal. It should not be seen solely through that lens. It was, fundamentally, a measure to protect the public from a significant public health threat.

179. There was simply too much at stake for the Government to have conferred such responsibilities on private service providers, whose ordinary roles were so far removed from IPC measures.

180. I note here that Rydges Hotels Ltd supported a finding that the Government assumed responsibility for the infection risks associated with the Hotel Quarantine Program.[221] It submitted that it was a matter for the Government as to where the Government should have placed contractual liability for PPE and infection control education,[222] but noted that it was the Government's responsibility to ensure effective IPC.[223] I agree.

181. As I have said before, the weight of the expert evidence before the Inquiry from all of the health and medical witnesses is that the state of science and learning about the COVID-19 virus, its modes of transmission, its highly infectious nature, what forms of PPE should be used, and where and when, was changing, evolving and developing.[224] Further, that state of learning was held not just in public health generally, but in infection control, more particularly, as a recognised field of expertise.

182. For either government department, be it DJPR through its contract provisions with hotels and cleaners or DHHS through its reliance on the contracting agency, to assume that hotels could or should have been making assessments about 'risk management' and what was 'adequate training' and 'relevant public health standards' for COVID-19 was completely inappropriate. There was no basis to assume that hotels would have had the specific expertise or experience in IPC and use of PPE to be making such assessments and, certainly, not to the degree required to contain this highly infectious virus or to the degree necessary to administer an effective and safe quarantine program.

183. The express provisions of the contracts placed primary responsibility for infection prevention control training and PPE supply and use on the contractors.[225]

184. In this regard, I repeat that it was the evidence of the Premier that it would 'absolutely' be a concern if the relevant departments 'didn't take an active role in ensuring that there was proper infection control and prevention measures in place', in particular where the Government had assumed such risk by bringing members of the public into the hotels.[226]

7.11 Recommendations

185. The recommendations that emerge from the conclusions in this Chapter are in Section 1 of the Interim Report. Recommendations 1-39 in Section 1 of the Interim Report, and adopted into this Final Report, contain the features of the recommended model for a facility-based quarantine program.

186. Rather than replicating recommendations 1–39 here, these recommendations can be found at pages 38–49 of this Report.

Endnotes

1 Prime Minister of Australia (Cth) (Press Conference, 27 March 2020) <https://www.pm.gov.au/media/press-conference-australian-parliament-house-act-270320>.
2 Prime Minister of Australia (Cth) (Media Release, 27 March 2020) <https://www.pm.gov.au/media/update-coronavirus-measures-270320>.
3 Transcript of day 25 hearing 25 September 2020, 2125.
4 Ibid.
5 Ibid.
6 Ibid.
7 Exhibit HQI0049_RP Witness statement of Mr Unni Menon, 7 [21]–[22].
8 Transcript of day 22 hearing 22 September 2020, 1816.
9 Ibid.
10 Ibid.
11 Ibid 1816-1817.
12 Transcript of day 21 hearing 21 September 2020, 1758.
13 Transcript of day 22 hearing 22 September 2020, 1816.
14 Exhibit HQI0177_RP First witness statement of Mr Christopher Eccles, 21 [80].
15 Ibid 20 [79].
16 Exhibit HQI0210_P Transcript of press conference by the Hon. Daniel Andrews MP 27 March 2020, 2; Transcript of day 25 hearing 25 September 2020, 2126.
17 Exhibit HQI0210_P Transcript of press conference by the Hon. Daniel Andrews MP 27 March 2020, 2.
18 Exhibit HQI0049_RP Witness statement of Mr Unni Menon, 7 [23].
19 Ibid 3 [12]; Exhibit HQI0184_RP Witness statement of Mr Simon Phemister, 7 [27].
20 Exhibit HQI0049_RP Witness statement of Mr Unni Menon, 3 [12].
21 Ibid 3 [13].
22 Ibid 3–4 [14].
23 Ibid 7 [25].
24 Ibid; Transcript of day 10 hearing 31 August 2020, 634.
25 Exhibit HQI0049_RP Witness statement of Mr Unni Menon, 7 [25]; Transcript of day 10 hearing 31 August 2020, 634.
26 Exhibit HQI0049_RP Witness statement of Mr Unni Menon, 7–8 [26].
27 Exhibit HQI0184_RP Witness statement of Mr Simon Phemister, 7 [31].
28 Exhibit HQI0032_P Witness statement of Ms Claire Febey, 2 [8].
29 Exhibit HQI0184_RP Witness statement of Mr Simon Phemister, 6–7 [26]–[27].
30 Ibid 10 [50]; Exhibit HQI0185(1)_RP Annexures to witness statement of Mr Simon Phemister, DJP.102.007.9895, DJP.102.007.9907.
31 Exhibit HQI0049_RP Witness statement of Mr Unni Menon, 8 [27]; Exhibit HQI0050_RP Annexures to witness statement of Mr Unni Menon, DJP.104.001.5070, DJP.104.001.5072, DJP.104.001.5077.
32 Exhibit HQI0049_RP Witness statement of Mr Unni Menon, [28].
33 Ibid 8 [29]; Exhibit HQI0184_RP Witness statement of Mr Simon Phemister, 11 [52].
34 Exhibit HQI0049_RP Witness statement of Mr Unni Menon, 8 [29].
35 Ibid 7 [25], 12 [43]; Transcript day 10 hearing 31 August 2020, 634.
36 Exhibit HQI0184_RP Witness statement of Mr Simon Phemister, 11 [55].
37 Exhibit HQI0184_RP Witness statement of Mr Simon Phemister, 17-18 [89]; Exhibit HQI0164_RP Witness statement of Mr Jason Helps, 12 [50]; Exhibit HQI0032_P Witness statement of Ms Claire Febey, 15-16 [63]–[64].
38 Exhibit HQI0049_RP Witness statement of Mr Unni Menon, 17 [84].
39 Exhibit HQI0032_P Witness statement of Ms Claire Febey, 15–16 [63]–[64].
40 Exhibit HQI0184_RP Witness statement of Mr Simon Phemister, 17–18 [89]; Exhibit HQI0164_RP Witness statement of Mr Jason Helps, 12 [50]; Exhibit HQI0032_P Witness statement of Ms Claire Febey, 15–16 [63]–[64].
41 Exhibit HQI0049_RP Witness statement of Mr Unni Menon, 9 [32].
42 Ibid 9 [31].
43 Ibid 10 [35]; Transcript of day 10 hearing 31 August 2020, 634–635.
44 Exhibit HQI0135_RP Witness statement of Ms Merrin Bamert, 25 [87].
45 Submission 03 Department of Health and Human Services, 48 [262].
46 Exhibit HQI0049_RP Witness statement of Mr Unni Menon, 10 [37].
47 Transcript of day 14 hearing 8 September 2020, 1026.
48 Transcript of day 10 hearing 31 August 2020, 635.

49 Ibid 657.
50 Transcript of day 16 hearing 11 September 2020, 1270.
51 Ibid.
52 Transcript of day 25 hearing 25 September 2020, 2125.
53 Ibid.
54 Exhibit HQI0210_P Transcript of press conference by the Hon. Daniel Andrews MP on 27 March 2020, VPOL.0006.0002.0014; see also Transcript of day 25 hearing 25 September 2020, 2136–2137.
55 Transcript of day 4 hearing 18 August 2020, 55–56.
56 Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 7 [21].
57 Ibid.
58 Ibid.
59 Transcript of day 3 hearing 17 August 2020, 40, 56–58.
60 Exhibit HQI0130a_RP Witness statement of Ms Pam Williams, 12 [22(c)].
61 Ibid 19 [41(d)].
62 Exhibit HQI0049_RP Witness statement of Mr Unni Menon, 11 [41].
63 Ibid 11 [42].
64 Transcript day 9 hearing 28 August 2020, 565; Exhibit HQI0046_RP Annexures to witness statement of Mr Rosswyn Menezes, RYD.0001.0010.0003; Exhibit HQI0048_RP Annexures to witness statement of Mr Karl Unterfrauner, STAM.0001.0001.0150; Exhibit HQI0050_RP Annexures to witness statement of Mr Unni Menon, DJP.104.004.8159; Exhibit HQI0185_RP Annexures to witness statement of Mr Simon Phemister, DJP.104.005.9140.
65 See eg Transcript day 7 hearing 24 August 2020, 313–318; Exhibit HQI0027_P Witness statement of Mr Kaan Ofli, 2 [10]–[15]; Transcript of day 5 hearing 20 August 2020, 154–156, 158, 178; Exhibit HQI0013_RP Witness statement of 'Returned Traveller 1', 2 [17]–[19]; Exhibit HQI0014_RP Witness statement of Mr Michael Tait, 7–8 [60]–[67].
66 Exhibit HQI0020_P Witness statement of Ms Liliana Ratcliff, 4 [33]–[34].
67 See eg Transcript day 7 hearing 24 August 2020, 313–318; Exhibit HQI0027_P Witness statement of Mr Kaan Ofli, 2 [10]–[15]; Exhibit HQI0014_RP Witness statement of Mr Michael Tait, 8 [62], 8 [64].
68 Transcript of day 9 hearing 28 August 2020, 516–7, 524–26, 571; Transcript of day 11 hearing 2 September 2020, 802.
69 See e.g. Transcript day 7 hearing 24 August 2020, 313–16; Exhibit HQI0027_P Witness statement of Mr Kaan Ofli, 2 [10], [13], [29]; Transcript of day 5 hearing 20 August 2020, 141; Exhibit HQI0014_RP Witness statement of Mr Michael Tait, 7–8 [62].
70 Transcript day 9 hearing 28 August 2020, 562-563; Exhibit HQI0046_RP Annexures to witness statement of Mr Rosswyn Menezes, RYD.0001.0001.0013, RYD.0001.0010.0003; Exhibit HQI0048_RP Annexures to witness statement of Mr Karl Unterfrauner, STAM.0001.0001.0150; Exhibit HQI0050_RP Annexures to witness statement of Mr Unni Menon, DJP.104.004.8159, DJP.104.001.5072, DJP.104.005.9142, DJP.101.001.7184; Exhibit HQI0185_RP Annexures to witness statement of Mr Simon Phemister, DJP.101.001.7184, DJP.104.004.8159, DJP.104.005.9142, DJP.105.003.0795, DJP.105.003.1082, DJP.105.003.1357; Exhibit HQI0066_RP Annexures to witness statement of Jamie Adams, MSSS.0001.0002.0050_0063.
71 Exhibit HQI0040_RP Witness statement of Mr Ram Mandyam 15 [99], 15 [101]; Exhibit HQI0041_RP Witness statement of Mr Shaun D'Cruz, 3 [12], 18-20 [89]-[101]; Exhibit HQI0042_RP Witness statement of Mr Stephen Ferrigno, 9 [34]–[35].
72 Exhibit HQI0040_RP Witness statement of Mr Ram Mandyam 13-14 [92]-[95]; Exhibit HQI0041_RP Witness statement of Mr Shaun D'Cruz, 19 [90]–20 [101]; Exhibit HQI0042_RP Witness statement of Mr Stephen Ferrigno, 9 [35].
73 Transcript of day 9 hearing 28 August 2020, 511.
74 Ibid.
75 Ibid.
76 Ibid 512. also Exhibit HQI0040_RP Witness statement of Mr Ram Mandyam, 13 [93], 15 [101].
77 Transcript of day 9 hearing 28 August 2020, 512–3.
78 Exhibit HQI0040_RP Witness statement of Mr Ram Mandyam, 14 [97], 15 [101].
79 Exhibit HQI0041_RP Witness statement of Mr Shaun D'Cruz, 22 [108].
80 Ibid 21 [105]–[107].
81 Ibid 22 [110].
82 Ibid 22 [111].
83 Ibid 23 [113].
84 Exhibit HQI0042_RP Witness statement of Mr Stephen Ferrigno, 9 [37].
85 Ibid 9 [38].

86 Ibid 9 [35], 10 [40]–[41].
87 Submission 03 Department of Health and Human Services, 31-32 [166]-[167].
88 Exhibit HQI0203_RP Witness statement of Infection Control Consultant DHHS, 6 [26].
89 See eg Ibid 15 [68].
90 Ibid 14 [61].
91 Ibid 16 [70].
92 Submission 03 Department of Health and Human Services, 31 [166].
93 Exhibit HQI0203_RP Witness statement of Infection Control Consultant DHHS, 5 [20].
94 Ibid 5 [21]–[22].
95 Ibid 5 [23].
96 Ibid 6 [27].
97 Ibid 16 [72].
98 Ibid 10 [44].
99 Exhibit HQI0186_RP First witness statement of Ms Kym Peake, 44 [229].
100 Exhibit HQI0001_P Witness statement of Professor Lindsay Grayson, 8 [38].
101 Ibid 9 [42].
102 Exhibit HQI0103_RP Witness statement of Dr Simon Crouch, 8 [39].
103 Ibid. See also Transcript of day 14 hearing 8 September 2020, 1076–1077.
104 Transcript of day 14 hearing 8 September 2020, 1067.
105 Exhibit HQI0106_RP Witness statement of Dr Sarah McGuinness, 7 [26].
106 Ibid 7 [27].
107 Ibid.
108 Transcript of day 26 hearing 28 September 2020, 2249.
109 Exhibit HQI0106_RP Witness statement of Dr Sarah McGuinness, 8 [28].
110 Ibid 8 [29].
111 Ibid 9 [30].
112 Ibid 9 [31].
113 Transcript of day 14 hearing 8 September 2020, 1112.
114 Exhibit HQI0049_RP Witness statement or Mr Unni Menon 4–5 [16]; Exhibit HQI0050_RP Annexures to witness statement of Mr Unni Menon, DJP.104.004.8157.
115 Exhibit HQI0185_RP Annexures to witness statement of Mr Simon Phemister, DJP.101.0001.7184.
116 Ibid DJP.104.004.8159.
117 Exhibit HQI0049_RP Witness statement of Mr Unni Menon, 4 [16].
118 Transcript of day 9 hearing 28 August 2020, 511-512.
119 Ibid 511.
120 Exhibit HQI0040_RP Witness statement of Ram Mandyam, 11 [82]; Transcript of day 9 hearing 28 August 2020, 520, 522.
121 Exhibit HQI0040_RP Witness statement of Ram Mandyam, 11 [82]; Transcript of day 9 hearing 28 August 2020, 520, 522; Exhibit HQI0185_RP Annexures to witness statement of Mr Simon Phemister, DJP.104.004.8159, Clause 2.1(f).
122 'Returned Traveller 10', Information provided to the Inquiry via the Intake and Assessment team between 15 July to 3 December 2020.
123 See eg transcript of day 9 hearing 28 August 2020, 520–521.
124 Exhibit HQI0032_P Witness statement of Ms Claire Febey, 19 [74].
125 Exhibit HQI0080_RP First witness statement of Ms Rachaele May, 2–3 [8].
126 Exhibit HQI0082_RP Second witness statement of Ms Rachaele May, 2–3 [6], [14].
127 Ibid 2 [8].
128 Ibid 4 [20(a)].
129 Ibid 4 [18].
130 Exhibit HQI0083_RP Annexures to second witness statement of Ms Rachaele May, DJP.103.007.7332-7335.
131 Transcript of day 16 hearing 11 September 2020, 1245–1246.
132 Exhibit HQI0128_RP Witness statement of Mr Michael Girgis, 3 [15].
133 Exhibit HQI0082_RP Second witness statement of Ms Rachaele May, 4 [19].
134 Ibid 4 [21].
135 Ibid 5 [22]; Transcript of day 13 hearing 4 September 2020, 970–972.
136 Exhibit HQI0082_RP Second witness statement of Ms Rachaele May, 6 [28].
137 Exhibit HQI0128_RP Witness statement of Mr Michael Girgis, 3 [12].
138 Submission 06 IKON Services Australia Pty Ltd, 1 [3]; Transcript of Day 16 hearing 11 September 2020, 1247, 1249.
139 Submission 06 IKON Services Australia Pty Ltd, 1 [4]; Transcript of Day 16 hearing 11 September 2020, 1250.

140 Submission 06 IKON Services Australia Pty Ltd, 6 [29].
141 Ibid 7 [35].
142 Exhibit HQI0082_RP Second witness statement of Ms Rachaele May, 9 [46].
143 For example, the agreement with IKON did not refer to the Second Cleaning Protocol because that was only introduced in June 2020, after the IKON contract had been finalised. Instead, the IKON contract referred, more broadly, to the latest recommended cleaning standards for COVID-19, as that was the direction from DHHS at the relevant time: Exhibit HQI0082_RP Second witness statement of Ms Rachaele May, 9 [45].
144 Exhibit HQI0082_RP Second witness statement of Ms Rachaele May, 8–9 [43].
145 Transcript of day 16 hearing 11 September 2020, 1251–1253.
146 Exhibit HQI0082_RP Second witness statement of Ms Rachaele May, 13–14 [62]–[66].
147 Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 9 [19(a)], 11 [26(d)].
148 Ibid 11 [27]; Transcript of day 16 hearing 11 September 2020, 1298–1299.
149 Submission 03 Department of Health and Human Service, 37 [193]; Exhibit HQI0131_RP Annexures to witness statement of Ms Pam Williams, DHS.0001.0015.0323.
150 Submission 03 Department of Health and Human Service 37 [195]; Exhibit HQI0131_RP Annexures to witness statement of Ms Pam Williams, DHS.0001.0015.0287, DHS.0001.0095.0001.
151 Submission 03 Department of Health and Human Service 37 [196]; Exhibit HQI0131_RP Annexures to witness statement of Ms Pam Williams, DHS.5000.0001.8769.
152 Submission 03 Department of Health and Human Service 37–38 [197]; Exhibit HQI0131_RP Annexures to witness statement of Ms Pam Williams, DHS.5000.0001.8954.
153 Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 15–16 [37], 16–17[40]; Exhibit HQI0082_RP Second witness statement of Ms Rachaele May, 10 [50].
154 Exhibit HQI0082_RP Second witness statement of Ms Rachaele May, 12–13 [60], 13 [63].
155 Ibid 13 [61].
156 Submission 04 Department of Jobs, Precincts and Regions, 4–5 [18(c)(i)], [18(c)(iii)].
157 Submission 03 Department of Health and Human Services, 38 [198].
158 Transcript of day 10 hearing 31 August 2020, 665–668.
159 Transcript of day 13 hearing 4 September 2020, 971.
160 Transcript of day 13 hearing 4 September 2020, 973–975.
161 Ibid 978.
162 Exhibit HQI0082_RP Second witness statement of Ms Rachaele May, 11 [55].
163 See paragraphs [111]–[118] of this chapter; Transcript of day 14 hearing 8 September 2020, 1118.
164 Exhibit HQI0080_RP First witness statement of Ms Rachaele May, 12 [66]; Exhibit HQI0032_P Witness statement of Ms Claire Febey, 25 [111]; Exhibit HQI0083_RP Annexures to second witness statement of Ms Rachaele May, DJP.103.008.1083, DJP.104.008.3703.
165 Submission 03 Department of Health and Human Services, 38 [201].
166 Ibid 36–37 [191].
167 Exhibit HQI0082_RP Second witness statement of Ms Rachaele May, 10 [48]–[49]; Exhibit HQI0083(1)_RP Annexures to second witness statement of Ms Rachaele May, DJP.103.008.2404.
168 Exhibit HQI0082_RP Second witness statement of Ms Rachaele May, 9–10 [47].
169 Transcript of day 9 hearing 28 August 2020, 585.
170 Exhibit HQI0082_RP Second witness statement of Ms Rachaele May, 15 [73], 16 [76]. This is consistent with the evidence of Mr Girgis (General Manager – IKON) who was generally contacted by a DJPR representative to confirm the details of the next infectious clean required to be performed: Exhibit HQI0128_RP Witness statement of Mr Michael Girgis, 4 [17].
171 Transcript of day 22 hearing 22 September 2020, 1899; Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 6 [19(a)].
172 Exhibit HQI0045_RP Witness Statement of Mr Rosswyn Menezes, 10 [36(b)]; Exhibit HQI0046_RP Annexures to witness statement of Mr Rosswyn Menezes, RYD.0001.0001.0641.
173 Transcript of day 23 hearing 23 September 2020, 1974.
174 Exhibit HQI0160_P Witness statement of Dr Annaliese van Diemen, 22 [103].
175 Exhibit HQI0106_RP Witness statement of Dr Sarah McGuinness, 6–9 [24]–[31].
176 Exhibit HQI0001_P Witness statement of Prof. Lindsay Grayson, 15 [65].
177 Ibid 15 [64].
178 Submission 03 Department of Health and Human Services, 30 [163] citing Exhibit HQI0135_RP Witness statement of Ms Merrin Bamert 10 [28], 13 [40]; Exhibit HQI0136_RP Annexures to the witness statement of Ms Merrin Bamert, DHS.0001.0021.0020.
179 Submission 03 Department of Health and Human Services, 32 [168] citing Exhibit HQI0135_RP Witness statement of Ms Merrin Bamert, 12 [35].

180 Submission 03 Department of Health and Human Services, 32 [168] citing Exhibit HQI0205_RP Witness statement of 'Senior Project Officer DHHS', 8 [36], [42]; Exhibit HQI0064_RP Witness statement of Ms Jan Curtain, 10 [60], 12 [74]; Exhibit HQI0047_RP Witness statement of Mr Karl Unterfrauner, 16 [41]; Exhibit HQI0024_RP Witness statement of 'Security 1', 2 [16].
181 Exhibit HQI0203_RP Witness statement of 'DHHS Infection Control Consultant', 6 [28].
182 Exhibit HQI0001_P Witness statement of Prof. Lindsay Grayson, 19 [75].
183 Exhibit HQI0184_RP Witness statement of Mr Simon Phemister, 17–18 [89]; Transcript of day 23 hearing 23 September 2020, 2002.
184 See eg Submission 03 Department of Health and Human Services, 41 [220].
185 Exhibit HQI0126_RP Annexures to witness statement of Ms Melissa Skilbeck, DHS.0001.0001.1532-1535 (version 2.0), DHS.0001.0001.2258-2261 (version 3.0).
186 Submission 03 Department of Health and Human Services, 32 [167].
187 Ibid 32 [169].
188 Transcript of day 10 hearing 31 August 2020, 640; Exhibit HQI0050_RP Annexures to witness statement of Mr Unni Menon, DJP.104.004.8159.
189 Transcript of day 10 hearing 31 August 2020, 640.
190 Exhibit HQI0050_RP Annexures to witness statement of Mr Unni Menon, DJP.104.004.8160.
191 Exhibit HQI0082 Second witness statement of Ms Rachaele May, 8 [39].
192 Ibid.
193 Exhibit HQI0104_RP Outbreak Management Plan Rydges Swanston, DHS.0001.0036.0156; Exhibit HQI0155_RP Annexures to witness statement of Prof. Brett Sutton, DHS.0001.00136.0205.
194 Exhibit HQI0032_P Witness statement of Ms Claire Febey, 19 [74].
195 Exhibit HQI0050_RP Annexures to witness statement of Mr Unni Menon, DJP.104.004.8159–8160.
196 Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 5 [14].
197 Transcript of day 25 hearing 25 September 2020, 2144.
198 Submission 03 Department of Health and Human Services, 17 [91], [93].
199 Ibid 17 [94].
200 Ibid 15 [80].
201 Exhibit HQI0049_RP Witness statement of Mr Unni Menon, 7 [23].
202 Exhibit HQI0082_RP Second witness statement of Ms Rachaele May, 3 [15].
203 Ibid; Exhibit HQI00049 Witness statement of Mr Unni Menon, 7 [21]–[23].
204 Exhibit HQI00035_RP Operation Soteria Operations Plan, DOJ.504.010.8488 (version 1.0); Exhibit HQI0126_RP Annexures to witness statement of Ms Melissa Skilbeck, DHS.0001.0001.1527 (version 2.0); DHS.0001.0001.2254 (version 3.0); Exhibit HQI0186_RP First witness statement of Ms Kym Peake, 49 [252]–[254].
205 Exhibit HQI0032_P Witness statement of Ms Claire Febey, 19 [74].
206 Exhibit HQI0126_RP Annexures to witness statement of Ms Melissa Skilbeck, DHS.0001.0001.1525.
207 Exhibit HQI0160_P Witness statement of Dr Annaliese van Diemen, 4–5 [24].
208 Submission 03 Department of Health and Human Services, 31 [166].
209 See eg Transcript of day 23 hearing 23 September 2020, 2011, 2012; Transcript of day 24 hearing 24 September 2020, 2081.
210 Exhibit HQI0049_RP Witness statement of Unni Menon, 10 [37].
211 Exhibit HQI0041_RP Witness statement of Mr Shaun D'Cruz, 4 [16].
212 Exhibit HQI0103_RP Witness statement of Dr Simon Crouch, 7 [37].
213 See Exhibit HQI0001_P Witness statement of Prof. Lindsay Grayson, 9 [42].
214 Exhibit HQI0128_RP Witness statement of Mr Michael Girgis, 3 [13].
215 Submission 04 Department of Jobs Precincts and Regions, 31 [111]–[112].
216 Ibid 32 [116(a)].
217 Ibid 32-33 [116(b)].
218 Ibid 33 [116(c)].
219 Ibid 33 [118].
220 Ibid 34 [121]–[122].
221 Submission 08 Rydges Hotels Ltd, 9 [28].
222 Ibid 14 [45].
223 Ibid 14 [46.2].
224 See eg Exhibit HQI0103_RP Witness statement of Dr Simon Crouch, 7 [37]; Exhibit HQI0008_RP Witness statement of Dr Charles Alpren, 13 [54].
225 Exhibit HQI0050_RP Annexures to witness statement of Mr Unni Menon, DJP.104.004.8159-816.
226 Transcript of day 25 hearing 25 September 2020, 2144.