CHAPTER 8

DHHS as control agency

Introduction

1. This pandemic hit Victoria at a time when it was just recovering from a terrible bushfire season. Without doubt, responding to COVID-19 placed extraordinary demands on a public service workforce that was already under strain. Those demands were well articulated by Pam Williams, Department of Health and Human Services (DHHS) Agency Commander, Operation Soteria, as follows:

> Operation Soteria required extraordinary effort from the leadership teams and staff across all the agencies involved. The expectations were high, and the pressure was intense, with long hours and difficult situations to address, with operational guidance being developed contemporaneously. Many staff had just finished working through the bushfire emergency and, without a break, had moved onto hotel quarantine. The majority of staff were not able to be backfilled in their usual roles, which added to the pressure. There was significant demand for staff across the whole COVID-19 response, with hotel quarantine being only one part of the response. Resources were stretched. While action was being taken to fill roles more long term, it was difficult to keep pace with the demand.[1]

2. As has been set out in Chapter 5, the Hotel Quarantine Program was set up over a weekend. Those with experience in developing complex health programs, such as Merrin Bamert, DHHS Agency Commander, Operation Soteria,[2] and Professor Euan Wallace, then Chief Executive Officer, Safer Care Victoria, stated that a program of this size and complexity would ordinarily have taken months to develop, with risk strategies in place.[3] Ms Bamert noted, '[i]n this case, we had less than 48 hours to get the program up and running and in the first week, we had five hotels activated and 1,550 returning passengers'.[4] In her evidence, Ms Williams quoted a higher number, stating that the number of returned travellers in the first week 'quickly reached over 2,000'.[5]

3. Given, as set out in Chapter 3, there was no pandemic plan for quarantining people in facilities, and the speed at which the Program was set up, operational policies and procedures for the Program were being finalised over the days and weeks following the commencement of the Program.[6]

4. Indeed, after the announcement at National Cabinet on 27 March 2020, all health agencies across the nation were having to grapple with contingency plans for the impact of COVID-19 on the healthcare sector while setting up their Hotel Quarantine Programs.

Structure of this Chapter

5. This Chapter examines the plans, structures, decision-making, management and governance of the Victorian Hotel Quarantine Program. It contains four sections:

    A. Section 1 sets out some basic concepts of the Victorian emergency management framework relevant to this Inquiry. This has been done to put the role of DHHS in the Hotel Quarantine Program into the operational context in which it commenced.

    B. Section 2 sets out how DHHS interpreted and performed its role and functions, and how it was structured in its work on the Hotel Quarantine Program relative to other Departments, the emergency management framework and internally.

    C. Section 3 analyses how those interpretations, decisions and structures impacted the operation of the Hotel Quarantine Program.

    D. Section 4 summarises my conclusions.

Section 8.1 — the emergency management framework

6. As set out in Chapter 5, while overall responsibility for the Program briefly lay with the Department of Jobs, Precincts and Regions (DJPR) on the first day of the Program, over the 24 hours that followed, governance structures for the Program were quickly reset to align with Victoria's emergency management framework. In order to examine how the Program unfolded, it is necessary to consider the foundational concepts of this emergency management framework, which informed the roles, actions and responsibilities constituting the Program.

7. Before doing so, it is relevant to note that parts of the emergency management framework discussed in this Chapter were replaced or superseded by the Victorian State Emergency Management Plan (SEMP) on 30 September 2020 and the *Emergency Management Legislation Amendment Act 2018* (Vic) (Amendment Act) on 1 December 2020. The changes, introduced by the SEMP and the Amendment Act, were not the subject of evidence to this Inquiry, noting that both the SEMP and Amendment Act commenced after the close of evidence. Accordingly, in what follows, I will address the emergency management framework, in the present tense, as it stood at the time of the Hotel Quarantine Program. Those engaged in emergency management reform should read the following and apply the findings and recommendations reached in this Chapter to the revised emergency management framework on this basis.

Foundational concepts

8. 'Emergency management' refers to the arrangements for, or in relation to, the mitigation of, response to and recovery from, emergencies.[7] The emergency management framework in Victoria contains an extensive array of documents, manuals and plans that endeavour to address the range of emergencies that could emerge, and the operational structures to be implemented when responding to those various types of emergencies. According to former Emergency Management Commissioner, Craig Lapsley PSM, the creation of Emergency Management Victoria, being the central agency responsible for emergency management in Victoria, was an outcome of two catastrophic emergencies — Black Saturday in 2009 and the Victorian floods in 2010.[8]

9. The emergency management framework has a statutory basis. In Victoria, it is established by two main statutes: the *Emergency Management Act 2013* (Vic) (EM Act) and the *Emergency Management Act 1986* (Vic) (1986 Act).

10. The EM Act has several objectives.[9] One of those objectives is of particular relevance to this Inquiry, being to establish efficient governance arrangements that, amongst other things, clarify the roles and responsibilities of agencies and facilitate cooperation between agencies.[10]

8.1.1 Functions of the Emergency Management Commissioner

11. One of the ways that the EM Act purports to achieve its aims is through establishing the office of the Emergency Management Commissioner.[11] The Emergency Management Commissioner has a number of functions, including:

    A. the coordination of the activities of agencies having roles or responsibilities in relation to the response to Class 1 emergencies or Class 2 emergencies[12]

    B. ensuring that control arrangements are in place during a Class 1 emergency or a Class 2 emergency and that the relevant agencies act in accordance with the state emergency response plan[13]

    C. ensuring that the Minister for Emergency Services is provided with timely and up to date information in relation to the response to major emergencies[14]

    D. being responsible for the preparation of the SEMP.[15]

8.1.2 Classes of emergencies

12. Emergencies are categorised as 'Class 1 emergencies', 'Class 2 emergencies' or 'Class 3 emergencies'.[16]

    A. a Class 1 emergency is a major fire or any other major emergency for which the Metropolitan Fire and Emergency Services Board, the Country Fire Authority or the Victoria State Emergency Services Authority is the control agency under the SEMP

    B. a Class 2 emergency is a major emergency other than a Class 1 emergency, a warlike act or act of terrorism (whether directed at Victoria or at any other State or Territory of the Commonwealth), hijack, siege or riot. A major public health emergency falls within this definition

    C. a Class 3 emergency is a major emergency that *is a* warlike act or act of terrorism, hijack, siege or riot. A Class 3 emergency is often referred to as a 'security emergency'.[17]

13. The COVID-19 pandemic, as a human disease emergency, was a Class 2 emergency under the emergency management framework.[18]

8.1.3 A number of plans are in place to 'operationalise' the emergency management framework

14. The EM Act provides the foundation for a range of plans to guide emergency activities.

15. The EM Act requires that the Emergency Management Commissioner arrange for the preparation of the State Emergency Response Plan (SERP).[19] The SERP puts 'meat on the bones' of the framework of the EM Act.[20]

THE STATE EMERGENCY RESPONSE PLAN

16. The SERP outlines the arrangements for a coordinated response to emergencies by all agencies with a role or responsibility in that emergency. The SERP contains provisions:

    A. identifying, in relation to each form of emergency specified, the agency primarily responsible for responding to the emergency (the control agency)[21]

    B. relating to the coordination of the activities of other agencies in support of a control agency in the event of the emergency (support agencies)[22]

    C. specifying the roles of the control and all support agencies in the event of an emergency[23]

    D. setting out provisions relating to consequence management[24]

    E. setting out the roles, responsibilities and process for appointing State Response Controller, Class 2 Emergency Controller and controllers under s. 39 of the EM Act.[25]

17. The Inquiry received into evidence the Emergency Management Manual Victoria (EMMV),[26] a compendium of the principal policy and planning documents that set out the emergency management arrangements for Victoria. The EMMV sets out the SERP at Parts 3, 7 and 8,[27] and provides details about the roles that different organisations play in the emergency management arrangements for different classes of emergencies.

THE STATE HEALTH EMERGENCY RESPONSE PLAN

18. The EM Act also provides for the preparation of sub-plans to the SERP. The State Health Emergency Response Plan (SHERP) is a such a sub-plan.[28]

19. When it comes to health emergencies, the SHERP is a critical document in the Victorian emergency management framework. The SHERP provides:

> ... an overview of the arrangements for the management of health emergencies in Victoria. This plan describes the integrated approach and shared responsibility for health emergency management between the Department of Health and Human Services (DHHS), the emergency management sector, the health system and the community.[29]

20. The emergency management framework encompasses plans at a high level, but also plans at different degrees of specificity, depending on the nature of the emergency. Aside from the SERP and the SHERP, there is a range of such plans that have been considered earlier in this Report at Chapter 3 (with respect to the state of emergency preparedness). I note them again here for completeness:

    A. The Victorian Health Management Plan for Pandemic Influenza.[30]

    B. The Victorian Action Plan for Pandemic Influenza.[31]

    C. The COVID-19 Pandemic Plan for the Victorian Health Sector.[32]

21. As set out in Chapter 3, none of these plans contemplate mass mandatory quarantine.

8.1.4 Control agency

22. A 'control agency' is defined, under the SERP, as the agency with the primary responsibility for responding to a specific form of emergency.[33]

23. The EMMV (Part 7) lists control agencies for specific emergencies.[34]

24. A control agency's responsibilities are set out in Part 3 of the EMMV.[35] Those responsibilities include:[36]

    A. planning to deliver their responsibilities according to their Part 7 roles, including planning to resource those responsibilities through agency resources, support agency resources or contract or supply arrangements with private industry

    B. preparing a sub-plan for the emergency when the arrangements for managing an emergency vary from the arrangements in the Response Plan

    C. confirming the arrangements for the appointment of controllers for the specific form of emergency for which the agency is the control agency

    D. responding to the form of emergency for which the agency is the control agency in accordance with the arrangements in the Response Plan or the relevant sub-plan

    E. notifying the Emergency Management Commissioner of major emergencies or situations that may affect the capability of the agency to perform its role or responsibilities.

25. The EMMV lists control agencies for specific emergencies. Not surprisingly, given public health is squarely the responsibility of DHHS (particularly preventing the spread of communicable diseases),[37] DHHS is designated as the control agency for human disease emergencies.[38] Such emergencies are Class 2 emergencies under the EMMV.[39]

Support agencies

26. A support agency is defined, under the SERP, as an agency that provides services, personnel or material support to the control agency.[40] The SERP details the roles and responsibilities of the support agency generally. In the context of Class 2 health emergencies, where DHHS is the control agency, the roles of key support agencies are also listed in the SHERP.[41]

Individual agencies perform specific tasks according to their role

27. The EMMV describes the activities and roles performed by the agencies involved in a response to an emergency. Part 3.2.1 of the EMMV distinguishes between the roles of coordinating, commanding or controlling functions in an emergency as set out below:

    A. **Coordination** means bringing together agencies and resources to ensure effective response to, and recovery from, emergencies.

    B. **Command** means the internal direction of personnel and resources, operating vertically within an agency.

    C. **Control** means the overall direction of response activities in an emergency, operating horizontally across agencies.[42]

Importance of control agency for emergency management

28. A control agency has the primary responsibility for responding to the specific emergency. This was explained by former Emergency Management Commissioner Lapsley to mean that the control agency is responsible for leading the response to the emergency, setting the strategic direction and developing and executing a management plan that involves all agencies supporting the response to the emergency.[43]

29. Mr Lapsley explained why having a single control agency is important in an emergency response. He said:

> It is a fundamental premise to have a single agency designated for the leadership and management of an emergency so that there is no ambiguity of who is accountable for the management of the emergency.[44]

30. Mr Lapsley went on to emphasise the need to have a clearly defined structure and accountability in an emergency as follows:

> [Clear lines of command and control are] of critical importance from an accountability perspective so that agency/organisational commanders have a clear understanding of who is in control of the major emergency and who is responsible for coordinating effort seamlessly ...[45]

Complex emergencies

31. In defining a 'control agency', the EMMV says:

> There are complex emergencies where a shared accountability across a number of agencies occurs. In these cases, there is a need for a single agency to be responsible for the collaborative response of all the agencies. For the purposes of consistency, the term control agency will be used to describe this lead agency role.[46]

32. There is no further definition in the EMMV as to what constitutes a 'complex emergency.' In the context of this pandemic, it was uncontroversial that this was a major or complex emergency that was having significant consequences across the state. Nevertheless, when there is a multi-agency response, where accountability is shared, there is still a need for a single agency to be responsible for that collaborative response. That responsibility falls to the control agency.[47] This issue took on considerable significance in this Inquiry and is dealt with in sections 2 and 3 of this Chapter.

The State Health Emergency Response Plan sets out key roles for DHHS

33. The SHERP — being a sub-plan of the SERP — sets out how DHHS is to operationalise its SERP responsibilities within the EM Act framework.[48]

34. Importantly, the SHERP sets out key roles where DHHS is the control agency for a health emergency, as follows:

Figure 8.1.1: Key roles for DHHS under the SHERP

State Controller (DHHS as control) / State Health Incident Management Team Lead (DHHS as support)	As agency lead, the Secretary to DHHS appoints the State Controller (by instrument of appointment) to enable appropriate focus on managing health consequences according to the nature of the emergency: • the Public Health Commander will be appointed State Controller for identified public health emergencies (most likely to occur in circumstances where a public health emergency is anticipated) • all other emergencies, including in the event of a rapid onset health emergency where the causation is unclear, the State Health Coordinator will be appointed as State Controller. The State Controller is responsible for the following initial decisions and actions, in consultation with the appropriate internal and external stakeholders: • verify the relevant response assessment (refer to Section 6.3.3) • determine the strategic objectives for response • determine the incident management model or activate pre-agreed plans for the initial response • establish incident management team(s) (as applicable) • ensure timely and appropriate public information and warnings are provided to the community • notify the EMC, support agencies and relevant health system service providers. The State Controller may appoint a Deputy Controller. The State Controller should delegate their function on the State Health Incident Management Team (that is, Public Health Commander or State Health Coordinator) to a deputy or equivalent.
State Health Emergency Management Coordinator (SHEMC)	The SHEMC is an executive-level public administration function performed by DHHS and appointed by the Secretary of the department. The SHEMC is responsible for ensuring that appropriate appointments are made to state tier functions (the State Health Commander, State Health Coordinator and the Public Health Commander), as well as providing executive administrative support to ensure these functions operate effectively. While an instrument of appointment will determine whether the Public Health Commander or State Health Coordinator performs the function of State Controller, the SHEMC may advise the Secretary to DHHS who should fulfil the function of State Controller (with advice from the State Health Incident Management Team) according to the nature of the emergency and response, and consistent with the instrument of appointment.

Public Health Commander (Public Health Command functional lead)	The Public Health Commander function is performed by the Chief Health Officer (or delegate). The Public Health Commander reports to the State Controller and is responsible for commanding the public health functions of a health emergency response (including investigating, eliminating or reducing a serious risk to public health). Performing the function of Public Health Commander does not alter in any way the management, control and emergency powers of the Chief Health Officer under the Public Health and Wellbeing Act 2008. In performing this function, the Public Health Commander will liaise directly with the State Health Commander and State Health Coordinator. For emergencies where the Public Health Commander is not appointed the State Controller, the Chief Health Officer's authority under the Public Health and Wellbeing Act 2008 remains unaffected, and their decisions on matters of public health should not be overridden by a State Controller.
State Health Coordinator (Health Coordination functional lead)	The State Health Coordinator function is performed by a senior DHHS officer appointed by the SHEMC. The State Health Coordinator reports to the State Controller and is responsible for coordinating DHHS' emergency response activities across the health system (including hospitals, primary health and other acute services) at the state tier. In performing this function, the State Health Coordinator liaises directly with the State Health Commander and Public Health Commander.
State Health Commander (Health Command functional lead)	The State Health Commander function is performed by the appointed Ambulance Victoria Emergency Management Director (unless otherwise appointed by the SHEMC). The State Health Commander reports to the State Controller and is responsible for commanding the pre-hospital and field response to an emergency (including ambulance services, first responder assistance, and spontaneous volunteers) at the state tier. In performing this function, the State Health Commander will liaise directly with the State Health Coordinator and Public Health Commander.

Source: Exhibit HQI0145_P Annexures to first witness statement of Emergency Management Commissioner Andrew Crisp.

8.1.5 Controllers and Commanders

35. The language of controllers and commanders, and deputy controllers and deputy commanders, is prominent throughout this Chapter, as it is the language of the emergency management framework. The roles set out above demonstrate this. As can be seen, the concepts reflect a distinction between 'Controller' and 'Commander'. That distinction reflects the difference between the concepts of 'control' and 'command' (as operating horizontally and vertically across agencies, respectively, in the emergency management structure) as set out in paragraph 27. That is, whereas a 'State *Controller'* is responsible for leading and managing the response to an emergency across agencies,[49] an 'Agency *Commander'* is at the top of a particular agency's internal response structure and supervises their own agency personnel and the work being done by that agency in response to the emergency.[50] This applies regardless of whether an agency is a control agency or a support agency for a particular emergency.

APPOINTMENT OF CONTROLLERS

36. The State Controller in any emergency sits above any particular incident and is responsible for the overall response to the emergency.[51]

37. As can be seen from the table above, in a Class 2 health emergency the SHERP provides for the Secretary to DHHS to appoint the State Controller (who, in the Hotel Quarantine Program, was referred to as the State Controller — Health) to enable appropriate focus on managing health consequences according to the nature of the health emergency.[52] According to the table, where there is an identified public health emergency, the Public Health Commander is appointed the State Controller — Health.[53] The Public Health Commander is the role performed by the Chief Health Officer (CHO) or delegate.

38. How this appointment process occurred in the Hotel Quarantine Program, and who was ultimately appointed to the State Controller — Health role, are questions I address in some detail below, in sections 2 and 3 of this Chapter.

39. Once appointed under the SHERP, the State Controller — Health's responsibilities include to:

    A. lead and manage the response to a Class 2 emergency

    B. establish a control structure for the Class 2 emergency as appropriate and monitor to ensure it suits the circumstances

    C. support the Emergency Management Commissioner to identify current and emerging risks, or threats in regard to the Class 2 emergency, and implement proactive response strategies

    D. support the Emergency Management Commissioner in the development of a state strategic plan for managing the Class 2 emergency.[54]

8.1.6 The declaration of a State of Emergency was part of the framework for the exercise of quarantine powers

40. The emergency management framework that I have outlined above (including the allocation of roles to the various offices) applies to a response to a major public health emergency, whether or not there is a declaration of a State of Emergency in place.[55]

41. As I have set out in Chapter 1, the Minister for Health declared a State of Emergency in respect of the COVID-19 pandemic on 16 March 2020. This enabled the conferral of emergency powers on Authorised Officers, including the power to detain people.[56]

42. This declaration, on 16 March 2020, was the first time that a State of Emergency had been declared under the *Public Health and Wellbeing Act 2008* (Vic) (PHW Act) with respect to a Class 2 emergency.[57] It formed part of the legal arrangements for how DHHS administered and enforced the Hotel Quarantine Program.

Section 8.2 — DHHS governance, decision-making and Operation Soteria

43. It is against this backdrop, having regard to the emergency management framework summarised above, that I now turn to the governance structures ultimately adopted, and the decisions made, by DHHS in its role as control agency within the Hotel Quarantine Program.

44. There was no controversy that the COVID-19 pandemic was a Class 2 health emergency or that this Class 2 health emergency meant that DHHS was the 'control' agency. How DHHS interpreted that role and its functions and responsibilities in the context of the Hotel Quarantine Program was, however, the subject of considerable dispute.

45. The purpose of this section is to set out, in detail, how that interpretation came to be applied in practice.

46. From the outset, I note that the roles, functions and responsibilities discussed in this section are often difficult to follow. This is perhaps to be expected since, as will be discussed in Section 3, the governance structures forming part of the Program were, themselves, often fragmented and confusing. In what follows, the governance structures are described by reference to the policies, roles and appointments that comprised them and according to the manner in which these matters evolved over time. I will then return, in Section 3, to analyse how these matters impacted the operation of the Hotel Quarantine Program.

8.2.1 Key relevant structures to the role of DHHS in the COVID-19 pandemic emergency

47. As discussed in Chapter 5, the Hotel Quarantine Program had two key objectives, albeit perhaps not clearly articulated, each of which was a health and human objective. The paramount purpose of the Hotel Quarantine Program, and the very reason for its existence, was to prevent the further spread of COVID-19 from returning overseas travellers into the Victorian community, thus protecting the health of all Victorians.[58] The secondary objective of the Program was to meet the health and other needs of those detained in quarantine.[59]

48. Infection control, outbreak management, healthcare, welfare and human services are core to the work of DHHS. Kym Peake, former Secretary of DHHS, stated that the purpose of the Department is to provide policy advice to government and to 'fund, regulate and deliver programs to enhance the safety, health and wellbeing of Victorians'.[60] Key responsibilities of the Department relate to public health and include preventing the spread of communicable diseases.[61]

49. In its ordinary operations, DHHS reports to five Ministers across the portfolios of Health, Ambulance Services, Housing, Disability, Ageing and Carers, Mental Health, Child Protection, and the Prevention of Family Violence.[62] To say that its remit is expansive is, perhaps, to understate the position. Victoria's CHO, Professor Brett Sutton, evocatively and aptly, described DHHS as a 'rather large beast'.[63]

50. In this regard, it is of note that, on 30 November 2020, the State Government announced a restructure of DHHS to separate the Department of Health (DoH) from the new Department of Families, Fairness and Housing (DFFH), effective as of 1 February 2021.[64]

CONCEPT OF OPERATIONS

51. In November 2019, Prof. Sutton and the Director of the DHHS Emergency Management Branch prepared a joint document, the *Concept of Operations, Department of Health and Human Services as a Control Agency and as a Support Agency in Emergencies* (the Concept of Operations), which was an overarching guidance document for staff working in DHHS in emergency-related roles.[65] The intended purpose of the document was to set out DHHS's operational functions, roles, key activities and deliverables at the state and regional tiers across all types of emergencies, including public health emergencies. It recognised DHHS's responsibilities in the PHW Act, the EM Act, the EMMV and the health-specific incident management and escalation arrangements identified in the SHERP.[66] Ms Peake explained that this document was relevant to a number of public health emergencies, including communicable disease emergencies.[67]

52. The Concept of Operations provided the following descriptions of state-level functions, leadership roles and key activities:

Table 8.2.1: Functions, leadership roles and key activities in a Class 2 health emergency

Function	Public Health Command	Departmental Command	Health Coordination	Relief & Recovery Coordination and Services	Control (Class 2)
Leadership Role	**Public Health Commander**	**State Departmental Commander**	**State Health Coordinator**	**State Departmental Commander**	**Controller**
Key Activities	Command the public health activities of an emergency response (including the investigation, management of public health risk, and communication of risk) Undertake actions to reduce pressure on the health system through control measures and advice Monitor the impacts of an emergency on public health Authorise public health communication to the public	Monitor the impacts of an emergency on the department's clients and funded services Undertake activities that support the safe deployment of DHHS personnel to acquit responsibilities of the department Coordinate activities to manage the consequence of these impacts on clients, funded services and DHHS staff Authorise public communications about impacts to departmental services	Monitor state-level impacts of an emergency across the health system Coordinate health sector emergency response activities to support the health system (including hospitals and primary health) Authorise health system impact communication to the public	Coordinate the provision of financial assistance to affected communities Coordinate the provision of emergency accommodation to affected communities Coordinate the provision of psychosocial support to affected communities Authorise relief and recovery public communications	Ensure implementation of control measures for the identified hazard(s) Manage the emergency consequences across government Authorise public information and warnings to the public Support the Emergency Management Commissioner and the sector
Decision-making	Chief Health Officer/ Public Health Commander	Department Incident Management Team (D-IMT)* leadership group Department Executive Board (BC/surge)	State Health Incident Management Team	D-IMT leadership group	State Control Team
State EM Committees	State Control Team State Coordination Team	N/A	State Control Team State Coordination Team State Emergency Management Team	State Relief & Recovery Team State Control Team State Coordination Team State Emergency Management Team	State Coordination Team State Emergency Management Team

Source: Exhibit HQI0126_RP Annexures to witness statement of Ms Melissa Skilbeck.

53. The Concept of Operations also provided for decision-making processes, as follows:

> During an emergency, whether in control, support or coordinating, the department will convene a single body to inform decision-making by leadership roles irrespective of the type of hazard that has precipitated the emergency. For the purpose of the SHERP, the departmental incident management team fulfils the function, and will operate as the State Health Incident Management Team under SHERP when required.
>
> The D-IMT [Department Incident Management Team] determines the strategic priorities for the department, and in some cases the health and human services and emergency management sectors, in responding to emergencies across all functions. The D-IMT provides guidance on required decision-making, across the span of strategic, tactical and operational decisions. The D-IMT provides direction for functional lead officers in the discharge of all key activities and activities for which the department is accountable.[68]

54. The Concept of Operations provided that membership of the Departmental Incident Management Team or State Health Incident Management Team under the SHERP should include:[69]

    - State Health Coordinator
    - State Health and Human Services (Departmental) Commander
    - Public Health Commander
    - State Health Commander (as required)
    - Regional Commanders (as required)
    - Functional lead officers.

55. The Concept of Operations also provided the roles for DHHS at the State Control Centre (SCC) when acting as a control agency, as follows:

> When the department is a control agency and the emergency is a public health emergency, an appropriate Class 2 controller will be recommended by the State Health Emergency Management Coordinator (Deputy Secretary Regulation Health Protection and Emergency Management) to the department's Secretary for appointment. In keeping with SHERP, the Chief Health Officer will normally be appointed the Class 2 Controller for identified public health emergencies, and when that occurs the Chief Health Officer will delegate the Public Health Commander role to the DCHO relevant to the main hazard or consequence. The Public Health Commander will then be the chair of the D-IMT.[70]

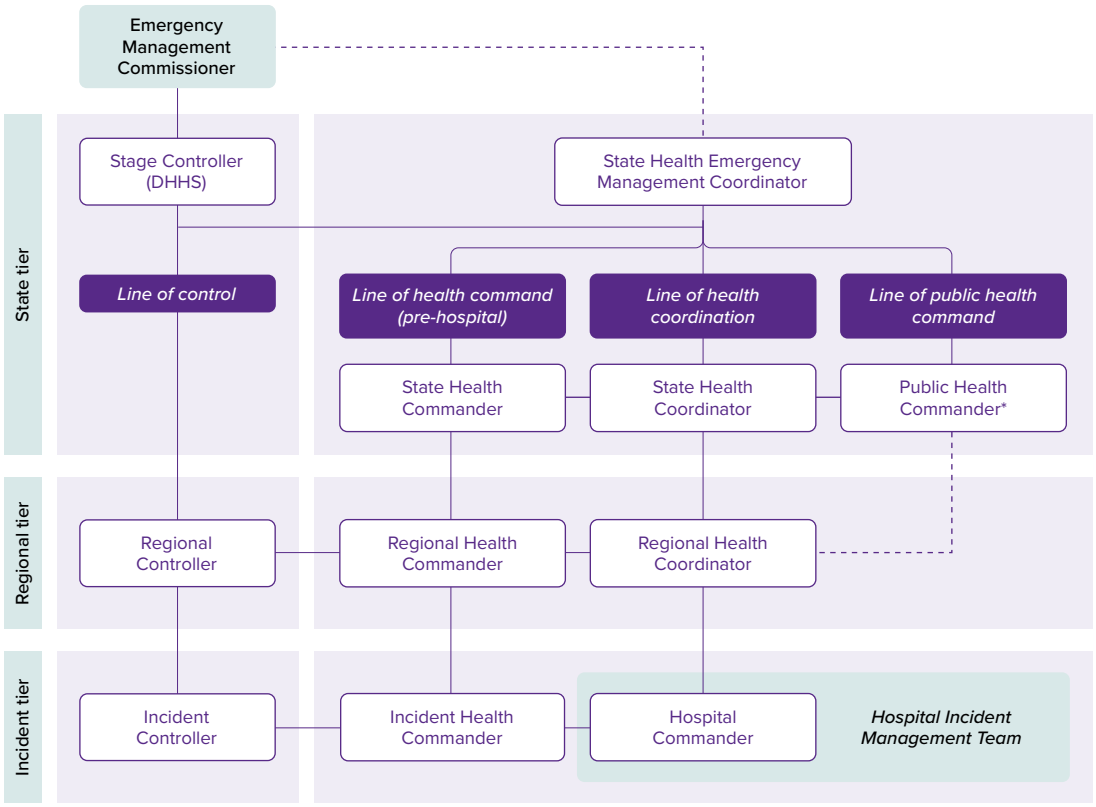
THE STATE HEALTH EMERGENCY RESPONSE PLAN

56. This is to be read in conjunction with the SHERP which, in the context of Class 2 health emergencies, outlines agency roles and responsibilities, and notes the capacity to use SCC facilities, in the following terms:

> Under the EMMV Part 7 – Emergency Management Agency Roles, DHHS is the nominated control agency for specified health emergencies in Victoria (refer to Section 1).
>
> DHHS is responsible for identifying unfolding or potential health emergencies, and escalating health emergency response arrangements outlined in this plan to ensure the health system can effectively respond and mitigate the adverse consequences for communities (refer to Section 6.3.3).
>
> DHHS may activate the State Emergency Management Centre (located at DHHS) when considered necessary for the effective management of an emergency. To ensure an effective response to adverse health consequences for communities DHHS may also, in consultation with the EMC, request activation of the State Control Centre (SCC) to provide support to the State Controller. The SCC provides a range of services to assist with the coordination and control of emergencies and has well-established protocols for working across all government agencies and for providing information and warnings to the community.[71]

57. The SHERP provides the following diagram of reporting relationships for Class 2 health emergencies, as reproduced in Figure 8.2.1.

Figure 8.2.1: Reporting relationship for Class 2 health emergencies



*Public Health Commander appointed State Controller for identifiable public health emergencies.

Source: Exhibit HQI0126_RP Annexures to witness statement of Ms Melissa Skilbeck.

8.2.2 DHHS's initial steps in its response to COVID-19 state-wide pandemic emergency

58. The recognition that the COVID-19 pandemic was a Class 2 emergency led to the use of the emergency management framework in order to respond to the serious risk posed to the Victorian community. However, as the arrangements under the SHERP apply on a continuous basis and did not require 'activation',[72] DHHS had already taken steps, from late January and into early February of 2020, to respond to the emerging COVID-19 pandemic emergency under the SHERP and in accordance with the Concept of Operations.

59. Ms Peake gave evidence that she and Melissa Skilbeck, Deputy Secretary Regulation, Health Protection and Emergency Management at DHHS (who also fulfilled the function of State Health Emergency Management Coordinator (SHEMC) under the SHERP),[73] met in late January 2020 to consider what action needed to be taken in respect to the COVID-19 pandemic.[74]

60. On 20 January 2020, DHHS established an Incident Management Team to coordinate the public health and sector response to the COVID-19 pandemic emergency.[75] This was the same day that the Australian Health Protection Principal Committee (AHPPC) first met to discuss the national response to the pandemic.[76]

61. Ms Peake stated that, on 1 February 2020, the same day that the AHPPC recommended that entry to Australia be limited for certain overseas arrivals due to the risk from COVID-19, she 'and others' were of the view that the COVID-19 outbreak met the definition of a 'major emergency' under the EM Act.[77] Not adopting the 'normal' course of appointing the CHO as the State Controller, Ms Peake appointed Andrea Spiteri as the Class 2 State Controller (later known as State Controller — Health) for the COVID-19 pandemic emergency.[78] Later, on 7 February 2020, Jason Helps was also appointed as State Controller — Health in response to the COVID-19 pandemic emergency.[79]

62. On 2 February 2020, DHHS established a State Health Incident Management Team for the COVID-19 pandemic emergency.[80] Dr Finn Romanes, Deputy Public Health Commander, gave evidence that he performed the role of the Public Health Commander on initial establishment of the State Health Incident Management Team in February 2020, however, that role transitioned to Dr Annaliese van Diemen, as Deputy Chief Health Officer (DCHO) and Public Health Commander, in March 2020.[81] Dr van Diemen also gave evidence that 'on the declaration of a state of emergency on 16 March 2020, [she] became the [Public Health Commander] for the purposes of the SHERP'.[82]

63. On 11 March 2020, the SCC was activated by the Emergency Management Commissioner, at the request of DHHS, to respond to the COVID-19 pandemic emergency.[83]

8.2.3 Hotel Quarantine Program is commenced

64. On 27 and 28 March 2020, those gathered at the SCC commenced implementing National Cabinet's decision that all international arrivals be required to quarantine in a designated facility for 14 days.[84] It was revealed in the course of those SCC meetings that DJPR had been engaged by the then Secretary to the Department of Premier and Cabinet (DPC) to run the Program.[85]

65. As of 27 March 2020, the two operating State Controllers — Health (Ms Spiteri and Mr Helps, both from DHHS) and the Deputy State Controllers (Christopher Eagle and Scott Falconer from the Department of Environment, Land, Water and Planning (DELWP)) were operating out of the SCC.[86]

66. On 3 April 2020, Pam Williams commenced in the role of COVID-19 Accommodation Commander.[87] The role was renamed Commander, Operation Soteria from 1 May 2020, though the titles continued to be used interchangeably.[88] As Commander, Operation Soteria, Ms Williams reported to the State Controller — Health (Ms Spiteri and Mr Helps).[89]

67. On 4 April 2020, DHHS established the Public Health Incident Management Team[90] — also referred to as 'Public Health Command'.[91] The structure was revised on about 8 April 2020 so as to better respond to the COVID-19 pandemic emergency.[92] The Public Health Commander and the DCHO (Dr van Diemen) led the Public Health Incident Management Team and reported to the CHO. In addition, also reporting to the Public Health Commander were four Deputy Public Health Commanders presiding over the following teams:[93]

    A. Pathology and Infection Prevention and Control (IPC)

    B. Case, Contact and Outbreak Management

    C. Strategy and Implementation

    D. Intelligence.

68. On 7 April 2020, due to the complexity of DHHS's contribution to the COVID-19 pandemic emergency, Ms Peake made a decision to divide functional responsibilities as follows:[94]

    A. the Regulation, Health Protection and Emergency Management Division, headed by Ms Skilbeck, was to be responsible for the emergency accommodation function (reporting through the Operation Soteria command structure) and enforcement and compliance functions. That division also retained responsibility for non-COVID-19 public health work

    B. the COVID-19 Public Health Command Division (COVID-19 PHC Division)[95] was to be responsible for managing the state-wide response to the critical public health risks arising from COVID-19, including the provision of public health advice to DHHS and other government agencies, IPC, case contact and outbreak management, physical distancing, public information and intelligence.

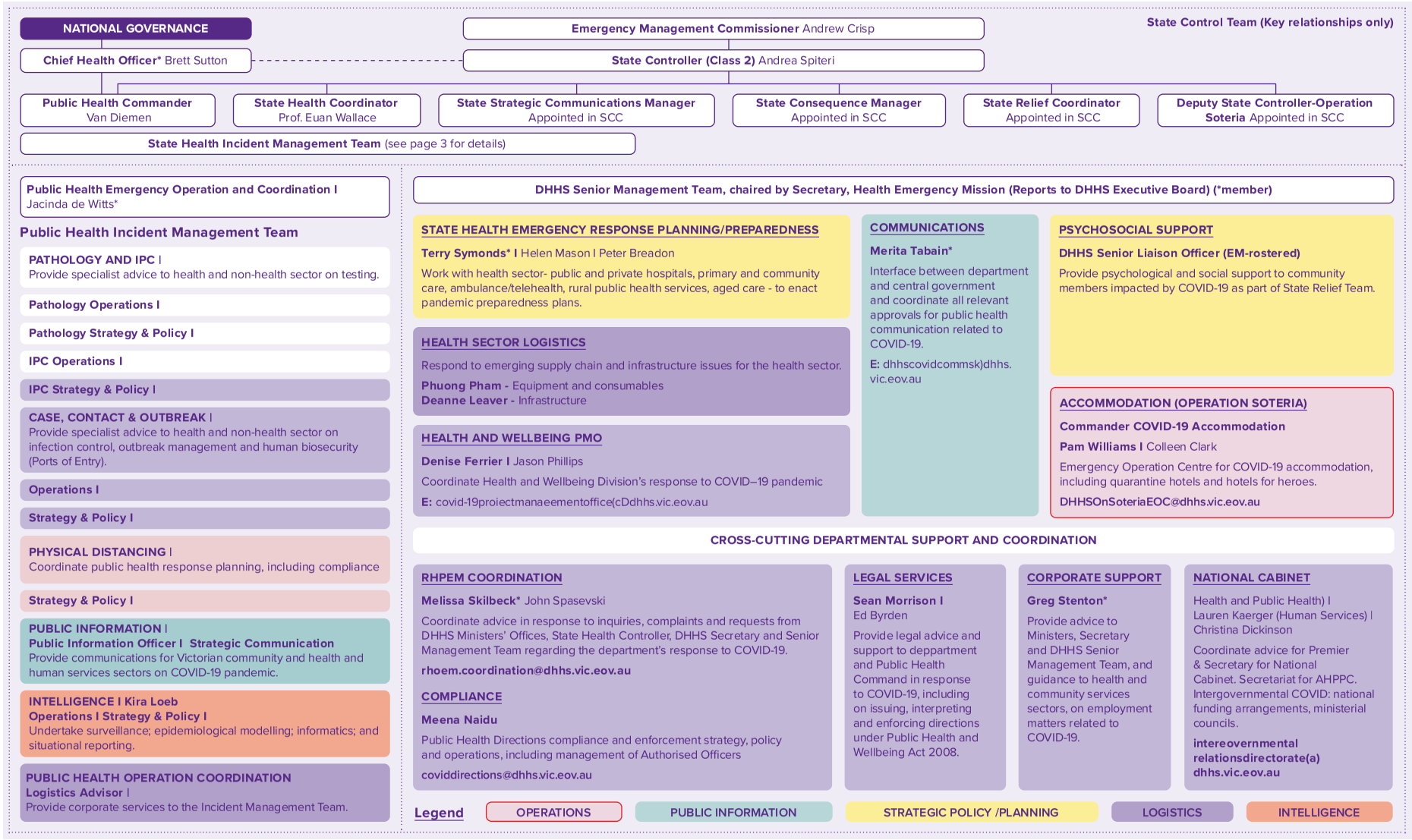
69. On 8 April 2020, Jacinda de Witts commenced in the role of Deputy Secretary, COVID-19 PHC Division.[96] Her usual role was Deputy Secretary, Legal and Executive Services Division.[97]

OPERATION SOTERIA MOVES OUT OF THE STATE CONTROL CENTRE

70. On 16 April 2020, Operation Soteria transitioned out of the SCC to a centre set up by DHHS in Fitzroy named the Emergency Operation Centre (EOC).[98] This move was a recognition that the Hotel Quarantine Program, known as Operation Soteria, needed to be run as a longer-term program rather than on an ongoing emergency footing. Ms Williams took on the role of leading Operation Soteria out of the EOC. This move was also in recognition of the realisation that Operation Soteria would be a significant and complex program and require specific attention.[99] It came to be the sole focus of Ms Williams's work.[100]

71. On about 30 April 2020, Merrin Bamert was also appointed Operation Soteria Commander, sharing the role with Ms Williams on a rostered basis.[101] Ms Bamert had previously held the role of Deputy Commander – Hotels.[102]

72. DHHS provided details of its organisational structure in response to both the COVID-19 pandemic emergency and the Hotel Quarantine Program, as of 18 April 2020, as part of a response to the Victorian Ombudsman.[103] The overall governance structure for the COVID-19 health emergency at that time is represented in Figure 8.2.2:



Source: Exhibit HQI0126(1)_RP Annexures to witness statement of Ms Melissa Skilbeck.

Figure 8.2.2: Governance structure for the COVID-19 health emergency April 2020

Relevant decision-making structures external to DHHS

73. Pursuant to the *Public Administration Act 2004* (Vic), as the then Secretary of DHHS and Department Head, Ms Peake was responsible to the relevant portfolio Ministers for the general conduct and the effective, efficient and economical management of the functions of her department and its administrative offices.[104]

74. As Secretary, Ms Peake described her 'key accountabilities' as being 'to provide strategic leadership and stewardship of the Department and associated service systems, to ensure compliance with our legislative and regulatory responsibilities, and to advise portfolio Ministers on policy and service improvements to raise health and wellbeing outcomes'.[105] She agreed that the responsibility to advise portfolio ministers included the responsibility to keep the relevant Ministers informed of 'significant issues' within their portfolios.[106]

CRISIS COUNCIL OF CABINET AND MISSION COORDINATION COMMITTEE

75. On 3 April 2020, DPC announced a new government and public service structure to respond to the COVID-19 pandemic emergency. This included the establishment of the Crisis Council of Cabinet (CCC) and the Mission Coordination Committee (MCC).[107] The CCC met for the first time on 6 April 2020.[108]

76. The CCC comprised seven ministers, each with a portfolio directed to the coordination of the COVID-19 response.[109] The CCC was tasked with determining 'all significant matters of policy, administration, budget and legislation required to respond to the COVID-19 pandemic crisis'.[110]

77. Departmental secretaries were given 'Mission Lead' roles and together formed the MCC.[111] Ms Peake was appointed to the role of Mission Lead Secretary — Health Emergency.[112] As such, she was to support the Minister for the Coordination of Health and Human Services, a role undertaken at the time by the Hon. Jenny Mikakos in addition to her role as Minister for Health.[113] The Mission was tasked with 'leadership of the health response to COVID-19'.[114]

78. Ms Peake was accountable directly to the Premier for delivery of that Mission.[115] As explained in her evidence, in the ordinary course of events, Ms Peake was accountable primarily to the five Ministers of DHHS, and not directly to the Premier.[116] Thus, her accountability as Mission Lead involved an extra line of reporting.

79. The Premier's letter to Ms Peake of 3 April 2020 outlined the new government structures that were being put in place, as follows:

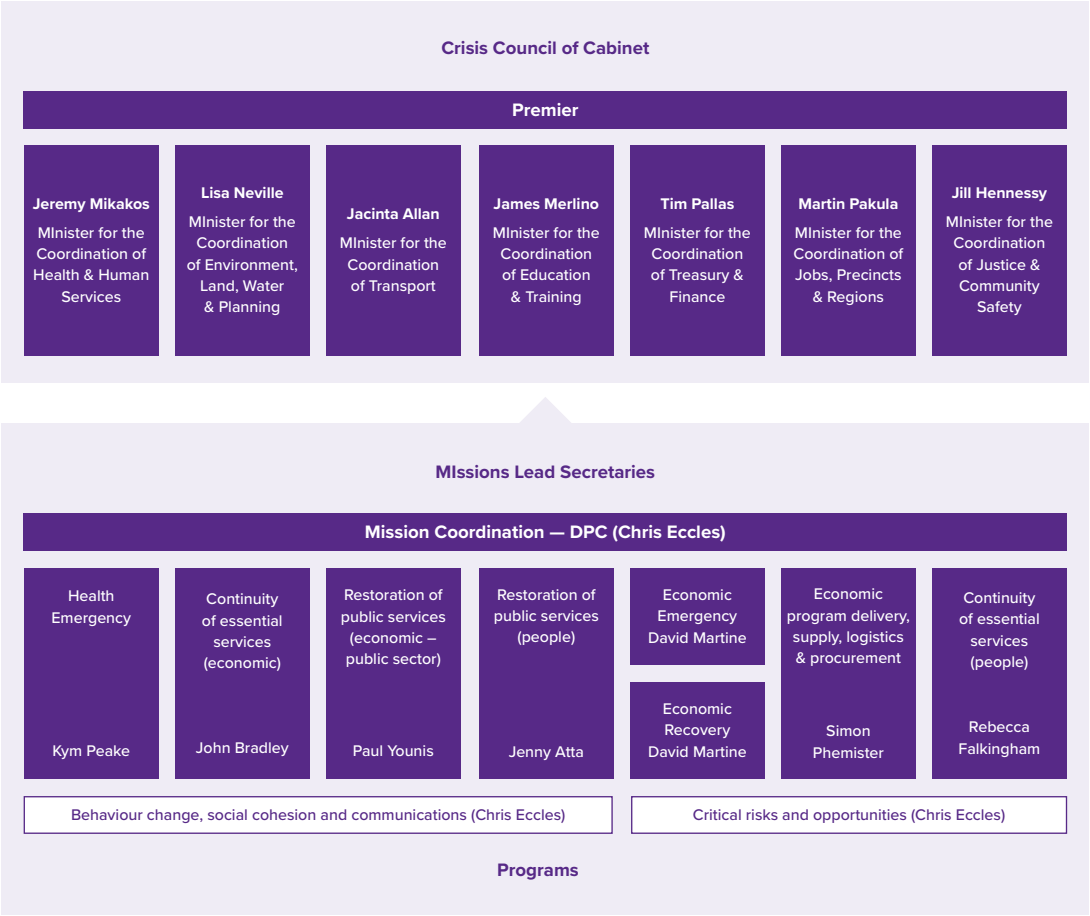
> In this role you are accountable to me for the delivery of the missions. You will assist the new Crisis Council of Cabinet (CCC) which I have convened and new portfolio Ministers appointed to act as 'Minister [sic] for the Coordination of the COVID-19 response. The CCC will determine all significant matters of policy, administration, budget and legislation required to respond to the COVID-19 pandemic crisis.
>
> The new portfolio Ministers will comprise the CCC and report to me in developing and implementing the Victorian Government response, which will be structured around the core missions outlined in Attachment A. I ask that you support the Minister for the Coordination of Health and Human Services - COVID-19 in this new portfolio.[117]

80. Ms Peake explained these changes as a 're-conceptualisation of the architecture of Government' to deal with the pandemic, which had been implemented due to the scale and complexity of the crisis.[118] She said:

> ... there were a whole series of risks, threats and consequences that did require a whole-of-Government policy and strategic set of decisions and did require decision-making about allocation of resources that go beyond the remit of the control agency and the control function, and that's precisely why our Government made the decision to establish, alongside the arrangements for the emergency management functions, the Crisis Council and the mission coordination structures.[119]

81. As of 3 April 2020, the structure of the CCC and Core Missions were as outlined at Figure 8.2.3.

Figure 8.2.3: Structure of Crisis Council of Cabinet and the Core Missions



Source: Exhibit HQI0193_P Letter from the Hon Daniel Andrews MP to Ms Kym Peake.

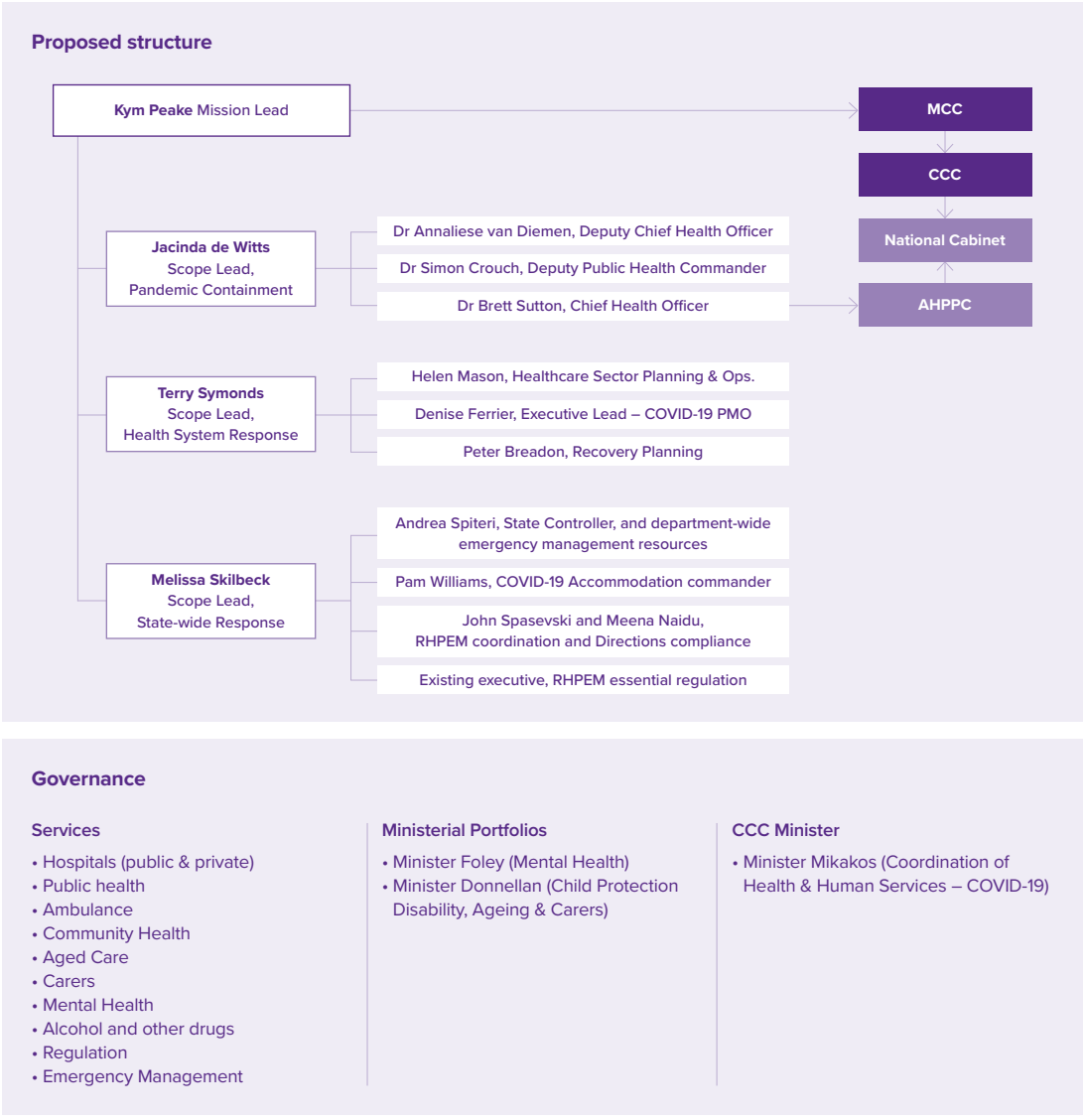
82. By his letter to Ms Peake, the Premier designated two immediate tasks to her: first, that she establishes an implementation plan for the Mission; second, that she nominates an Associate Secretary to be responsible for the day-to-day administration of her Department.[120]

83. Despite the direction from the Premier that she should divest herself of ongoing responsibilities as Secretary to DHHS, Ms Peake retained her day-to-day responsibilities for health[121] and appointed a Deputy Secretary only for responsibility of the day-to-day management of the human services aspect of her usual role.[122]

84. Even though this was a departure from what the Premier had requested of her expressly, and in writing, she did not raise it with the Premier directly.[123] Rather, Ms Peake explained that, following subsequent discussions at the Victorian Secretaries Board (VSB), she retained some of her day-to-day responsibilities because 'health and public health were so intrinsically tied to the mission responsibilities'.[124] As Ms Peake was aware, there were no minutes or records of that discussion available.[125] Nor has the Inquiry received any such minutes or records. Nevertheless, Ms Peake explained to the Inquiry that she was satisfied that she 'acquitted' the Premier's request by way of her discussions at the VSB meeting and with the then Secretary to DPC, Christopher Eccles.[126]

85. Ms Peake confirmed that the Mission Implementation Plan that was created following the Premier's request included a governance structure that was in place for some time prior to June 2020.[127] That structure was as outlined at Figure 8.2.4.

Figure 8.2.4: Mission structure and governance

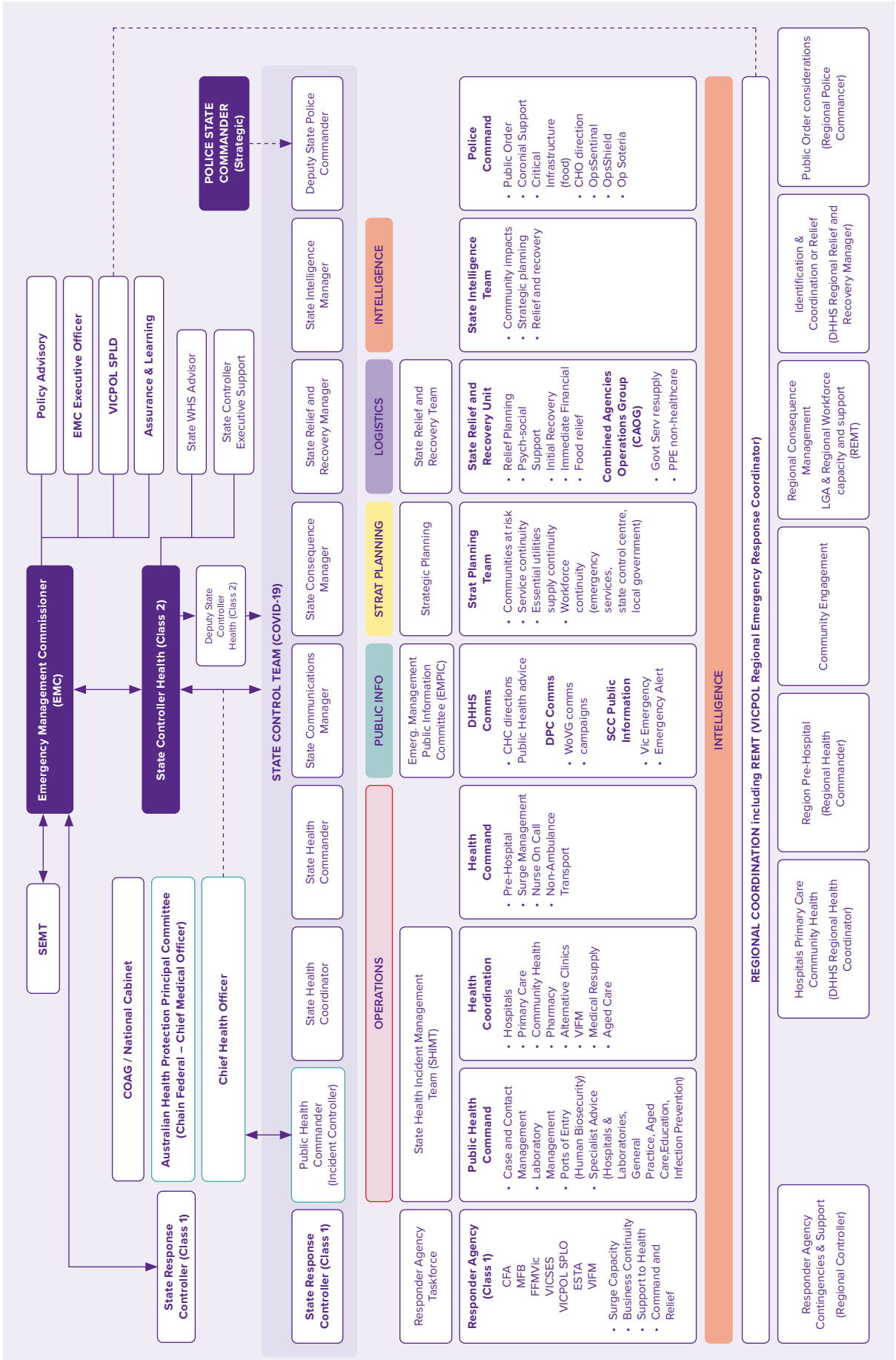


Source: Exhibit HQI0194_RP Mission Implementation Plan.

86. This structure showed, and Ms Peake agreed,[128] that there was a direct reporting line into the MCC and the CCC from the emergency management framework through Ms Skilbeck. Separately, there was a reporting line into the CCC through Public Health Command from Ms de Witts.

87. In evidence, Ms Peake was also shown the State Governance Structure for the COVID-19 pandemic emergency, as contained in the State Operations Arrangements document as of 22 May 2020, as outlined in Figure 8.2.5.[129]

Figure 8.2.5: State governance structure for the COVID-19 pandemic emergency



Source: Exhibit HQI0167_RP EMV State Operational Arrangements COVID-19.

88. Given the maze-like presentation of this document, when asked if people in charge understood the intersection of the CCC and MCC structures with the State Operational Arrangements, Ms Peake responded that, in the beginning of the pandemic, she did not think that, due to their emergency management background, staff would have expected there to be such an intersection between the emergency management frameworks and the whole-of-Government Cabinet structures. She explained that a lot of work was done to determine how that intersection would work but that, ultimately, and in her opinion, the arrangements were well defined and documented.[130]

89. It was suggested by Ms Peake that the State Operations Arrangements governance structure was 'an elaboration of the emergency management element [of the Mission Structure]'.[131] When it was put to Ms Peake that the two structures had differing reporting lines, that is, that the State Controller — Health reported to the Emergency Management Commissioner under the emergency management framework and to Ms Skilbeck under the Mission Structure, Ms Peake said:

> They're related to each other, but one is for the purpose of policy, resourcing, decision-making. And this [the operational arrangements] is for the command structure, for making sure that where we are operationalising a response, that we have the elements in place for that response.[132]

90. Later in her evidence, Ms Peake explained that there were different processes and structures for reporting to Cabinet than there were for operational functions on the ground. She said:

> So I think that it is appropriate, and it is really understood by members of my staff that the reporting lines for a Government decision-making process are one set of reporting lines, and the operational structures for either a program or an emergency management operation are acquitting a different purpose.[133]

91. It was Ms Peake's evidence that the structures and governance frameworks were, at least after some time, well understood. As will be discussed later in this chapter, there is evidence from other DHHS witnesses, including those involved in the operational elements of the Hotel Quarantine Program, that suggests the separation of decision-making from operations, a bifurcation that Ms Peake described as appropriate, was not well understood and, at times, served to fracture and confuse roles and responsibilities and lines of reporting and accountability as designated under the SHERP.

8.2.4 Establishment of separate roles for Regulation Health Protection and Emergency Management Division, and COVID-19 PHC Division (decision-making structures within DHHS)

92. Prior to the COVID-19 pandemic emergency, Prof. Sutton headed up the Health Protection Branch, which sat in the Regulation Health Protection and Emergency Management Division.[134] The Health Protection Branch consisted of two DCHOs; the DCHO (Communicable Diseases), a role fulfilled by Dr van Diemen, and DCHO (Environment), a role fulfilled by Dr Angela Bone.[135] The communicable diseases team within the Health Protection Branch formed the basis of what would become the Public Health Command and, later, the COVID-19 Public Health Division.[136]

93. As noted above, on 7 April 2020, Ms Peake divided functional responsibility for the COVID-19 pandemic response across two Divisions in DHHS. As a result, public health functions (in respect of the COVID-19 pandemic emergency) were taken out of the Regulation Health Protection and Emergency Management Division and formed the separate COVID-19 Public Health Command (PHC) Division, with a second reporting line from Ms de Witts to Ms Peake.[137] This was also reflected in the Mission Structure, where information regarding 'pandemic containment' came to the MCC through Ms de Witts and the COVID-19 PHC Division and information about the 'state-wide response' came to the MCC through Ms Skilbeck.[138] I discuss the DHHS COVID-19 PHC Division in more detail below, at Section 8.2.6.

94. Ordinarily, the CHO reported to Ms Skilbeck as Deputy Secretary, Regulation Health Protection and Emergency Management.[139] However, from about 8 April 2020, when Ms de Witts was seconded to assist the COVID-19 emergency response, the CHO had a dual reporting line to both her and to Ms Skilbeck.[140] Neither Ms Skilbeck nor Ms de Witts have a background in public health.[141]

95. During examination, Prof. Sutton explained that he continued to have a reporting line to Ms Skilbeck because his statutory obligations to protect the health and wellbeing of Victorians outside of the COVID-19 pandemic emergency continued and he remained accountable to Ms Skilbeck in respect of that work.[142]

96. Prof. Sutton also gave evidence that, although he reported to Ms de Witts, she did not have a role in approving public health advice.[143] Prof. Sutton did not accept that Ms de Witts's role was as a mere conduit for that advice but agreed that she was 'a point of liaison for that advice into the Department'. He explained her role:

> … as ensuring that the issues that arose that required executive awareness and action at the executive board level of DHHS or reporting through to the Secretary were facilitated … And so, it was to try and bring a more sustained, almost bureaucratic structure to that command-and-control structure …[144]

97. It is apparent that the DHHS leadership made a decision early in the COVID-19 pandemic emergency response (probably understandably, at the time, in consideration of the enormous volume of work being undertaken) to separate the Department's public health structures from the operational aspects of Operation Soteria and the wider COVID-19 pandemic emergency response.

98. This had ramifications for the operation of the Hotel Quarantine Program through Operation Soteria.

State Controllers — Health

99. As was noted above, Ms Peake, on the advice of Ms Skilbeck, did not adopt the 'normal' course of appointing the CHO, Prof. Sutton, as the State Controller — Health. Ms Peake appointed Ms Spiteri as State Controller — Health on 1 February 2020 and, on 7 February 2020, Mr Helps was also appointed as State Controller — Health.[145]

100. The functions of the State Controller — Health in a Class 2 emergency are set out in paragraphs 35 to 39 above. In a Class 2 emergency, the first-listed responsibility for the State Controller — Health is to 'lead and manage the response to a Class 2 emergency'.[146]

101. Mr Helps and Ms Spiteri gave evidence that the role of State Controller — Health did not operate in the Hotel Quarantine Program as would ordinarily be envisioned under the SERP and the SHERP. Mr Helps explained that critical decision-making for the emergency response was undertaken by National and/or State (Crisis) Cabinets.[147] He described these among the 'key control decision-makers' and said they, rightly, included decisions made by the CHO or the AHPPC, given their expertise in public health.[148]

102. Mr Helps explained:

> … the structure that we set up in Victoria meant that the Chief Health Officer and the Public Health Commander had absolute control of the public health emergency across the entire State, so they were the Incident Controllers for the emergency across the State.
>
> The State Controller — Health role was to complement the public health response by managing the consequences, the broader community consequence, of that emergency. So, my role wasn't to effectively lead the decision-making in regards to public health or national or State policy in regards to the significant restrictions on civil liberties, on international trade, et cetera.[149]

103. Mr Helps agreed in examination that, ordinarily, the EMMV envisaged a decision-making and leadership role for the State Controller. He stated that, in the context of Operation Soteria, the State Controller — Health could not fulfil that role. He added, however, that this was 'well known and well recognised'.[150]

104. Ms Spiteri agreed that, ordinarily, the State Controller — Health would be vested with significant decision-making power under the EM Act, particularly in the context of an emergency such as a bushfire, which is generally a more localised emergency. However, due to the far-reaching nature of the decisions made (in the context of a pandemic), that decision-making was occurring elsewhere, namely at National and State Cabinet levels. She added, however, that there was still a decision-making element to the role.[151]

105. Ms Spiteri accepted that the State Controller — Health's principal responsibility in Operation Soteria was to be operationally accountable for the quarantine of returned travellers.[152] In practice, this meant the State Controllers — Health were responsible for ensuring:[153]

A. there was an appropriate operations plan in place, with clear roles and responsibilities allocated for the Program

B. all necessary structures and governance arrangements were in place to manage the emergency, including the escalation and resolution of issues

C. environmental safety at the hotels. That meant ensuring public health guidance was provided to those in charge of the people on the ground, drawing on the expertise of the Public Health Command.

106. Ms Spiteri was at pains to emphasise that, while she and Mr Helps were in 'direct control' of ensuring that public health resources and advice, including PPE and relevant instructions, physical distancing guidance and behavioural expectations were provided to those working in the Program, it was a complex environment with many players:

> The accountability for the hotel environment was … it was a complex space. You had a hotel that was owned and managed by the hotel company. We were effectively … and I think Ms Williams went to this the other day in her statement … renting space in it, through the Department of Jobs, Precincts and Regions, DJPR. We had our own staff in that … the Department of Health and Human Services had their own staff in that environment, so did DJPR, so did Victoria Police and so did a number of contracted companies as well. So overall the contribution to the safety of the environment was to ensure that there was guidance and instructions provided specifically to this emergency.
>
> …
>
> **But every person working in that environment, from an occ. health and safety perspective, was responsible both for themselves and for complying with those instructions, and also their own organisations as a workplace were responsible as well** (emphasis added).[154]

107. Ms Spiteri explained that public health information was sought from the Public Health Commander and Deputy Public Health Commanders in the Public Health Incident Management Team, and agreed that the information was then 'provided to all parties that were involved in that environment'.[155] She explained that by 'all parties' she meant the employers of those contracted staff working in the Hotel Quarantine Program, as well as the DHHS staff deployed into the hotels.[156]

Deputy State Controllers

108. The role of Deputy State Controller — Health was created on 29 March 2020.[157] It was filled by Mr Eagle and Mr Falconer, both of DELWP.[158] The role ceased on 1 May 2020, when Operation Soteria moved from the SCC to the EOC.[159]

109. The Deputy State Controller — Health position was created specifically to enact the role of the Controller of Operation Soteria.[160] This position was in the 'control line', meaning that each agency with responsibilities designated under the *Operation Soteria Operations Plan* was thereby accountable to the Deputy State Controller — Health.[161] However, notwithstanding the description of his role, Mr Eagle saw it differently and described his role as 'a coordinator between the agencies and the State Controller — Health'.[162] He agreed that the model deployed had a line of command whereby each agency had an Agency Commander at its head and those Agency Commanders would then escalate information through to him as the Deputy State Controller — Health.[163] He would then coordinate and escalate those issues to the State Controller — Health.[164]

110. Mr Eagle explained that he did not make decisions in relation to public health matters.[165] He said that he reported to the State Controller — Health and escalated questions and issues from other agencies working in the Program, including a significant number of queries relating to public health issues, but had no interaction with the broader DHHS arrangements.[166] When it was put by Counsel Assisting, Mr Eagle agreed that his:

> … role as Deputy State Controller — Health had 'health' in the title but what [he was] really doing was coordinating the logistical arrangements of the program, rather than also coordinating in any hands-on sense the delivery of public health services or public health expertise.[167]

111. Mr Eagle said that the Deputy State Controller — Health role had no power delegated under any act, and all activities he undertook, or directions given, were on the direction of (and, thus, pursuant to the powers vested in) the State Controller — Health. No one reported to him and he was only there for information flow between Agency Commanders and the State Controller — Health.[168]

112. Mr Eagle gave evidence that, during the course of the operation, it was common practice for conversations to occur, and directions to be given, directly between the DHHS State Agency Commander and the State Controller — Health or from other Agency Commanders directly to the State Controller — Health (leaving out the Deputy State Controller — Health). When asked if this made his role more difficult, Mr Eagle said that it did not. He said that this process made passing on information more efficient, without it being filtered through him.[169] Mr Eagle's evidence demonstrated a disjunct between his title and the apparent intention of the role and any apparent role in the chain of command relating to a 'health' input beyond being a conduit for information to the State Controller — Health.

113. In any event, the role of Deputy State Controller — Health changed with the establishment of the EOC in mid-April. The Deputy State Controller — Health assisted in supporting the Commander, Operation Soteria (Ms Williams and Ms Bamert) in this transition, but Mr Eagle said he had little to do with the EOC because the position of Deputy State Controller — Health was discontinued once the transition to the EOC was completed.[170]

8.2.5 Establishment of Emergency Operation Centre (EOC)

114. From the early days in Operation Soteria it was recognised that the Hotel Quarantine Program would be in place for likely up to 12–18 months.[171] The emergency management response arrangements were not something designed to be maintained long-term, and it was determined that the Hotel Quarantine Program should transition from an emergency operation to a departmental program.[172] Over the following weeks, a plan was created to transition the Program to be led by the DHHS COVID-19 Accommodation Commander, Ms Williams.[173]

115. From 16–17 April 2020, the Hotel Quarantine Program operations team moved from the SCC to the DHHS office in Fitzroy, where the EOC was established for the purpose of running the Hotel Quarantine Program.[174]

116. Both Ms Williams and Ms Bamert described the COVID-19 Accommodation Commander role as one of responsibility for the chain of command ***within*** DHHS, as it related to the department's obligations to Operation Soteria.[175]

117. As the COVID-19 Accommodation Commander positions were within DHHS, they reported up the line to the Deputy Secretary, as did the State Controllers — Health (that is, they shared a common reporting line).[176] The COVID-19 Accommodation Commander was the State Controller — Health's avenue into the Hotel Quarantine Program.[177] Ms Spiteri stated, after Operation Soteria shifted to the EOC, that the State Controller — Health roles were still positioned at the SCC, overseeing the entire COVID-19 response.[178]

118. Ms Bamert said that, as Commander, Operation Soteria, she was:

> … responsible for the day-to-day management of Operation Soteria … providing strategic and operational direction and leadership to Operations in the fulfillment of the Department's command, relief and health coordination responsibilities … providing operational leadership for returning passengers from arrival at the airport, whilst quarantined in the hotels, until exit.[179]

119. Ms Bamert described this as including 'operationalising' the public health policy developed by the CHO and Public Health Command, as well as coordinating activities for which other agencies were responsible.[180]

120. Ms Williams described her role as Commander, Operation Soteria in the following terms:

> So our Department had responsibility for the broad, if you like, the broad policy environment in which Hotel Quarantine was operating, so we were working with our public health and wellbeing colleagues around the broader policy environment in which Hotel Quarantine was operating. So, we were then operationalising those policy requirements, and we had staff in all the hotels, and our staff in the hotels were essentially overseeing what was happening in the hotels and helping to support guests in all their needs and ensuring that the hotels were operating appropriately. They would feedback to me through the operations leads and the Deputy Commanders any issues that were occurring. So, we were essentially dealing with quite a complex environment that was changing quite rapidly. We developed a set of procedures and protocols, and the support agencies would refer to us for guidance and policy advice around the functions that they were performing.[181]

121. Ms Williams and Ms Bamert gave evidence that their roles included ensuring that relevant advice, guidance, policies and procedures from within DHHS were implemented in the hotels. It was also their evidence that, in some cases, it was the responsibility of others to undertake that same task and it was those others, therefore, who were vested with responsibility for ensuring adequate implementation. During examination, Ms Williams was asked, in the context of cleaning policies for the hotels, whether it was the responsibility of DHHS to bring those specific policies to the attention of the hotels. Ms Williams ultimately asserted that it was not DHHS's responsibility but, rather, the responsibility of DJPR or the hotel contractors themselves.[182]

122. Dr van Diemen was asked to comment on the responsibilities of the Commander, Operation Soteria as outlined in the *Operation Soteria Operational Plan* where it is said that the 'DHHS Commander COVID-19 Accommodation is responsible for … ensuring a safe detention at all times'.[183] In response, Dr van Diemen said:

> I think, looking at that point in retrospect, it could be interpreted that the DHHS Commander was responsible for the safe detention environment of individuals in hotel quarantine, or it could be interpreted that the Commander is responsible for the overarching hotel quarantine environment.[184]

123. This lack of clarity and consistency as to the nature of the roles, reflected both in the documentation guiding Operation Soteria and in the subjective understanding of those involved as to the limits of their accountability in the Hotel Quarantine Program, unfortunately, was a repeated theme, which I discuss further below in Section 3.

Role of the Chief Health Officer in the Hotel Quarantine Program

124. For the purposes of a response to a Class 2 emergency, the SHERP envisaged that public health expertise would be embedded in the command structure of the health emergency response by appointment of the CHO to the role of State Controller. The non-appointment of Prof. Sutton as State Controller — Health, his views about that and the impact of it are dealt with from paragraph 254 below.

125. As CHO, Prof. Sutton was responsible for the Public Health Command structure, including the Public Health Incident Management Team.[185] In that role, he was vested with capacity to raise issues directly with the Minister for Health and the Secretary to DHHS.[186] However, it was Prof. Sutton's evidence, emphasised particularly in two affidavits produced following the close of the evidentiary hearings, that, despite those accountabilities, he and Public Health Command 'were not in day-to-day decision-making roles'[187] and, as such, were somewhat disenfranchised in the running of the Program.

126. Prof. Sutton gave evidence that one of his key areas of focus in the COVID-19 pandemic emergency response was in relation to his membership on the AHPPC and attendance at almost daily meetings of the AHPPC since mid-February 2020. In this capacity, he contributed to the nationwide response to the pandemic, including through the preparation of briefings and recommendations.[188]

127. He described his other areas of responsibility in relation to the pandemic, more generally, as:[189]

    A. playing a leading role in public communications in relation to the government-controlled measures (the directions and the enforceable requirements)

    B. providing advice, taking into account AHPPC recommendations, on COVID-19 and appropriate mitigation measures and the matters they address in their public statements and in Victoria, by advising the Minister for Health, the Premier and the CCC on policy settings for key public health issues

    C. making decisions on critical matters, normally raised with him by the DCHOs, usually where something was of high consequence and/or importance, or otherwise contentious or sensitive and therefore escalated to him.

128. Dr van Diemen gave evidence that, because the emergency response to the pandemic required the exercise of powers contained in the PHW Act, under which the CHO is the 'primary person', she continued to report to the CHO in her capacity as Public Health Commander because, 'it was made clear that [the CHO], regardless of whether he was the State Controller, would retain control over and ultimate responsibility for the public health response'.[190]

8.2.6 Structure and function of Public Health Command (Public Health Incident Management Team and, later, COVID-19 PHC Division)

129. Prof. Sutton gave evidence that the size and structure of the DHHS Public Health Team evolved over time due to the COVID-19 response.[191]

130. Dr van Diemen explained that the Public Health Incident Management Team is an emergency management structure that was 'stood up' in response to an incident.[192] The Public Health Incident Management Team was stood up in respect of the COVID-19 pandemic emergency and as 'the incident' continued and multiplied, it became necessary for the structure of the Public Health Incident Management Team to develop into a more regular government structure.[193] That structure became the COVID-19 PHC Division.

131. Ms de Witts described the key functions of the COVID-19 PHC Division as follows:[194]

    A. Case, Contact and Outbreak Management, which was responsible for undertaking contact tracing and responding to outbreaks

    B. Intelligence, which was responsible for undertaking surveillance, epidemiological modelling, informatics and situational reporting

    C. Physical Distancing, which was responsible for formulating the public health directions required to manage the virus (but not for compliance with those directions, which was managed by the Enforcement and Compliance branch within the Regulation, Health Protection and Emergency Management Division)

    D. Pathology and IPC Policy, which was responsible for advising on testing issues, working with public and interstate laboratories and research institutions, setting overarching IPC policies for the State, providing cleaning and personal protective equipment (PPE) policies (available publicly on the department's website) and providing specific advice on complex settings

    E. Public Information, which was responsible for providing communications for the Victorian community and health and human services sectors on the COVID-19 pandemic (which included content input from the other teams as needed)

    F. Public Health Operation Coordination, which was responsible for providing corporate services (such as finance support, HR support, procurement and rostering) to the Division.

132. Each of the Deputy Public Health Commanders reported to the Public Health Commander who, in turn, reported to the CHO.[195]

Role of the Public Health Commander

133. Dr van Diemen's usual role was DCHO – Communicable Diseases. This role sits in the Health Protection Branch of DHHS.[196] In the context of the COVID-19 pandemic emergency, she was also the Public Health Commander (as described above). In each role, she was required to report to Prof. Sutton as CHO.[197]

134. Dr van Diemen also had functions under the PHW Act, separate from her role as Public Health Commander and as DCHO. She was delegated a number of the CHO's powers pursuant to instruments of delegation and was also an Authorised Officer under the PHW Act.[198] It was in that latter capacity that she issued detention directions under the PHW Act, which gave the legal bases for the Hotel Quarantine Program. While Dr van Diemen signed the directions identifying her role as the DCHO, she explained in her evidence:

> So all of the directions were issued as an authorised officer. The fact that I was Deputy Chief Health Officer was, I suppose, inconsequential to the issuing of directions, but as an authorised officer, yes, I did issue a large number of other directions both in terms of the primary issuing of the direction and in terms of re-issuing of directions as the State of Emergency was extended on a number of occasions.[199]

135. The SHERP describes the role of the Public Health Commander as follows:

> The Public Health Commander reports to the State Controller and is responsible for commanding the public health functions of a health emergency response (including investigating, eliminating or reducing a serious risk to public health).
>
> Performing the function of Public Health Commander does not alter in any way the management, control and emergency powers of the Chief Health Officer under the PHW Act.
>
> In performing this function, the Public Health Commander will liaise directly with the State Health Commander and State Health Coordinator.
>
> For emergencies where the Public Health Commander is not appointed the State Controller, the Chief Health Officer's authority under the PHW Act remains unaffected, and their decisions on matters of public health should not be overridden by a State Controller.[200]

136. In final submissions, DHHS contended that, as the Public Health Commander led the Public Health Incident Management Team, Dr van Diemen '[sat] between the emergency and the Public Health Teams and provided direct input into decision-making as a member of the State Control Team'.[201]

137. Somewhat at odds with that submission, Dr van Diemen gave evidence that, despite what is said in the SHERP, and despite the various governance structures placing the Public Health Commander in the State Control Team with a direct line of report to the State Controller — Health,[202] in practice she did not report to the State Controller — Health but reported to the CHO and, instead, fulfilled an advisory role to the State Controller — Health.[203] She described her role as Public Health Commander in respect of the Hotel Quarantine Program as:

> Under SHERP, where DHHS is the control/lead agency, as it is for the current emergency, the PHC is responsible for commanding the public health functions of a health emergency response (including investigating, eliminating or reducing a serious risk to public health). The hotel quarantine program was not a public health function but an emergency management function and response relating to a health emergency. As such, my functions as PHC in relation to the hotel quarantine program related to the issuing of directions as delegate of the CHO (although that role is not undertaken in the capacity of PHC); and as PHC, issuing guidance and advice relating to COVID-19, and setting policies and procedures to address the health and wellbeing of returned travellers. The State Controller has oversight for the implementation of that advice, guidance, policies and procedures.[204]

138. Prof. Sutton agreed in his evidence that there was no clear or direct reporting line from Public Health Command into Operation Soteria. Specifically, in respect of Dr Romanes, Prof. Sutton observed:

> The Deputy Public Health Commanders, all four of them, reported to the Public Health Commander, who reported to me. So, I wouldn't say that it's a report directly into the State Controller, but Dr Romanes, in particular, was engaged in advice on policy and other guidance matters to Operation Soteria more than most. But it was a … it was more in the liaison role than a direct line of command.[205]

139. However, in Prof. Sutton's later affidavit evidence he said:

> While Dr van Diemen as DCHO reported to me as CHO, she also reported to the State Controller in her role as Public Health Commander in Operation Soteria. In this way, the command roles for the Hotel Quarantine Program were not in the Public Health – Incident Management Team but were under the State Controllers within the emergency management framework.[206]

140. The role of the Public Health Commander as envisaged in the SERP and SHERP reflects the intention that there be a strong public health focus in the response to any health emergency. The actual role that Public Health Command did have, and the role that it should have had, is discussed in greater detail below in Section 8.3.

Infection Prevention and Control (IPC)

141. Dr Katherine Ong was the Deputy Public Health Commander Pathology and Infection, Prevention and Control. In early April 2020, Dr Ong established an Infection Prevention and Contol Cell (IPC Cell) at the request of Dr van Diemen (as Public Health Commander).[207] As I have described earlier, in Chapter 7, the IPC Cell was initially staffed by **one** DHHS IPC Consultant, along with two part-time IPC consultants. The IPC Cell expanded over time, with two additional part-time IPC consultants joining in mid-April 2020 and a further part-time consultant joining in mid-May 2020.[208]

142. However, Dr van Diemen gave evidence that, at the time of a request from Operation Soteria in early April 2020 to the 'infection control' team, that team consisted of one person.[209] Later in her evidence Dr van Diemen explained:

> At the beginning of the pandemic, there was a single person who was employed as an IPC consultant for public health matters specifically in my team in communicable diseases. That person, obviously when COVID started, was primarily working or entirely working on COVID, and we have since employed a number of other people into the Incident Management Team or into the public health operations for COVID. But at that time there was a single person. I believe there's one other person in the Department who is an IPC consultant who joined us, and I would have to check at what point she did, but she wasn't employed as such in her substantive role in the Department.[210]

143. The DHHS IPC Consultant gave evidence that she had no formal role in the Hotel Quarantine Program and the IPC Cell was only responsible for providing advice and guidance from time-to-time as queries from those working in the Hotel Quarantine Program were received.[211] Prof. Sutton's evidence echoed that of the Consultant. He explained that the IPC Cell, through the Public Health Incident Management Team, provided advice:

> … to innumerable settings across the State, from public transport settings to residential settings to various other settings, and so oversighting how that guidance or policy direction was implemented across the State in all of those settings was not part of our purview.[212]

144. DHHS, subsequently, engaged an external IPC consultant through Infection Prevention Australia to assist with providing IPC advice to the Hotel Quarantine Program.[213] The arrangement commenced around the time that the Rydges Hotel in Carlton was established as a 'hot hotel'.[214] Dr van Diemen gave evidence that the advice produced by Infection Prevention Australia was only looked over by DHHS's internal team but developed by the external person for the Hotel Quarantine Program.[215]

145. Further discussion of the IPC advice and training that was implemented in the Hotel Quarantine Program and, in particular, in relation to the hot hotels, is contained in Chapter 9.

Case, Contact and Outbreak Management

146. Dr Simon Crouch and Dr Clare Looker fulfilled the role of Deputy Public Health Commander Case, Contact and Outbreak Management (CCOM) within the Public Health Incident Management Team; a role that was shared on a rostered basis.[216]

> The Public Health Incident Management Team, led by the Public Health Commander, has responsibility for the public health management of COVID-19 cases and outbreaks. When an outbreak is identified, an Outbreak Management Team (OMT) will be constituted under the guidance of the Deputy Public Health Commander Case, Contact and Outbreak Management (DPHC CCOM).[217]

147. According to the Outbreak Management Plan, the core members of an OMT included the Outbreak Lead, who reports to the Deputy Public Health Commander, CCOM (Dr Crouch and Dr Looker), the Case and Contact Management Lead and the Epidemiology Lead, who both report to the Outbreak Lead, and the DHHS Agency Commander who represented the State Controller — Health and an Outbreak Squad Coordinator. [218]

148. Under the Outbreak Management Plan, an OMT is to be created in respect of each outbreak that occurs. Each OMT is led by an Outbreak Lead with responsibility for overseeing the outbreak response.[219] Dr Sarah McGuinness stated that she had the overall role of 'Outbreaks Lead', which is distinct from the role of Outbreak Lead for a specific outbreak, despite the near-identical title.[220]

149. Dr Crouch explained that Outbreak Squads were established by the Outbreak Squad Coordinator, if deemed necessary by the OMT.[221] The Outbreak Squad was the 'eyes and ears on the ground'.[222] It was required to report back to the OMT and provide advice on the ground, including in relation to IPC, PPE and cleaning.[223]

150. Dr Crouch stated that, while the Outbreak Lead for an OMT should be required to directly report to the Deputy Public Health Commander CCOM, it was decided that the Outbreak Squads would report directly to Ms de Witts, as Deputy Secretary, COVID-19 PHC Division and not via the Deputy Public Health Commander CCOM, who were also, separately, reporting at that time to Ms de Witts.[224]

151. A detailed discussion of the outbreaks that occurred at the Rydges and Stamford hotels is contained in Chapter 9.

Strategy and Implementation (Planning)

152. Dr Romanes was the Deputy Public Health Commander, Strategy and Implementation (also known as Deputy Public Health Commander – Planning).[225] The responsibilities of the Deputy Public Health Commander – Planning included responsibility for the Physical Distancing Cell. The functions and role of the cell were to advise the Public Health Commander and to provide evidence and an informed policy rationale for decisions. The cell also prepared and consulted on policy and procedures.[226]

153. While Dr Romanes, as Deputy Public Health Commander – Planning, was not directly involved in Operation Soteria, Prof. Sutton described him as being engaged in advice on policy and guidance matters to Operation Soteria 'more than most'.[227] Dr Romanes's statement includes a reference to this in his description of his role as Deputy Public Health Commander – Planning:

> As DPHC Planning, I took an active role in advocating on behalf of the PHC/DCHO and CHO for a central location for all plans that drive actions and an involvement by Public Health Command in the operational structure for the hotel quarantine program, including recommending clear governance, clear lead roles, and comprehensive operational plans to assist officers and detainees. In mid-April it was decided between the PHC/DCHO and the State Controller that the Public Health – Incident Management Team would be responsible for providing policy and procedures and the Emergency Operation Centre would be responsible for implementing those procedures.[228]

154. It seems that it was around this time (that is, mid-April 2020) when Dr Romanes's active involvement (as described) lessened.[229]

155. Dr Romanes stated that his team's role in the Hotel Quarantine Program was most active up until about 15 April 2020.[230] In this period, his team developed a range of policies and procedures, including the draft *COVID-19 DHHS Physical Distancing and Public Health Compliance and Enforcement Plan*[231] and the *COVID-19 Interim Healthcare and Welfare Mandatory Quarantine plan* — a single policy addressing the healthcare and welfare of people in mandatory quarantine.[232]

156. However, like other members of Public Health Command, it was Dr Romanes's evidence that he was not responsible for **implementing or overseeing** those procedures, and that work was to be carried out by the DHHS run EOC.[233]

8.2.7 On-site at Quarantine Hotels

157. There was a range of personnel on-site at any given time at each of the hotels engaged in the Hotel Quarantine Program, including hotel staff, cleaning contractors, nurses and doctors from various agencies, security guards contracted and subcontracted and some employed by hotels, specialised cleaning contractors, DJPR staff and DHHS staff including Authorised Officers and Team Leaders. A central question during the Inquiry was not only who was in charge of the operation of the Hotel Quarantine Program overall, but who was in charge at each of the sites. DHHS as the control agency and the department that held the legal powers to detain people in quarantine had an on-site presence reposed in two roles: Team Leaders and Authorised Officers.

DHHS TEAM LEADERS

158. The evidence of Ms Williams was that DHHS Team Leaders were on-site every day from early in the morning to late in the evening. She explained they had a roving person overnight and that there was an Authorised Officer on-site at all times.[234] Ms Bamert agreed that as Commander, Operation Soteria, part of her role was to provide leadership to the DHHS Team Leaders, and to enable them to report through the Operation Soteria command structure as required.[235]

159. Ms Williams gave evidence that many of the DHHS Team Leaders had worked in previous emergencies and, therefore, had some training.[236] This included staff from within DHHS as well as those from other government departments.[237] However, in her evidence, Ms Bamert conceded that Team Leaders were recruited from a range of backgrounds[238] and that she had concerns about DHHS's capacity to provide 'suitably skilled' personnel.[239]

160. Ms Williams gave evidence about how public health advice was 'operationalised' in the Hotel Quarantine Program, explaining that EOC operational staff attended on-site at the hotels and worked with DHHS Team Leaders on the ground.[240]

161. While Ms Williams described the role of DHHS Team Leaders as being to coordinate and problem solve,[241] she also noted that significant reliance was placed on contractors operating in the Hotel Quarantine Program. She explained:

> So there were a range of people who were operating according to their contractual obligations and their understanding of their responsibilities and they had managers. And our team leaders were there to coordinate the issues, to ensure that guest issues were dealt with promptly, and that the hotel was operating well. If there was a hotel issue, they would deal with the hotel manager on a day-to-day basis. If it was a significant issue, they would go to the DJPR site leader. Those site leaders, as I mention in my statement, were there initially quite a lot and then they were remote at other times. So as the program went on, they were more remote. They would deal, if there were security issues, they would deal with the security team leader. If there were bigger problems than they could deal with on-site, they would escalate either to DJPR or they would come through us in the Emergency Operation Centre.[242]

162. Ms Williams was asked whether she would, based on her explanation above, characterise the Team Leaders as being 'in charge' on-site, to which she responded that the term was 'somewhat loaded' in the context of the Inquiry.[243] She described the Team Leaders as being 'our representatives on-site'.[244] She went on to say:

> This was an environment where the usual things that you do to develop a team weren't possible. Sitting close to one another and sharing stories and being able to have team meetings were all more difficult. So it was a difficult environment but the team leader was our representative on the site. They worked closely with other people. The hotel managers were managing their hotel. Security companies had team leaders on-site who were managing their operation. DJPR was overseeing that side of it. We had our nurses and mental health nurses, et cetera, and the coordination came through our team leader.[245]

163. Ms Bamert described the role of the Team Leaders as being to:

> … coordinate people on the ground and to really support processes, to make sure that the nurses had anything they needed, to be a conduit back into the command structure, to, you know, provide us with any evidence of the risk or, you know, any concerns that they might have had that we could look for systematic failures. So, you might have an issue at one hotel, is that pre-empting other issues at other hotels? It was to work very closely with the DJPR site leader as well to look at implementing the policies that were written.[246]

164. Noel Cleaves, Senior Authorised Officer, gave evidence that, in some cases, the DHHS Team Leaders did dictate operations on the ground in hotels. For example, he said that operational decisions, such as the suspension of all fresh air breaks, were communicated to Authorised Officers (via emails or verbally) by the DHHS Team Leaders.[247] He went on to observe that 'the hotels, for the time I was involved in the program, did not run as a classic pyramid organisational structure … it wasn't as clear as there was one person who had ultimate authority for everything that happened inside that hotel'.[248] Mr Cleaves went on to explain, consistent with Ms Williams, that 'the DHHS team leaders had a coordination function and performed that well but they did not have operational control over authorised officers'.[249]

165. Murray Smith, who held the position Commander, COVID-19 Enforcement and Compliance, gave evidence that the DHHS Team Leaders were the 'port of call for services provided by DHHS' and that, for functions falling outside of those services, other Departments had site managers in the hotels.[250]

166. Jan Curtain of Your Nursing Agency said, in her evidence, that 'DHHS would appoint a Team Leader for each shift who would be in charge of each hotel during that shift'.[251] Likewise, Eric Smith of SwingShift Nurses gave evidence that the DHHS Team Leaders had the 'responsibility for ensuring health and safety risks were properly managed'.[252]

167. The evidence of Ms Williams and Ms Bamert was that DHHS Team Leaders performed a coordination function in the hotels but that should not be characterised as evidence that Team Leaders were 'in charge'. Despite this, the perception of some other witnesses, who were on the ground in hotels and who were not DHHS employees, was that DHHS Team Leaders were in charge of the Program at the hotel sites.

AUTHORISED OFFICERS

168. Authorised Officers are common across the Victorian Public Sector. Agencies with regulatory functions often appoint officers as Authorised Officers to exercise compliance and enforcement functions under the legislation administered by those agencies.

169. Authorised Officers, for the purposes of the PHW Act, may be appointed by the Secretary to DHHS under s. 30(1) of that Act. Only public servants (that is, those people employed under Part 3 of the *Public Administration Act 2004*) may be appointed as Authorised Officers under s. 30(1), with s. 106(i) of the *Public Administration Act 2004* (Vic) expressly precluding police officers employed pursuant to the *Victoria Police Act 2013* (Vic) from the Act's operation. Accordingly, members of Victoria Police are not eligible for appointment as Authorised Officers for the purposes of the PHW Act.[253]

170. Appointed Authorised Officers can exercise the general powers and functions conferred on them under Part 9 of the PHW Act. Those powers include entry, search and seizure powers that may be exercisable for certain limited purposes, including investigating whether there is a risk to public health or to manage or control a risk to public health,[254] or to monitor compliance with the PHW Act or its regulations, or to investigate a possible contravention of the PHW Act.[255]

171. Authorised Officers may be further authorised to exercise specific powers in the case of a risk to public health. Section 189(1) of the PHW Act provides that, if the CHO believes it is necessary to do so to investigate, eliminate or reduce a risk to public health, the CHO may authorise Authorised Officers appointed by the Secretary (or a class or classes of authorised officers appointed by a specified Council or Councils) to exercise any of the public health risk powers. Those powers are set out at s. 190(1) of the PHW Act.

172. Under s. 199(2) of the PHW Act, the CHO may, for the purpose of eliminating or reducing the serious risk to public health, also authorise Authorised Officers appointed by the Secretary (or a class or classes of authorised officers appointed by a specified Council or Councils) to exercise any of the public health risk powers and 'emergency powers'.

173. The 'emergency powers' are set out at s. 200(1) of the PHW Act. They are to:

> a. subject to this section, detain any person or group of persons in the emergency area for the period reasonably necessary to eliminate or reduce a serious risk to public health;
>
> b. restrict the movement of any person or group of persons within the emergency area;
>
> c. prevent any person or group of persons from entering the emergency area; and
>
> d. give any other direction that the authorised officer considers is reasonably necessary to protect public health.

174. Section 200(2)–(8) of the PHW Act sets out the requirements that must be satisfied by Authorised Officers when exercising the emergency powers under s. 200(1). One of those requirements relates to reviews of detentions under s. 200(1)(a).[256] Section 200(6) of the PHW Act provides:

> … an authorised officer must at least once every 24 hours during the period that a person is subject to detention under subsection (1)(a) review whether the continued detention of the person is reasonably necessary to eliminate or reduce a serious risk to public health.

175. Section 203 sets out heavy penalties for a person who refuses or fails to comply with a direction given to a person or a requirement made of the person, in the exercise of a public health risk power or an emergency power; a person subject to a direction to quarantine, for example, may be fined up to almost $20,000 for failing to comply with a direction.[257]

176. The fundamental role of the Authorised Officers in the Hotel Quarantine Program was to exercise those powers conferred on them by the PHW Act to give effect to the detention direction notice issued by the DCHO as an Authorised Officer. It was the detention direction notice issued by Dr van Dieman as an Authorised Officer that compelled people into detention in hotel quarantine, dealt with applications for temporary leave or exemption from quarantine and authorised the discharge of people at the end of their mandatory stay in quarantine.

177. Mr Cleaves described the role of the Authorised Officer as 'to manage the compliance aspects of the Hotel Quarantine Program, that is to ensure compliance with the detention direction notices that have been issued to all of the incoming international passengers'.[258] In his evidence, Mr Cleaves stated that the role of Authorised Officers was heavily focused on (amongst other things) understanding and interpreting detention direction notices, and making reasonable judgements about the appropriate ways to deal with instances of non-compliance.[259]

178. The roles of Authorised Officers, as described by Mr Smith and Mr Cleaves, were consistent with the role of Authorised Officers as described in DHHS policies issued to Authorised Officers. By 30 April 2020, around a month after Operation Soteria was established, the role of the Authorised Officer within hotels was set out in the *Annex 1 – COVID-19 Compliance Policy and Procedures–Detention and Authorisation* document (Annex 1).[260]

179. Annex 1 described the Authorised Officer's role in terms of monitoring compliance as to 'provide oversight and ensure compliance with the direction and detention notice'.[261] The specific roles and responsibilities in doing so included:[262]

    A. check that security are undertaking floor walks to encourage compliance and deter non-compliance

    B. oversee and provide advice on compliance related issues (including to respond to requests from security to address compliance and to seek assistance from security or Victoria Police to support compliance efforts)

    C. administer permission to leave and monitor compliance

    D. raise any exemption requests with the Authorised Officer Team Leader in the first instance.

180. Annex 1 also gave specific guidance as to the scope of the role of the Authorised Officer. It said that Authorised Officers 'should be aware that their role and scope is related to administration of, and compliance with, the direction and detention notice under the [PHW Act]'.[263]

COMMANDER COVID-19 ENFORCEMENT AND COMPLIANCE

181. Mr Smith stated that, in his role as Commander, COVID-19 Enforcement and Compliance, he was responsible for the entire enforcement and compliance command structure. This included supervision of all Authorised Officers, Authorised Officer Team Leaders and Senior Authorised Officers.[264] Mr Smith reported to the State Controller — Health throughout his involvement in the Hotel Quarantine Program,[265] rather than to the Accommodation Commanders of Operation Soteria.

182. In response to questions about the on-site role of Authorised Officers, Mr Smith gave evidence that his role was limited to exercising powers under s. 200(1) of the PHW Act, including serving detention notices on returning travellers, ensuring compliance with those notices, managing permissions and exemptions and, ultimately, approving people's release at the end of their detention.[266] Mr Smith said that Authorised Officers had no role in supervising any other staff at the hotel, including security staff or in overseeing IPC or the use of PPE at the hotels.[267] He advised that the person in charge of overseeing those functions generally was the Commander, Operation Soteria through the DHHS Team Leader,[268] a role distinct, and in a separate line of command and reporting, from the roles of the Authorised Officers and Authorised Officers' Team Leader and, indeed, himself.

183. Claire Febey, Executive Director, Priority Projects at DJPR gave evidence that she thought that the work of overseeing security should have been under the direction of Authorised Officers as representatives of DHHS.[269] Ms Febey explained that she held this view because the people in quarantine were being held on the legal authority of the Authorised Officers, as delegates under the PHW Act, with the role of security being to support those Authorised Officers in the exercise of the legal powers vested in them.[270]

184. Mr Smith's evidence was, however, that despite Authorised Officers operating as delegates of the DCHO, and despite what is set out in Annex 1 at paragraph 179, they played no part in the oversight of those people who were engaged in ensuring enforcement of that detention (namely, the security guards).[271] His evidence indicates that Authorised Officers played no part in ensuring the safety of the environment in which those people were detained, that is, ensuring compliance with IPC and PPE protocols.[272]

Section 8.3 — Analysis and conclusions: faults and shortcomings within the DHHS response

185. Having now discussed the manner in which DHHS interpreted, structured and performed its work in the Hotel Quarantine Program, this section focuses on how that approach ultimately impacted the operation of the Hotel Quarantine Program.

186. As noted in the introduction to this Chapter, there is no doubt that DHHS staff who worked within the Hotel Quarantine Program (whether in leadership positions or on the Program's frontlines or in providing advice and guidance) worked long hours, under enormous pressure, likely at a cost to their own wellbeing. I accept that individuals working within the Hotel Quarantine Program acted in good faith and with good intentions and performed their roles under immense pressure with stretched resources.

187. Notwithstanding this, there were significant systemic flaws and shortcomings within the DHHS response that affected the Program's capacity to achieve its objectives. These are the subject of this section.

8.3.1 The 'control agency' function and the Hotel Quarantine Program

188. As has been set out previously, within 24 hours of National Cabinet's decision to direct all international arrivals into quarantine for 14 days, the Hotel Quarantine Program was being developed to align with Victoria's emergency management framework. This decision was understandable at the time, given a public health emergency had been declared. As described in Section 8.1 of this Chapter, within Victoria's emergency management framework different types of emergencies are given classifications that are intended to then direct that the agency with the recognised expertise to deal with that class of emergency becomes the designated **control** agency.

189. There was no controversy as to the classification of this emergency as a Class 2 public health emergency. Further, there was no controversy over which agency therefore became the 'control agency'. It was DHHS as the agency responsible for public health in this State, as the name of that Department quite clearly contemplates, and the emergency management framework designates. Indeed, by the second iteration of the Operation Soteria Plan, developed on 28 March 2020, DHHS was designated as the control agency with operational command for each phase of the Program.[273] Where the controversy lay was in the interpretation of what it meant to be the '**control** agency'.

190. DHHS accepted that it was the control agency for the overall response to the COVID-19 pandemic. DHHS appeared to accept that its responsibilities included the control of the identified hazard, which, in the context of the pandemic response, was the virus.[274] However, the precise functions and responsibilities of DHHS as control agency in the context of the Hotel Quarantine Program were matters of deep disagreement before the Inquiry.

DHHS executive view of the meaning of 'control agency' was qualified by it being a 'complex emergency'

191. A theme of the evidence from DHHS witnesses (from the Minister through to the executive and into the frontlines of the Operation) that emerged throughout the Inquiry was that their Department was not 'in charge' or 'in control' of the Hotel Quarantine Program overall, as their interpretation of being a 'control agency' should be seen through the lens of the Hotel Quarantine Program being a 'complex' emergency within the meaning of the emergency management framework. This, it was said, meant the role of DHHS was a 'coordinator' or 'collaborator' and not a 'controller'. The senior executive, indeed, through to former Minister Mikakos, interpreted the concept of 'control agency' as meaning that DHHS had a 'shared accountability' with the range of other agencies participating in the delivery of the Hotel Quarantine Program. It had some responsibilities and accountabilities but was not in control of the Hotel Quarantine Program overall.[275]

192. The essence of the Departmental witnesses' evidence was that the 'control agency' role required coordination of the multi-agency approach, as conceived in the concept of a 'complex emergency' that resulted in all agencies involved having a shared accountability for the overall delivery of the Program.[276]

193. Ms Peake gave evidence that the role of DHHS,[277] as the control agency, was 'to provide operational control by ensuring appropriate governance was in place, to facilitate sharing of intelligence, enable escalation and resolution of operational issues'.[278] She said that DHHS's role was to bring together all departments and agencies with defined roles and responsibilities as part of the Hotel Quarantine Program.[279] She further stated that, as the control agency, DHHS worked to 'coordinate the input of all relevant departments and agencies'.[280]

194. Ms Peake gave evidence that, although DHHS was the control agency in emergency management terms, this was classified in emergency management terms as a 'complex emergency', stating:

> … the scale and complexity of this operation means that there have had to be capabilities and skills and legal powers and resources from every Department that have been brought to bear, some of which fit within the scope of [the EMMV] and an emergency management multi-agency response, some of which are just relevant to the normal functions of each department administered under the *Public Administration Act* and *Financial Management Act*, and for parts of the response, the role of the control agency has been to determine who should be the appropriate lead.[281]

195. When pressed on the EMMV language of the need, even in a complex emergency, for there to be a single agency responsible for the collaborative response, Ms Peake responded that DHHS 'As the control agency, was responsible for determining for each of the operations that it was clear, the scope was clear, the roles and responsibilities was clear and the governance was clear, yes, that is my evidence'.[282]

196. Ms Skilbeck gave evidence the effect of which was that the term 'control agency' caused confusion. She explained:

> The key role in the control agency in something as big as this particular emergency, 'control agency' becomes something of a misnomer where really most of the activity is coordinating across the array of agencies and departments that have come together to respond as fulsomely as the Victorian public sector can to this emergency. So, it is both control in a very specific sense of the word, the public health response to a novel coronavirus; and the coordination role … little c 'coordination', to make the distinction, because I think 'Coordination' is defined in the SERP as well … but coordination across the many agencies that have come to support the response.[283]

197. The understanding proffered by Ms Skilbeck was consistent with that of former Minister for Health Mikakos, who expressed a view that control agency was a 'highly misunderstood' term and the fact that DHHS was the control agency 'doesn't mean that DHHS had control as such'. Former Minister Mikakos said 'I think the best way to understand it is a coordination role. And the Hotel Quarantine Program was a multi-agency response with shared accountability. There were many Departments and agencies involve'.[284]

198. Former Minister Mikakos, consistent with Ms Peake's evidence, identified two roles for DHHS in the Hotel Quarantine Program, which were to (a) provide the legal framework for the detention notices that compelled people into quarantine and (b) to provide for the health and wellbeing of those people in quarantine.[285]

199. This view that DHHS did not have overall responsibility for the Hotel Quarantine Program was echoed by those Departmental employees working closer to the frontlines of the Program. As noted above, when Ms Williams was asked during her evidence who was 'in charge' of the hotel sites in the Program, her response was that the terminology 'in charge' was 'somewhat loaded' in the context of the Inquiry.[286]

200. The framing, interpretation and impact of the term 'multi-agency' response was consistent through the DHHS management witnesses. The two appointed State Controllers — Health, Mr Helps and Ms Spiteri, gave evidence about their understanding of the emergency management language of 'command', 'coordination' and 'control'. Mr Helps noted that 'there was a lot of coordination in the role'[287] as did Ms Spiteri, who stated, when describing her role as State Controller that it 'became one of overall co-ordination of the implementation of both Chief Health Officer and government decisions and directions across government agencies, through the operational arrangement for COVID-19, using the structures and resources of the State Control Centre'.[288]

201. At odds with this evidence and the position taken by DHHS throughout the Inquiry is the position taken by Mr Helps on the first weekend of the Program's commencement, when he made plain to Ms Febey from DJPR that he was the State Controller, and DHHS was the control agency for the Program.

202. In the context of Mr Helps learning that DJPR had been assigned the initial lead on 27 March 2020, Mr Helps was firm in clarifying with Ms Febey that DHHS should instead be the lead department. Ms Febey's evidence to the Inquiry was that, when she discussed DHHS's role as control agency with Mr Helps on 29 March 2020 at the SCC, he 'emphasised that DHHS was the control agency and needed to be in charge as it was accountable for the Program'.[289] In the below follow-up email from Mr Helps to Ms Febey on 29 March 2020 with the subject line 'DJPR-DHHS role clarity', Mr Helps stated that: '[a]s the Control Agency, DHHS has overall responsibility for all activities undertaken in response to this emergency'.[290]

> Dear Claire,
>
> As you are aware The Department of Health and Human Services (DHHS) is the Control Agency for the COVID-19 Pandemic, and at this time I am the State Controller — Health appointed by the Control Agency under the Emergency Management Act. Prof Brett Sutton is the Chief Health Officer leading the Public Health response under the Public Health and Wellbeing Act.
>
> As the Control Agency, DHHS has overall responsibility for all activities undertaken in response to this emergency. The response to the direction for all passengers returning to Victoria after 11.59 p.m. 28/03/20 requiring to be quarantined in approved accommodation is being led by Dep State Controller Chris Eagle as 'Operation Soteria'.
>
> As discussed today I am extremely grateful to the support DJPR have provided to date, your team have demonstrated flexibility, good planning and expertise which has contributed to making the first day as successful as it could be. I also look forward to your team continuing to support Operation Soteria.
>
> It is important however that we clarify some roles and responsibilities and work on a transition plan over the next day or so. Chris Eagle will work with you on this. Many of the roles DJPR provided in the planning, and operationally today will need to transition to the Deputy State Controller and DHHS as the Control Agency. I would like to clarify that, at a minimum, I would request DJPR continue to provide the valuable work in procurement of hotels and the services required to support people under the direction to detain, I don't underestimate the complexity of this task in the current environment. It will be vital that DHHS make the operational decisions in regard to which hotels we utilise and when, along with other decisions which require a risk assessment by the Chief Health Officer or delegated Authorised Officer.

> It was a pleasure to discuss this with you today and I sense the value of working closely on this for both agencies.
>
> Please contact me again if I can assist or if a resolution cannot be reached during the handover process.
>
> Regards
> Jason Helps
> Deputy Director Emergency Operation and Capability | Emergency Management Branch

203. When Ms Peake appeared before the Inquiry, Ms Peake speculated as to an explanation for Mr Helps's statement, '[a]s the Control Agency, DHHS has overall responsibility for all activities undertaken in response to this emergency'. She said that she thought that what Mr Helps meant by it was that DHHS had 'overall responsibility for ensuring any operation through the State Control Centre was appropriately scoped, involved the right people and had appropriate operational governance within it'.[291]

204. However, the plain meaning of Mr Helps's email, which was sent at the outset of the Hotel Quarantine Program, is consistent with the evidence of all of the other witnesses not aligned with DHHS, as set out below.

205. Notwithstanding the remainder of non-DHHS witnesses being at odds with this view, during the Inquiry and in closing submissions, DHHS sought to rely on the definition and acceptance of this situation as a 'complex emergency' to maintain its position that its role was to coordinate rather than be 'in charge' or 'in control' or the agency with the overall responsibility for the operation of the Hotel Quarantine Program.

206. In closing submissions, DHHS extracted the passage from Part 7.1 of the EMMV it relied on and referred to throughout the Inquiry, which I set out again as follows:

> There are complex emergencies where a shared accountability across a number of agencies occurs. In these cases, there is a need for a single agency to be responsible for the collaborative response of all the agencies. For the purposes of consistency, the term control agency will be used to describe this lead agency role.[292]

207. DHHS submitted that no one agency could respond alone to such a complex emergency and that this 'does not reflect the reality of emergency management'.[293]

208. A few observations are noteworthy with respect to this submission.

209. First, it appears from this submission, that DHHS is referring to its role in the response to the entire pandemic state-wide rather than the operation of the Hotel Quarantine Program. The submission refers in a broad and sweeping way to the crisis structures of government and whole-of-government leadership and decision-making on overall directions for the COVID-19 response.[294]

210. Second, the DHHS submission refers to the other agencies involved in the delivery of the Hotel Quarantine Program, pointing out that agencies such as DJPR and private contractors all held their own responsibilities and accountabilities, ostensibly in support of the position that DHHS was a coordinator, rather than a controller of the Program that was in charge of, or responsible for, the Hotel Quarantine Program. The problem with this position is that the two concepts are not mutually exclusive. That agencies such as DJPR engaged in responding to the emergency are properly accountable for their actions is not in question. But that concept of accountability does not obviate the need for the control agency to be more than a mere coordinator. Indeed, the language DHHS seeks to rely upon seems plain enough: 'There is a need for a single agency to be responsible for the collaborative response of all agencies'.[295]

211. Third, this submission was not consistent with the evidence of the Emergency Management Commissioner or, indeed, any other witness who gave evidence on this issue who was not an employee of DHHS. That is, DHHS was alone in holding this view. It appears to have been the only agency confused or unclear about its role — despite the State Controller initially being very clear with Ms Febey in this regard.

212. Emergency Management Commissioner Andrew Crisp and former Emergency Management Commissioner Lapsley both provided their opinions as to the interpretation of control agency and the importance of that role. Mr Lapsley, said:

> It is a fundamental premise to have a single agency designated for the leadership and management of an emergency so that there is no ambiguity of who is accountable for the management of the emergency.[296]

213. Mr Lapsley went on to emphasise the need to have clearly defined structure and accountability as follows:

> [Clear lines of command and control are] of critical importance from an accountability perspective so that agency/organisational commanders have a clear understanding of who is in control of the major emergency and who is responsible for coordinating effort seamlessly … There are numerous examples where emergencies have been poorly managed because of structures and accountabilities being poorly defined, understood and acted upon.[297]

214. Emergency Management Commissioner Crisp stated that one of the main reasons for placing Operation Soteria within the emergency management framework was for role clarity. He stated '[i]t was important to put a control structure around the particular operation and again based on our experience of our running operations about having a control agency and then support agency, being really clear as to their role. It is really important and useful in terms of achieving a good outcome'.[298]

215. Emergency Management Commissioner Crisp gave his view as to who was responsible for the Hotel Quarantine Program at the SCC meeting held in the afternoon of 28 March 2020. He said '[a]nd Jason [Helps] touched on it before in terms of who's in charge. It is the Department of Health and Human Services for this operation because, as I said, it fits in with the State's structure and under the State Controller — Health'.[299] In examination, Emergency Management Commissioner Crisp said that he made those remarks to make it 'absolutely clear who was running the operation'.[300]

216. The Premier, when asked for his view as to who he thought had responsibility for the Hotel Quarantine Program, gave evidence that DHHS 'as the designated control agency, was primarily responsible for the Program'[301] and that, from 8 April 2020, he 'regarded Minister Mikakos as accountable for the Program'.[302]

217. However, as noted above, former Minister Mikakos expressed a much narrower view of DHHS's role in respect of the Hotel Quarantine Program:

> [W]hilst the DHHS was designated as the control agency for the overall COVID-19 pandemic response in Victoria, this meant it had a coordinating role across numerous government departments and agencies in responding to the health emergency … The fact that the DHHS is designated as the control agency for the pandemic response as a whole did not mean that the DHHS was running Operation Soteria.[303]

218. Simon Phemister, the Secretary to DJPR, gave evidence that 'consistent with its role as a support agency as understood in the emergency management context', DJPR was 'subject to the control and direction of DHHS'.[304]

219. The Hon. Martin Pakula MP, Minister for Jobs, Precincts and Regions, gave evidence that, as control agency, DHHS was 'in charge, if you like, and had overall responsibility' and that it was the role of DJPR to assist DHHS.[305]

220. The Hon. Lisa Neville MP, Minister for Police and Emergency Services, said 'I'm very clear about how these arrangements work. It was a Class 2 pandemic. In this case it was a health emergency, therefore the control agency was DHHS'.[306]

221. Similarly, Chief Commissioner of Victoria Police, Shane Patton, stated that 'Victoria Police had only a supporting role in the HQP, which was in the control of DHHS'.[307]

222. The weight of the evidence is that, at all material times, DHHS had 'overall responsibility' for the Hotel Quarantine Program as (a) not only the government agency responsible for public health, but (b) also the government agency that had responsibility for the exercise of the statutory powers of detention that mandated the detention of people in quarantine and (c) the designated control agency in the emergency management framework in which the Program was set. The fact that it did not see itself as having this responsibility and did not accept this responsibility, either during its involvement in the Program or throughout this Inquiry, can be understood as being a progenitor of many problems that eventuated in the Hotel Quarantine Program.

'Shared accountability'

223. Separate, although related to the concept of multi-agency collaboration, is the concept of 'shared accountability' upon which DHHS sought to place much weight. It is plain that this language comes from the language of 'complex emergencies' from the EMMV.[308] In this 'shared accountability' model, DHHS sought to create a delineation between what it saw as its areas of responsibility, being (a) public health and wellbeing and (b) the statutory framework for the making of the detention orders. During the Inquiry, this position was particularly aimed at DJPR in the 'shared accountability' model but included the private contractors as well.

224. As has been stated several times already in this report, the evidence is uncontroversial that, in its first 24 hours, the Hotel Quarantine Program was initiated as a departmental operation run by DJPR.[309] As a result, a number of the initial operational decisions were, in effect, inherited by DHHS when it became control agency under the transition on 28 and 29 March 2020 into the emergency management framework.[310]

225. It is plain, as a matter of fact and practicality, in an emergency response such as the set up and operation of the Hotel Quarantine Program was, that no single agency will have all the resources, expertise and experience to respond alone. It is also plain that agencies that are given responsibilities to deliver aspects of the component parts of the Program, as was the case here, bear responsibility for that proper delivery.

226. The evidence of DHHS witnesses and former Minister Mikakos was that accountability was 'shared' between DHHS and other agencies.[311] They explained that this model of 'shared accountability' was expressly provided for by the emergency management framework. In her first statement to the Inquiry, Ms Peake offered the observation that emergency management has reflected a general trend in the public sector toward 'collaborative governance'.[312]

227. The concept of 'shared accountability' is, indeed, expressly identified in the EMMV. However, what many DHHS witnesses failed to acknowledge in their invocation of the concept of 'shared accountability' was the necessity for designation of overall responsibility and the expressly stated requirement for a single agency to be the lead agency.[313]

228. Senior figures within DHHS, including the former Minister, regarded the Department's function as a control agency for the operation of the Hotel Quarantine Program as an exercise in 'collaborative governance', where the role was one of coordination and facilitation but not one in which it was functioning as the single agency with overall responsibility for the Program.

This was a mischaracterisation of its role and function in the Hotel Quarantine Program and one that had significant ramifications throughout its operation, despite the individual hard-working efforts of many individuals working inside DHHS.

229. In the shared accountability model, DHHS sought to silo its responsibilities as related to the health and wellbeing of the people in quarantine. This created an artificial and unworkable notion that, somehow, the health and wellbeing of the people in quarantine could be separated out from the operation of the environment in which they were being detained.

8.3.2 Support agency role: DJPR

230. Once it became apparent over that first weekend to Ms Febey of DJPR that DHHS was the lead Department, she understood that DJPR would act as a *support agency* to DHHS.[314] As noted above, the SERP defines a support agency as an agency that provides services, personnel or material support to the control agency.[315]

231. Ms Febey gave evidence that it took a few days into the Program to clarify exactly what that supporting role meant in practice.[316] Ms Febey understood, in functional terms, that DJPR was:

    A. contracting hotels and other services

    B. meeting day-to-day needs of people in quarantine

    C. arranging food

    D. implementing a call centre function for people in quarantine

    E. providing logistical support on the ground; for example, around deliveries, Uber Eats, exercise, smoking, et cetera.[317]

232. From that point onwards, Ms Febey understood, correctly in my view, that DJPR was required to act as a support agency to DHHS and was to work under its direction.[318] That DJPR did a substantial amount of work towards the Program did not change Ms Febey's view that DHHS was, from that point, the control agency.[319]

233. When Ms May, of DJPR, took over from Ms Febey as DJPR Agency Commander, Ms May stated that she understood she was required to take direction from DHHS in relation to matters of policy and procedure and could only act on the directions of DHHS.[320] Ms May described her role as Agency Commander of DJPR as also having responsibility for supporting the directions of the State Controller — Health via the DHHS Commander. Her evidence was that she was also required to establish a DJPR command structure, lead DJPR resources and ensure a timely flow of information to the DHHS Commander.[321] Ms May gave evidence that she did establish a command structure within DJPR, as required by the EMMV framework, and all DJPR staff on the Hotel Quarantine Program ultimately reported to her.[322]

234. Ms May gave evidence that she understood that Operation Soteria was run by its DHHS Commander, Ms Williams, and that she understood that DJPR would work under the direction of the DHHS Commander.[323]

235. Ms Williams saw it differently, saying she had no control or authority to direct others within the Operation, for example, DJPR, Authorised Officers or on-site medical staff.[324] However, DHHS (through the former Secretary and Minister) accepted that it could have transferred conduct of the contracts for hotels, security guards and cleaning being held and managed by DJPR to itself at any time. To disavow its capacity to exercise all of the necessary powers to take control of the Program is an untenable position for this government agency to take in the face of such an important program.[325]

236. As Emergency Management Commissioner Crisp stated in his evidence when asked about the reason for drawing a distinction between a control agency and support agencies: '[i]t is always very important to know who is in control, who is running a particular operation'.[326]

237. In other words, in any emergency response, it is essential that there is clarity as to roles, chains of command and lines of control. The fact that there were conflicting views about what it meant for DHHS to be the 'control agency' is a matter of considerable concern. It is also of concern that it does not appear to have been identified and escalated as an issue by DHHS, through which it could have sought clarification as to its functions and role from the Emergency Management Commissioner, or through its Minister or the CCC.

238. It would not be hard to understand that DHHS staff may have felt exhausted and overwhelmed given the enormity and range of the Department's functions, tasks and responsibilities during the early months of the pandemic. However, as previously stated, the impact of DHHS not taking overall responsibility for the Hotel Quarantine Program, and endeavouring to reframe this responsibility as one in which it was but one part of a collaborative approach of all agencies, left the Program without a responsible, accountable supervisor. Coordination is one thing. Being accountable to ensure that the collaborative approach does not break down or that, by reason of the collaboration and involvement of multiple agencies, there are not governance or operational gaps in meeting the aims of an emergency response, is another.

239. In my view, the designation of DHHS as control agency vested it with clear responsibility to deliver that response with the collaboration of multiple support agencies responsible for the proper delivery of that support agency response, as was required, **and** to ensure that those agencies were working together so that the response fulfilled its aims. But that did not remove or vary the overall need and responsibility for the single agency, DHHS, to take control of the Program and exercise the necessary vigilance required to ensure its safe and proper operation shaped into a best practice model.

240. Accordingly, I do not accept the DHHS submission that it 'delivered on the appropriate role of the control agency in a complex emergency'.[327] At a minimum, as control agency, DHHS was responsible for ensuring that the plans for the Operation, including division of responsibilities, chains of command and overall accountability, were understood by all operating within it. Evidence of this clear leadership role is documented in several iterations of the Operation Soteria plan and further evidenced by the leadership hierarchy of the Program, where all key roles were either filled with DHHS staff or staff appointed by DHHS.

241. Notwithstanding the language contained in the EMMV, while DHHS accepted it was the control agency, it sought to re-define what 'control agency' meant in the emergency management context. The impact of this was multilayered.

242. By mischaracterising or misinterpreting its role as the control agency, it left the Hotel Quarantine Program without a manager, without a leader and without what was critically needed for such a high-risk program: an agency to be in charge and take responsibility to ensure, to the best of its ability, that the Program was being operated to minimise the risks inherent in it.

243. That such a misinterpretation or mischaracterisation of the role and function of this central aspect of the response to a public health emergency could become so embedded in the minds of the senior management of DHHS — all the way through to the Minister — points to the obvious need to clarify the meaning and role of control agency, whether it be a complex emergency or not.

244. To ensure that such a situation does not emerge again, I make the following recommendation:

Recommendation 74: That the Emergency Management Commissioner clarifies the language used in the Emergency Management Manual Victoria to ensure that there is no possibility of any ambiguity about the role and responsibility of the Control Agency, including a more fulsome definition of what constitutes a complex emergency and the role of the designated control agency in a complex emergency.

Not enough public health experts to go around? The breadth of DHHS's role in responding to the pandemic

245. As part of its ordinary operations, one of the key responsibilities of DHHS is in preventing the spread of communicable diseases.[328] Within the structure of Victoria's response to the pandemic, 'the department had responsibility for public health interventions to suppress the virus (including through investigation [and] management of public health risk'.[329] As noted above, Ms Peake stated that DHHS 'was also responsible for stewardship of health and human service sector responses to the pandemic, including overseeing delivery of services that support the health and wellbeing of Victorians'.[330]

246. It is well understood and accepted that, throughout the relevant period in which the Hotel Quarantine Program was implemented, DHHS had responsibility not only for the Program, but for numerous other aspects of Victoria's response to the pandemic.[331] DHHS continued to attend to its broader public health functions throughout the Hotel Quarantine Program. I have been cognisant of that fact when assessing the roles, responsibilities and accountabilities of personnel and DHHS within the Hotel Quarantine Program including the DHHS Public Health Team.

247. I accept the submission advanced on behalf of DHHS that 'the hotel quarantine program was one part of a State-wide emergency response to the pandemic'.[332] However, this changes nothing, other than to confirm that the resources of DHHS were severely stretched. Further, Ms Peake gave evidence of the 'understanding, in late March 2020, that the major form of transmission of COVID-19 in Australia at that time was from returned travellers'.[333]

248. Because the major form of transmission, as understood at that time, was from returned travellers, the Hotel Quarantine Program was the State's most critical bulwark against the further spread of disease and the devastation feared by its proliferation. The purpose of the Program — to contain the spread of the virus — and the magnitude of the decision to deprive citizens of their liberty to achieve that aim, means that it had to be given primary focus in relation to its conception, development, resourcing, oversight and operation. There is evidence that the ability to properly resource the Hotel Quarantine Program with the health and medical expertise needed was compromised by not enough public health experts either employed by DHHS or available to DHHS to fulfil the necessary functions and demands of the Hotel Quarantine Program.[334]

249. As an example, as at early April, the evidence is that DHHS had only one IPC expert, employed by the Microbiological Diagnostic Unit Public Health Laboratory in a 'shared capacity' with the Department[335] (noting that Dr van Diemen would later establish a new IPC Cell led by a public health physician and comprised of infection control consultants).[336] As stated above, that person initially provided advice across Victoria in response to the pandemic. When that DHHS consultant had no capacity to respond to Operation Soteria requests for further specialised advice regarding the Hotel Quarantine Program, including in the context of establishing the Rydges Hotel in Carlton as a designated COVID-19 hotel, it was recommended that Operation Soteria engaged an outside consultant for advice. DHHS engaged Infection Prevention Australia as a contractor on a number of occasions.[337] Similarly, DHHS engaged nursing agencies to provide nursing services and a newly created company to provide general medical practitioners.[338] It is no criticism at all of DHHS that it engaged this assistance, particularly in response to not only the unprecedented pandemic to which it was responding but the unpredictable numbers and limited information on the health needs of those coming into Hotel Quarantine. These factors made it very difficult to plan for, particularly given there had been no contingency plans in place at the time the Hotel Quarantine Program was announced.

250. A number of the public health officials had concurrent responsibilities in both their substantive and emergency management roles. Included in this was the DCHO, Dr van Diemen, who was also the Public Health Commander. Mr Helps referred to the entire Public Health Team as being very stretched at the time, with resourcing being an issue.[339] Dr van Diemen similarly expressed a view that:

> In an ideal world, we would have placed multiple public health positions in both the Emergency Operation Centre and the State Control Centre. But the reality was there weren't enough to go around and we needed to determine where people would sit and many … most of the public health positions in the response were covering more than one role at any given time.[340]

251. The limited number of employees with public health and infection control expertise posed practical difficulties to the Program meeting its objectives.

Engagement with medical experts outside DHHS

252. Dr Julian Rait, the President of the Australian Medical Association (AMA), gave evidence that there was insufficient engagement with stakeholders and experts outside DHHS in the establishment of the Program:

> We believe that there was no shortage of experts in Victoria who could have assisted the government with establishing hotel quarantine – but somewhere along the line, the government didn't view engagement with these types of experts as being necessary.
>
> Overall, there is not a culture within government and within the DHHS of meaningful engagement with stakeholders. There appears to be a lack of appropriate planning, collaboration and two-way communication between the DHHS and its external stakeholders. There need to be more genuine attempts to seek feedback, test assumptions and ideas, obtain input from experts, and collaborate in planning and understand the experience on the ground.[341]

253. This sentiment was expressed by others who made contact with the Inquiry. These were not issues that were tested during the Inquiry, although the statement made by Dr Rait formed part of the evidence. Suffice to say here that, given the position held by Dr Rait and the issues raised by him, in particular the issues that address the availability of experts to DHHS through the AMA, the Secretary to DHHS and the Minister for Health should engage with the President of the AMA to address and understand the issues raised by him.

Recommendation 75: That the Secretary of DHHS engages in discussions with the President of the Australian Medical Association to address the availability of medical expertise to meet current and future surge and planning demands for public health emergencies.

8.3.3 Not appointing Chief Health Officer as State Controller — Health

254. Related to the issue of 'not enough public health experts to go around' was the impact of the non-appointment of the CHO as State Controller — Health. As set out above, the default position in the SHERP for Victoria is that the CHO will be appointed as the State Controller — Health. As Secretary of DHHS, Ms Peake was aware of the presumption under the SHERP that the CHO is the presumed appointment.[342] As DHHS was the control agency for a Class 2 health emergency, Ms Peake had the authority to appoint a State Controller — Health and to depart from the normal course. She chose to depart from it. In February, Ms Peake was advised by Ms Skilbeck (an economist by training) to appoint someone other than the CHO, Prof. Sutton, as the State Controller — Health.[343]

255. Instead of the CHO, as previously stated, two executive members of DHHS were appointed to the role of State Controller — Health by the Secretary of DHHS in response to the COVID-19 pandemic.[344] The first, Ms Spiteri, Executive Director of Emergency Management, DHHS, was appointed on 1 February 2020. The second, Mr Helps, Deputy Director of Emergency Operation and Capability, DHHS, was appointed on 7 February 2020.[345] They performed the role of State Controller — Health according to a rostered arrangement.[346] Both were very experienced in emergency management.

256. Ms Peake gave evidence that, despite the presumption in the SHERP that the CHO would fulfil the function of State Controller, this was not always the case and her decision not to appoint the CHO was due to:

> [M]y understanding of the very significant operational responsibilities the CHO was already undertaking in response to the pandemic at both state and national level.[347]

257. In Ms Peake's view, given the other duties of the CHO in response to the overall public health emergency, it was not practicable for him to take on the role of State Controller — Health.

258. Ms Skilbeck spoke about her reasons for making that recommendation. Ms Skilbeck explained that she viewed the Hotel Quarantine Program primarily as a significant logistics program that required logistical expertise rather than public health knowledge.[348] She also referred to the other responsibilities falling to the CHO at the time.[349]

259. Shortly after Ms Spiteri's appointment, Ms Skilbeck provided Ms Peake with a brief that documented her reasons for recommending the appointment of Ms Spiteri rather than Prof. Sutton as State Controller. In her brief, Ms Skilbeck explained as follows:

> I recommended the State Health Coordinator as controller for the 2019-nCov outbreak to manage the growing social and economic impacts of the virus across government and provide access to the needed logistics and communications support, rather than hazard (virus) control. Specifically, through the State Co-ordination Team, departments are providing necessary planning, logistics and communications support to the public health response.[350]

260. In her reasons, Ms Skilbeck went on to note the key role the CHO played in developing advice through the AHPPC, that he held 'the central role in media and other interfaces' and the dearth of public health physicians in the Department.[351] Ms Skilbeck acknowledged that Prof. Sutton did not agree with the decision to appoint someone other than him as State Controller — Health.[352]

261. In reflecting on his not having been appointed State Controller — Health, Prof. Sutton said that the position of State Controller — Health would have given him a significant 'line of sight' perspective over operational elements for which he (as CHO) was accountable because it was his authority, pursuant to the PHW Act, which was the source of legal power for the Program. He said that it was important for him to have line of sight of the application of those controls and to have 'situational awareness of those operational activities'.[353] Moreover, in Prof. Sutton's view, it would have been preferable to appoint 'a public health physician with communicable disease experience and tropical medicine experience and [his] specific qualifications and experience'.[354]

262. In her evidence, Dr van Diemen (who was DCHO and Public Health Commander and the person who authorised the detention notices placing people in quarantine) stated that it would have been 'perhaps more ideal' to have someone who had a public health background and greater communicable disease focus as the State Controller.[355] However, she said that she could understand the reasoning that was advanced for the appointments that were made, given the enormous demands on everybody's time.[356]

263. As previously noted, Ms Skilbeck explained, in her evidence, that Ms Spiteri and Mr Helps were chosen, '[To] provide access to the needed state level logistics and communications support, rather than hazard (virus) control'.[357]

264. Emergency Management Commissioner Crisp was consulted by Ms Skilbeck about the proposed appointment. He stated that the rationale for the departure from the normal position was explained to him by Ms Skilbeck, and he agreed with that position. He did so on the basis that the CHO was too busy with other responsibilities.[358]

265. Both Ms Peake and Ms Skilbeck knew that Prof. Sutton did not agree that someone else should be appointed, and there was discussion between them about the disagreement.[359] Despite that conversation, Ms Peake remained of the view that it was just not feasible that the CHO could perform the role of State Controller — Health, and doing so would have compromised his other functions.[360]

266. Both Prof. Sutton and Dr Romanes expressed their concerns that those in the leadership roles in the Hotel Quarantine Program were people without significant public health experience. It was the view of Dr Romanes that those appointed to senior leadership positions 'did not have significant public health experience' and that this resulted in the Hotel Quarantine Program being 'characterised and managed predominantly as an accommodation or logistics program'.[361] In his evidence, Prof. Sutton agreed that he, too, had reservations about the lack of Public Health Command involvement in Operation Soteria.[362]

267. Ms Peake gave evidence that, by the time of her appearance before the Inquiry, she was aware of various statements made by DHHS staff, including the CHO, the DCHO/Public Health Commander and Dr Romanes, to the effect that if the CHO had been appointed State Controller, public health expertise may have been more embedded in the governance of the Hotel Quarantine Program.[363] Her view was that it was important to reflect on the practical realities of the 'bandwidth' of public health at the time of the appointments, having regard to other DHHS tasks.[364] She said that it had been, and remained, her view that it was not practicable for Prof. Sutton to execute his statutory obligations of CHO at the time and take on that facilitation of multiagency operations across government, and that the Public Health Command was established to ensure there was public health input into Operation Soteria and into other operations that were in train at the same time.[365]

268. Ms Spiteri stated that this was the first appointment of a State Controller for a Class 2 human disease pandemic in Victoria with 'a remit to coordinate whole of Victorian Government planning and responses to the broader impacts and consequences of the pandemic'.[366]

269. Ms Spiteri referred to the detail of what is contained in the SERP that includes to lead and manage the response to a Class 2 emergency, establish a control structure for the Class 2 emergency as appropriate and monitor to ensure it suits the circumstances, and give directions to other incident controllers, if applicable.[367]

270. Ms Spiteri stated that '[p]ractically, the Chief Health Officer was an 'incident controller', operating across the state, with powers under the *Public Health and Wellbeing Act 2008* to make directions to mitigate and control the spread of the virus.[368] I understand this aspect of Ms Spiteri's evidence to be that the CHO had delineated statutory powers under the PHW Act and, therefore, his role and functions were independent of the State Controllers and not affected by the roles performed by her or Mr Helps.

271. Ms Spiteri went on to state:

> This meant the role of State Controller — Health for this Class 2 emergency became one of overall coordination of the implementation of both Chief Health Officer and government decisions and directions across government and agencies, through the operational arrangements for COVID-19, utilising the structures and resources of the State Control Centre.[369]

272. Ironically, given the stated rationale for the non-appointment of Prof. Sutton as State Controller — Health, it was the evidence of Mr Helps that he was not able to effectively meet many of the role functions described, given the complex national and state arrangements and the role of the CHO and Public Health Commander. That is, it was his view that control decisions were made at national and state cabinet levels and that the CHO and the Public Health Commander had absolute control of the public health emergency across the entire state. [370] Mr Helps gave this evidence notwithstanding that the Public Health Commander role reported to him.

273. Mr Helps described the role of the State Controller as quite different in the COVID-19 pandemic compared with other emergency situations. Typically, the role of State Controller is one of decision-making and leading in an emergency response.[371] However, due to the complex nature of the emergency, and the tendency for the decisions to intersect with so many areas (human rights, economic, trade, industry, transport), Mr Helps considered that the regular emergency management arrangements were not appropriate as the predominant decision-making tools.[372]

274. Ms Spiteri, echoing the views of DHHS executives, saw her role as State Controller — Health as *co-ordinating* activities.[373] Ms Spiteri did state that she had operational accountability for the quarantine of people and a responsibility, under the guidance of the public health experts, to ensure that there was guidance and instruction provided and that there was a plan and arrangements and a governance structure. Ms Spiteri's evidence was that she was satisfied that she had the right structure in place to enable information to go to the people who needed it.[374]

275. In an odd and inexplicable side note, it appears from documents compelled under Notices to Produce, that, about six days after appointing Ms Spiteri as State Controller, by an instrument of appointment dated 7 February 2020 and approved by Ms Skilbeck, Ms Peake did in fact appoint Prof. Sutton to the role of State Controller — Health, together with Dr Bone and Mr Helps.[375] It would appear that Prof. Sutton was not advised of this appointment, given his evidence that he was unhappy that he was not so appointed.

276. The briefing memorandum that accompanied the other three appointments made by that same instrument made no reference to Prof. Sutton, nor did it suggest that he be appointed.[376]

277. The explanation proffered by Ms Peake as to her reasons for executing the instrument of appointment that included Prof. Sutton; namely, that he was appointed merely as an alternative, or backup, State Controller,[377] is at odds with the reasons that she (and Ms Skilbeck) gave for not appointing him only days earlier. It is also at odds with the fact, as I have found it to be, that Prof. Sutton was not advised of this appointment and made even more inexplicable in light of the evidence given by Ms Peake that she had discussed Prof. Sutton's views with him in the wake of Ms Spiteri's appointment. I found the explanation given by Ms Peake on this topic to be, at the very least, confounding.

278. The impact of this decision (apparently) not to appoint the CHO as State Controller — Health meant that the senior person in this State with the recognised public health expertise necessary to oversee such a Program did not have any active oversight role in the Program. This deprived the Program of that expertise and created another fragmented line of reporting, accountability and opportunity lost for oversight of the Hotel Quarantine Program. Further, given the CHO and DCHO were accountable for the exercise of the statutory powers under the PHW Act, both of them considered it important that they should have visibility over the activities undertaken in respect of the exercise of those powers. This is a position that, in my view, is unarguably correct.

279. Both Prof. Sutton and Dr van Diemen raised their concerns about this internally, for example, with Prof. Wallace as evidenced by Prof. Sutton's email to Prof. Wallace dated 13 April 2020, extracted at paragraph 318 below.[378] However, despite this concern, Prof. Sutton did not elevate the issue to the former Minister for Health with whom he met regularly.[379]

8.3.4 The Public Health Commander and Incident Management Team: state-wide role vs Hotel Quarantine Program

280. Adding to the apparent complexity of the governance of the Hotel Quarantine Program was another layer of either intersecting pathways or parallel lines, depending on the way it was viewed, created by the emergency management framework and the statutory role and powers of the CHO. It was said to emerge in this way.

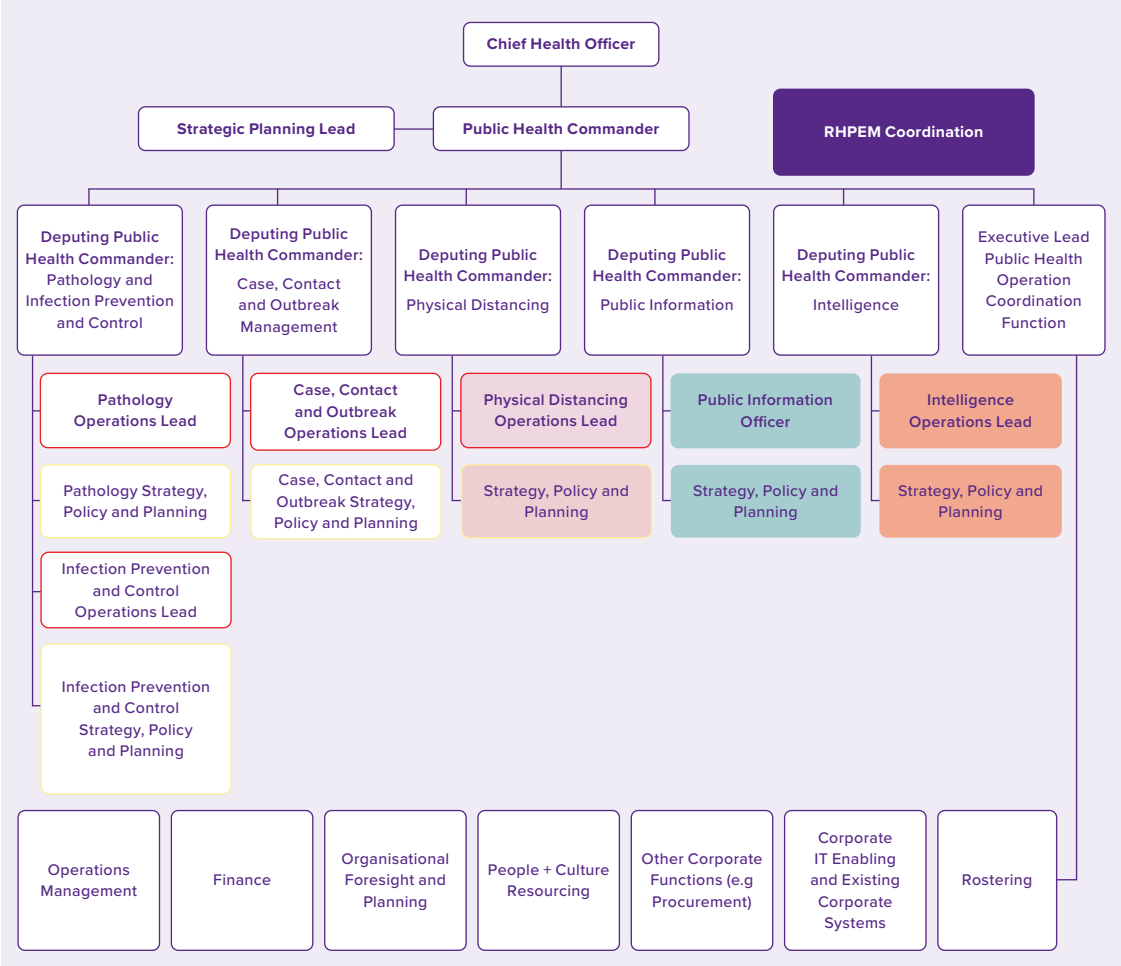
281. The common emergency experience (for example, bushfires or floods) is that incident control is exercised in response to a geographical incident (for example, a particular fire ground). If there are multiple incidents (such as several different bushfires), each Incident Control Team will be supported by the Regional and State Controllers. It is an hierarchical system.[380]

282. According to Mr Helps, the COVID-19 emergency differed from that norm because the 'incident' encompassed the entire State. In his view, the 'Incident Control' function lay with the CHO by reason of his statutory powers and with the Public Health Commander by reason of the appointment under the emergency management framework. In his view, this meant, in practice, the Incident Management had the same 'footprint' as the State Control and was not within a traditional hierarchy.[381] According to Mr Helps, this meant there was no hierarchy between Incident Management and State Control.[382] The State Operational Arrangements COVID-19 described Incident Management, as it was applied to this emergency, in this way:

> Incident Management for a state-wide Health Emergency will be managed by a single Incident Management Team (IMT) that brings together Public Health Command Operations (Case and Contact Management, Laboratories, Ports of Entry, Specialist Advice), Planning (Health Service, Public Health and other services), supported by Intelligence, Public Information. The incident footprint is the State of Victoria. The Incident Controller is the Public Health Commander.
>
> The Public Health Commander reports to the Chief Health Officer, Victoria's health response is working in conjunction with other States and National response, with Governance arrangements at a National level leading key National policy.

> The State Controller — Health, where appointed, will manage impacts of COVID-19 across the broader community that require the coordination of agencies in response to the consequences. It is difficult to predict precisely where or when specific COVID-19 impacts are going to occur, so it has been determined that a state level response is the best method to manage these emergencies.
>
> Management of the impacts and consequences of COVID-19 on the affected community will be undertaken by emergency management agencies and government departments. This management of consequences requires agencies and government to work together in a coordinated way, therefore, a coordination centre (remote or in a facility) may be established, to facilitate identification and manage the response to the consequences rather than to control the emergency.[383]

Figure 8.3.1: State Operational Arrangements – COVID-19 Version 3.0



Source: Exhibit HQI0167_RP EMV State Operational Arrangements COVID-1.

283. This diagram demonstrates the size and complexity of the Public Health Incident Management Team. Although the incident management team sat within the State Governance Structure (see above), in practice, because the incident encompassed the entire State, it was running parallel, rather than under, the emergency management leadership.

284. This parallel structure added to the complexity of the COVID-19 pandemic emergency response and hence the Hotel Quarantine Program. The Public Health Commander under the SHERP leads the Incident Management Team. The role is to have oversight of the public health response to the health emergency. In this particular emergency, there was an operations aspect to the role (contact tracing, outbreak management, et cetera), a planning aspect (implementing and easing of restrictions, health planning), an intelligence aspect (epidemiology, data, surveillance) and a logistics function (human and physical resources to response to emergency).[384]

285. The SHERP contemplates the Public Health Commander reporting to the State Controller — Health, as it is presumed under the SHERP that the CHO will be the State Controller. However, because the CHO was not (apparently) appointed the State Controller, the Public Health Commander reported directly to the CHO, as he had ultimate responsibility for the public health response, not the State Controller.[385] Although this was not in line with the emergency management arrangements, according to Dr van Diemen, this was 'an agreed approach by everybody'.[386]

286. The Public Health Incident Management Team is part of the emergency management structure and sits under the Public Health Commander. The Public Health Incident Management Team was initiated in response to the declaration of the COVID-19 pandemic. As the pandemic developed, the Public Health Incident Management Team became larger and more multi-layered as it adjusted for the scale and requirements of the emergency across the entire State. It seems to have developed into a more permanent structure.[387]

287. The Public Health Incident Management Team provided advice to the State Controller — Health in relation to the health aspects of the COVID-19 response across the entire State. This was both in an informal capacity and a more formal setting by creating policies and guidance around general IPC, among other things across many different settings. This guidance was provided to those running the Hotel Quarantine Program but, largely, was not tailored to the Hotel Quarantine Program and its very particular and unique requirements. Much of the advice was directed to the broader population, including various industries, as part of the COVID-19 response as a whole.[388] As such, the advice was often not particularly helpful as it was not engaged with the very particular circumstances in Hotel Quarantine.

288. Mr Helps's conclusion that there was no hierarchical relationship between incident management and State Control, as there would be in a more 'traditional' emergency such as a bushfire or a flood, raises the question as to how appropriate the emergency management framework was to operate the Hotel Quarantine Program. I return to this question at 8.3.12

8.3.5 Hotel Quarantine: logistics and compliance program vs public health program

MISCHARACTERISATION OF THE PROGRAM

289. While the decision not to (apparently) appoint the CHO as State Controller for the state-wide response to the pandemic may have some coherence if the response is conceived of as a complex logistics exercise, that coherence diminishes in the context of the operation of the Hotel Quarantine Program. This Program was much more than a logistical exercise of moving people in and out of accommodation, feeding them and keeping them detained under guard in their rooms. It required clinical oversight and governance with expert advice and oversight on IPC, which was always its greatest challenge and its greatest risk given what its objectives were and its very reason for being set up: to quarantine people in a government-run program for 14 days to minimise the risk of transmission of the virus into the community.

290. The views about its primary characterisation as a logistics or public health program largely split inside DHHS as between the emergency management division and the public health division. Dr Romanes saw Operation Soteria as 'characterised and managed predominantly as an accommodation logistics program' but that 'public health consideration needed to be concurrently addressed'.[389]

291. Ms Bamert saw a real need for someone who was part of the Operation Soteria management team to have IPC expertise at that management level.[390]

292. In evidence, Dr van Diemen agreed that she, Prof. Sutton and Dr Romanes all expressed concern that there was an absence of health focus in the governance of the Hotel Quarantine Program.[391]

293. Both Prof. Sutton and Dr Romanes expressed concerns that those in the leadership roles in the Hotel Quarantine Program were people without significant public health experience.[392] Dr Romanes offered the following view in his statement to the Inquiry:

> From what I could see, the program was characterised and managed predominantly as an accommodation or logistics program. I drew this view from observations of the appointment of senior leadership figures that did not have significant public health experience, and that the Operation Soteria governance meetings I attended did not involve the [Public Health Commander] initially and did seem to me to focus heavily on logistics considerations. While the program had significant logistical challenges attached to its implementation at that time, these were part of the challenge only and I felt that public health considerations needed to be concurrently addressed.[393]

294. Part of the evidence I relied upon in reaching a conclusion on this issue was based on the reality of the on-site presence at the hotels. DHHS Team Leaders appeared to be liaisons who were maintaining 'representation' of DHHS on-site for daily issues. The other DHHS presence on-site was the Authorised Officers, whose role was characterised as overseeing compliance with the detention directions.

295. The weight of the evidence was that the Program was characterised as a compliance and logistics exercise rather than a public health program. The conceptualisation of the Program in this way created tension within DHHS, and also meant that the necessary attention was not paid to the central risk of the Program and, ultimately, to the whole State, being the risk of outbreaks inside the hotels or into the community at large.

296. While the Hotel Quarantine Program was not in existence or even contemplated when the decision was made to (apparently) not appoint the CHO as State Controller — Health, the consequence for the Program was that, when it was brought under the control of the State Controllers — Health, it was also being brought under emergency management, rather than public health governance.

297. The essential rationale behind the designation of DHHS as the control agency in response to a health emergency was that public health expertise, rather than logistical support, was the unique function that was required at the helm in the SCC infrastructure. That was the purpose for which DHHS was designated as the control agency in the first place.

298. No system of IPC in the context of this pandemic was going to be perfect. It goes without saying that this virus can, and has, crossed over containment lines even in best-practice settings, such as hospitals and other healthcare settings. However, the starting point for a Program to minimise the risk of transmission events is one that sees itself as a public health program, not a logistics program, and therefore places those with the right expertise into lead positions.

8.3.6 Transfer of Operation Soteria to the Emergency Operation Centre

299. As noted above, at Section 8.2.5, in recognition that Operation Soteria needed to be placed into a longer-term programmatic footing rather than an ongoing emergency response, it was moved out of the SCC by mid-April and into a location in Fitzroy, the EOC. According to Ms Williams and Ms Bamert, this was done in the recognition that this would be a significant and complex program that was likely to be in place for 12–18 months.[394] Further, it was understood and accepted that the emergency management structure was not one that was designed for long-term, sustained responses.[395]

300. Ms Williams observed that a 'surge workforce', appropriate for an emergency over a few weeks, was harder to sustain over months. Ms Williams further stated that people recruited in a surge workforce come from a range of backgrounds and work experience and have a significant turnover rate. Longer-term appointments allow for a team structure and proper training and supervision.[396]

301. Ms Williams reflected that 'the extent and complexity of clinical needs in hotel quarantine was substantial; direct service provision by a public health service would have assisted in managing those needs, both at the hotel and when escalation to hospital care was necessary'.[397] Ms Williams also reflected that approval of public health policy and transfer into implementation of policy around infection control and cleaning needed to happen much more quickly.[398]

302. Ms Williams pointed out that, at the start of the Program and observing what was happening overseas, hospitals were preparing for large numbers of COVID-19-positive patients. Once this pressure abated, Alfred Health assumed its role at the Brady Hotel in mid-June 2020.[399]

303. While I accept the concern about hospitals getting overwhelmed by patients being a reason for not moving to this clinical model earlier, it was actually in the wake of the two outbreaks from hotel quarantine that Alfred Health accepted the role at the Brady Hotel.[400]

304. Notwithstanding that transfer with the intention of moving the Program out of the emergency management framework, Ms Williams and Ms Bamert (who came into the SCC on 30 April 2020[401]) continued with titles taken from the 'chain of command' emergency management structure: COVID-19 Accommodation Commanders and, ironically, DHHS named its new location as the 'Emergency Operation Centre'.

305. The move away from the SCC with the intention of setting the Program onto a longer-term footing was sensible and correctly assessed as consistent with the needs of the Hotel Quarantine Program. That it remained entwined with the emergency management structure, and that DHHS did not take the opportunity to re-conceptualise what was needed in the wake of that transition, was an opportunity lost in mid-April.

8.3.7 Chain of command inside DHHS: who was in command of whom?

306. Notwithstanding Ms Peake's evidence that 'there was a healthy and engaged relationship between the Public Health Command that was created to provide that input into all of the operations, including Operation Soteria',[402] the evidence was completely at odds with this, in particular on the topic of the chain of command within DHHS.

307. There was considerable evidence, some that emerged after the close of the evidence and final submissions, of confusion and tension about who was in command of whom inside DHHS. The split that emerged was as between the emergency management personnel within DHHS and the public health witnesses. There was conflicting evidence about reporting lines and chains of command as between these two groups.

308. Mr Helps, State Controller — Health, stated that he believed his role in the Program was 'very complex to navigate' and that '[t]rying to coordinate across very different levels of governance (Public Health Command, Government and Emergency Management) was a constant challenge'.[403] As explained above, in evidence, Mr Helps said that 'my role wasn't to effectively lead the decision-making in regards to public health or national or State policy'.[404] Mr Helps said that it was 'well known and well recognised' that he was not able to fulfil the full suite of responsibilities that usually fell to the State Controller because those decisions were being made elsewhere by other people, including by the CHO.[405] Ms Spiteri said that a lot of decisions were made by 'other people in other places'.[406] I accept from both Mr Helps and Ms Spiteri that their roles were vast and complex. That does not assist, however, in clarifying the chain of command inside DHHS.

309. In his affidavit of 4 November 2020, Mr Helps said that 'the governance and responsibility of the Hotel Quarantine Program was with Public Health Command'.[407]

310. On the other hand, Prof. Sutton's evidence to this Inquiry was that he understood the Operation Soteria Commander to be responsible for running the Hotel Quarantine Program.[408] In his affidavit of 4 November 2020, he was emphatic that the Program was not under the overall control of the Public Health Command, stating: 'I did not consider myself to be and was not the overall head of a chain of command in relation to Operation Soteria generally'.[409] He stated that he was so divorced from the command arrangements that he was not even aware of the detail of the governance arrangements:

> [W]hile I do not know in detail how policy or oversight of people in detention was handled in the Hotel Quarantine Program, I was aware that there was another management structure, in Operation Soteria and under the State Controller and Operation Soteria Commander.[410]

311. The account of the Public Health Team's role that was offered by Braedon Hogan (DHHS Agency Commander) fell somewhere between those diametrically opposed positions: by affidavit, dated 3 November 2020, Mr Hogan stated that 'there was involvement of the public health team in the decision-making process'.[411]

312. On 1 April 2020, Dr Romanes wrote to a number of senior people involved in Operation Soteria, stating:

> Just an important reminder: all policy and oversight of people in detention is being handled in a strict chain of command, from:
>
> • Chief Health Officer to
>
> • Deputy CHO (today — Simon Crouch) to
>
> • Deputy Public Health Commander Planning (Finn Romanes) to
>
> • Director Health Regulation and Reform (Meena Naidu) to
>
> • Authorised Officers (under Noel Cleaves and some other managers).
>
> It is important that all direction, policy, reporting and arrangements do not break this chain.[412]

313. This 'chain of command' was not reflected in version 2.0 of the *Operation Soteria Operational Plan,* which was authorised for release on 24 April 2020. The section of that Plan dealing with governance included the following:

> Operation Soteria is led by the Deputy State Controller (Operation Soteria) working to the State Controller — Health, to give effect to the decisions and directions of the Public Health Commander and Enforcement and Compliance Commander.[413]

314. Dr Romanes has since stated (by affidavit, dated 3 November 2020) that '[t]his chain of command I outline in my email was only intended to refer to the legal process and accountability of detaining people and allowing exemptions from that process'.[414]

315. However, on 9 April 2020, Dr Romanes sent an email to a number of senior officials within Operation Soteria, including Ms Spiteri. In it, he stated, in emphatic terms, that: '[t]here are now a considerable complexity and considerable risk that unless governance and plans issues are addressed there will be a risk to the health and safety of detainees'.[415]

316. On 10 April 2020, Deputy Secretary, Ms de Witts (who sat above, and was bureaucratically responsible for the work of, the Public Health Team), wrote to State Controller, Ms Spiteri, about escalation of detention issues. In that email she said that, in respect of general concerns raised by people in quarantine (for example, requests for exercise or pharmaceuticals), 'I think the public health commander just needs to receive regular reports on 'detention' issues and themes, and separately to be assured that the detention policy is being followed to promote the health and well-being of residents (e.g. exercise granted etc.)'.[416] In respect of serious matters of safety or welfare that were 'non-medical' in nature (such as family violence or child protection issues), Ms de Witts indicated that 'expedited reporting to the public health commander is needed on any issues that could impact the psychosocial or physical health of people detained in the hotel'.[417] In respect of both streams, Ms de Witts was clear that 'any human rights issues need to be escalated to the public health commander'.[418]

317. By email to Prof. Sutton, dated 13 April 2020, Prof. Wallace, in his capacity as State Health Coordinator, wrote as follows:

> I understand that there is a bit of tension between PH and EM - everyone trying to do their best.
>
> I have had a look at the health and wellbeing arrangements for the Operation - looks like there are some holes /opportunities for improvement.
>
> I really wanted to get your view re: governance etc

> I understand that the persons are detained under your order. Assuming this is correct, this brings with it a level of accountability/responsibility for the health and welfare of those detained. Is that a cause for concern to Annaliese, Finn etc?
>
> Is that the main pressure point or is there something else?[419]

318. Prof. Sutton responded by email within less than half an hour, stating that:

> I think the main point of tension is exactly that, Euan. Operation Soteria was – as an illustration – set up and put into place through EMV / State controller without even getting my approval or even input. Annaliese was similarly excluded. That, in and of itself, is astounding to us. It was seen as an almost wholly logistic exercise and had EM governance without an understanding of where accountability sat, or perhaps should sit.
>
> The mandatory quarantine regimen was a policy recommendation of National Cabinet, for all jurisdictions to put into place under relevant legislation. For us, that means that the CHO nominates and authorises an authorised officer to write a direction. In this case, Annaliese wrote the direction so was effectively the 'maker' of the entire scheme and has responsibility in law for it.
>
> I agree that everyone is trying to work constructively in this space. But there is clearly a disconnect with our EM colleagues, perhaps especially in EMV who understood their role as controller of the scheme and effectively excluded those with significant accountability. That is a source of unease - moral and legal![420]

319. Prof. Wallace conveyed concerns about the 'overall responsibility' of the Program to Ms Skilbeck by email, dated 1 May 2020:

> In essence, who is responsible for the quarantined detainees. there is not a consensus on this and lack of consensus/clarity fundamentally undermines governance and decisions.
>
> The structure suggests that the Accommodation Commander reporting to State Controller is responsible. However, there is also an opinion that PH is ultimately responsible because the passengers are detained under their direction.[421]

320. In an email to Ms de Witts on 17 May 2020, Mr Helps similarly raised serious concerns about governance and outbreak management:

> At present my greatest concern (quite selfishly) is that lack of engagement and reporting with the State Controller from Public Health, whilst it is recognised the Public Health Commander/ CHO have control of, and responsibility for, the Public Health aspects of this emergency, there is also legislative responsibilities and expectation on the State Controller for the broader risks, add to this the role of the missions and CCC and it is a complex space for us all to navigate, and one that exposes us all to risk if we are not connected and supporting each other.[422]

321. What was being raised at a senior level inside DHHS was a serious internal division of views about where the internal lines of command and responsibility lay, and the risks associated with the situation if left unaddressed.

322. Ms Williams stated that, as Operation Soteria Commander, she was 'responsible for the day to day management of Operation Soteria command'.[423] Ms Bamert (who was 'twinned' in the role with Ms Williams) similarly stated that, as Operation Soteria Commander, she was 'responsible for the day to day management of Operation Soteria' and that her 'responsibilities were to operationalise the public health policy developed by the Chief Health Officer and Public Health Command as well as coordinate activities for which other agencies were responsible'.[424]

323. In an email to Safer Care Victoria, sent on 21 May 2020, Ms Bamert stated 'I am not sure who you would say was in charge at that point'[425] as at 11 April 2020. That was the date of the first incident investigated by Safer Care Victoria.[426]

324. While Ms Bamert sought to clarify, in evidence, that she was describing a lack of clarity in the governance arrangements as at 11 April 2020, and that that was a catalyst for the transition to the EOC,[427] Mr Helps continued to express concerns about the governance arrangements as late as 17 May 2020, almost two months into the Program.[428]

325. In giving her view about the internal chain of command, Dr van Diemen stated that the State Controller – Health had oversight of the implementation of advice, guidance, policies and procedures issued by her as Public Health Commander.[429] That view followed from her stated position that '[t]he hotel quarantine program was not a public health function but an emergency management function and response relating to a health emergency'.[430] She was of the view that the implementation of health and welfare policies and protocols (promulgated by the Public Health Incident Management Team) would actually be performed by the Emergency Operation Command, which sat with Ms Williams.[431]

326. Dr van Diemen reflected, in her statement, that fragmented responsibilities 'were indicative of some inconsistencies in understandings between different staff and departments as to who was considered to be ultimately responsible for certain aspects of the program, including oversight of operations on the ground'.[432]

327. In his further affidavit of 12 November 2020, Prof. Sutton emphasised, consistent with his earlier email to Prof. Wallace, 'that public health were not briefed and were not involved and did not have operational control of matters in respect of which we felt we had a moral and perhaps legal responsibility'.[433] He further stated that 'public health were not in day to day decision making roles'.[434]

328. The above evidence leads to the inevitable conclusion that senior DHHS employees did not share a joint or even consistent understanding of who was 'in charge' of the Hotel Quarantine Program as between the various teams inside DHHS. There were divergent views as to who fulfilled what functions and what their respective roles were within the Program. There were also differing views amounting to a fundamental disagreement inside DHHS as to who was reporting to whom inside which chain of command, and who was subordinate to whom.

329. This level of confusion and disagreement inside the DHHS chain of command invariably contributed to the ultimate position that no division inside DHHS saw itself as having the power or authority or ability to be responsible for the operation of the Hotel Quarantine Program. For such a high-risk program to be left in this situation was a catastrophe waiting to happen.

8.3.8 Liaison officer as link to respond to governance issues

330. The Inquiry heard evidence that, in response to these and other concerns about the internal governance and chain of command issues raised in early April by the Public Health Team, a position of Public Health Liaison was to be created to embed in Operation Soteria the link between the DHHS Public Health Team and Operation Soteria.[435] Version 2.0 of the *Operation Soteria Operational Plan* included, under its Organisational Structure, the role 'SCC Public Health Liaison' with a direct line of report to the Public Health Commander.[436]

331. Prof. Sutton gave evidence that he was unsure when the role was specifically created but understood that the position was established, out of an agreement between Dr van Diemen and the State Controller — Health, shortly after the development of Version 2.0 of the *Operation Soteria Operations Plan*.[437] Prof. Sutton said that even the establishment of this role was 'not an optimal way of getting line of sight into the operation of the Program with respect to health and welfare'.[438]

332. When asked directly whether she agreed the role had been created, Dr van Diemen responded as follows:

> So, yes, in respect to the creation of the plans and policies around it. There were a number of members of my team who were on any given day the direct liaison points between the Operation Soteria team and the Public Health Team. It was more than one single formal role. There was in particular liaison into the planning team and liaison into the Case, Contact and Outbreak Management Team for the times when there were cases of more outbreaks in the hotels.[439]

333. Dr van Diemen gave evidence, however, of her continued advocacy for the establishment of a permanent clinical lead to be embedded in the Operation Soteria command structure to ensure health expertise in the operational aspects of the Program. She pressed for this role to be established even after the recognition of the need for a public health liaison officer.[440]

334. Dr van Diemen said that she commenced pushing for the creation of a clinical lead position in late-April 2020.[441] However, by the time she made her statement in mid-September 2020, she remained unsure as to whether that role had ever been filled. At the time she ceased her involvement with the Program in July 2020, there was no clinical lead or liaison in place to her knowledge.[442]

335. Ms Bamert gave evidence that, in response to Dr Romanes's request, she had sought the creation of a public health liaison role during the development of version 2.0 of the *Operation Soteria Operational Plan*. Ms Bamert said she 'had a job card written' for the role, then went on to explain:[443]

> ... in the end what we got was a clinical governance lead who was a nurse practitioner in infection control. It did take us some time to get that resource come in [sic], which was a fantastic resource.

336. Ms Bamert accepted that there were some delays in fulfilling the position of clinical governance lead, and this did not occur until the second week of June 2020.[444] I take Ms Bamert's evidence to refer to the Clinical Lead that Dr van Diemen was pressing for, noting that, as at the time of her statement, Dr van Diemen was unable to say whether such role had been filled. It is plain that there were some differences in the views of Ms Bamert (Commander, Operation Soteria) and Dr van Diemen (Public Health Commander) as to what roles, fulfilling which duties, were created and when.

337. Prof. Wallace gave evidence that the role of 'clinical governance lead' was created based on recommendations made by his organisation and only following the commissioning of two reports investigating serious incidents in the Hotel Quarantine Program.[445]

338. In an email, dated 27 April 2020 and addressed to Ms Williams and Dr Crouch, Senior Medical Advisor, Communicable Diseases Section at DHHS and Deputy Public Health Commander for CCOM, Ms Bamert noted that '[i]n our EOC structure planning we discussed early on having a Public Health Liaison Officer, EOC role that was based in the EOC and liaised and supported public health central teams'.[446] Ms Bamert asked Dr Crouch for his thoughts about the idea and proposed a way of progressing the proposal. Dr Crouch replied: '[i]n general a public health liaison does not sound unreasonable but give [sic] the wide ranging remitting [sic] Annaliese [van Diemen] would need to be happy and engaged with the process. I have cc'd her here'.[447]

339. Mr Helps gave evidence in relation to the possible value of a public health liaison role working within Operation Soteria command. When asked to reflect on whether he thought the public health liaison role was missing from Operation Soteria he said:

> I think a liaison officer would have made communication back to those really busy people within our Public Health Command at times easier. We may have got … we got a lot of queries from other Departments working, and I'm talking initially, into … that were working in the program, around things like PPE, et cetera. If we had had … and there was one built into the structure but as Ms van Diemen articulated yesterday, the number of doctors we had available at the time at times prohibited that being a full-time position. So yes, I probably would have pushed harder to have that. I think we would have got some more timely responses. But I don't want that to sound like a criticism. Our public health colleagues, they were busy. An additional resource would have potentially assisted.[448]

340. It would appear, on the basis of the foregoing, that, from the perspective of those within the EOC responsible for running Operation Soteria, there was no dedicated 'Public Health Liaison' role in Operation Soteria prior to the later creation of the Clinical Liaison role. This is so, despite Prof. Sutton's evidence that agreement had been reached to create such a position, and despite the role actually appearing in the Organisational Structure for Operation Soteria.

341. Putting to one side the differing evidence as to whether that position was actually created, the chain of command issues appeared to require more than the creation of 'a link'. In an email sent by Dr Romanes on behalf of the CHO and DCHO, he called for an urgent review of the governance of Operation Soteria. By that email, those members of the Public Health Team demanded the urgent creation of a 'single plan' to guide the Program.[449]

342. Following the close of evidence on 25 September 2020, the Inquiry sought and received a further statement from Mr Helps in the form of a sworn affidavit and accompanying material. As noted above, Mr Helps stated that 'the governance and responsibility of the Hotel Quarantine Program was with Public Health Command. I believe that all other Department staff (including Emergency Management Command, EOC Command, Compliance and Enforcement, Health and Wellbeing and others) were operating subordinate to, and in support of Public Health Command'.[450]

343. DHHS submitted that public health leadership, advice and expertise was sought by, and operationalised in, Operation Soteria, including through the CHO and Public Health Commander relying on the evidence of Dr van Diemen, Ms de Witts and the Infection Control Consultant, as well as from Ms Williams and Ms Bamert.[451]

344. The first issue to extract from this submission is the difference between the provision of guidance and advice and policy and the **implementation** of that guidance and advice and policy. Implementation requires more than passing on information; it implies the need for a system in place to ensure that this guidance and advice and policy is being adopted and used systematically, is fit for the purpose and is subject to monitoring and supervision.

345. The second issue of note with this submission is that it is not where the weight of the evidence lay. The Infection Control Consultant relied upon for this submission stated that she was not involved in the Hotel Quarantine Program apart from providing some advice from time-to-time. Ms Bamert, herself, saw the need to have public health embedded in the EOC[452] and Dr van Diemen described herself as remaining 'somewhat conflicted' over the removal of Prof. Sutton as the State Controller.[453] The further problem with this submission is that it relied on the views of those not in the Public Health Team.

346. Witnesses from inside the Public Health Team expressed the view that they did not consider they had sufficient oversight of what was happening inside the Hotel Quarantine Program. There was clearly a distinction being drawn between providing advice and guidance to various issues as they arose, as opposed to being properly embedded into the design and operation of the Program with the 'on the ground oversight' of the Program.

347. The DHHS submission that Public Health Command and advice was 'clearly significantly embedded in the Hotel Quarantine Program'[454] is not supported by the evidence of the Public Health Team members Dr Romanes, Prof. Sutton and Dr van Diemen or, indeed, Ms Bamert. There was advice and guidance being produced by public health members but that does not address the chain of command issues.

8.3.9 Lack of oversight 'on the ground'; who was in charge on-site?

348. Given all of the above, it comes as no surprise that there was confusion and misunderstanding on the ground as to who had what role and who was 'in charge' of the operation. Indeed, given the refusal of DHHS to see the Program as its responsibility to lead and manage, through its senior management, it effectively characterised the hotel quarantine sites as the bringing together of a range of agencies that all had accountabilities back up through their own management structures.

349. This difficulty with the conceptualisation of how hotel sites worked can be seen in the oral evidence of Ms Spiteri. She described the hotel site as a 'complex space'.[455] Ms Spiteri described the fact that a number of agencies and contractors were working in the space. Ms Spiteri summed up DHHS's responsibility as one in which its overall 'contribution to safety of the environment was to ensure that there was guidance and instructions provided specifically to this emergency. And what I mean by that is that the instructions around the public health aspects were provided into that environment'.[456]

350. Ms Spiteri went on to describe the space as follows: 'You had a hotel that was owned and managed by a hotel company. DHHS were renting space in it through DJPR … We had our own staff in that environment, so did DJPR, so did Victoria Police and so did a number of contracted companies as well'.[457]

351. Ms Spiteri saw DHHS's responsibility as providing information about PPE and behaviour such as social distancing, with responsibility from an occupational health and safety perspective, lying with every person and their organisations.[458]

352. Ms Williams's view was that 'each agency undertook responsibility for their own staff and contractors, including to ensure their contractors were provided with training as to correct use of PPE'.[459] According to Ms Williams, DHHS was responsible for providing training to its staff on-site (hotel Team Leaders and Authorised Officers) as to correct use of PPE and was also responsible for providing training to its contracted staff on-site (although she noted that 'the Department's contracted nursing and medical staff could be assumed to have familiarity with correct use of PPE').[460]

353. DHHS Team Leaders present at quarantine hotels were there to 'coordinate and problem solve'.[461] As set out above, Ms Williams explained that, if there was a problem with security, the Team Leader would raise it with security managers. If there was a problem with the hotel, the Team Leader would raise it with the hotel manager. If a problem needed to be escalated beyond security or hotel management, it would be escalated to DJPR.[462]

354. No one has sought to ascribe responsibility for managing IPC, welfare services or delivery of clinical care to the Department's Team Leaders. There is no evidence to suggest that it was their role.[463]

355. Ms Spiteri's description of how the sites worked is echoed by the following observation of Nurse Jen about her experiences working on-site as a nurse at the Park Royal Hotel: '… things were siloed — there was a sense that everything was nobody's job. The [DHHS] staff were in charge, but nobody really reported to anyone'.[464]

356. There were Authorised Officers on-site at each hotel. The evidence revealed that the perception of the role of Authorised Officers on-site depended upon who was being asked. There was considerable evidence that many on-site personnel assumed that it was the Authorised Officers who were 'in charge' on-site, as they were the ones with the legal powers to detain and discharge people in quarantine and grant fresh air breaks and temporary leave.

357. Luke Ashford, an Authorised Officer on secondment to DHHS, gave evidence that he was not clear as to what the role of the Authorised Officer would be when he was first seconded to Hotel Quarantine from Parks Victoria.[465] He was appointed as an Authorised Officer on 28 April 2020. At the time, his general idea was that Authorised Officers would be assisting Victoria Police to conduct door knocks and spot checks at homes.[466] By 25 May 2020, when Mr Ashford started his first shift, he still did not have any formal idea of what he would be required to do in his role as an Authorised Officer.[467] Mr Ashford's evidence was that he received no specialist training in respect of performing Authorised Officer duties for DHHS.[468] His training related to the use of the COVID-19 app and equality and diversity training. He had no training on infection control.[469] Mr Ashford did not receive any finalised documents or instructions as to his functions and role.[470]

358. Mr Cleaves said that Authorised Officers had no management or control over other aspects of the Hotel Quarantine Program; their role was heavily focused on the compliance aspects with the detention notices as they applied to the people under detention.[471]

359. Further, Mr Cleaves's evidence was that Authorised Officers were discouraged from helping others with tasks unrelated to detention. He said:

> Over time it became clear that we needed to settle into what was described as our lane, and one of our Commanders would regularly use that phrase of 'stay in our lane', which we clearly understood to be focusing on the things for which we were accountable, which was the legal detention process, as I've mentioned a number of times.[472]

360. Arrangements for Authorised Officers at each hotel posed challenges for those in hotel quarantine. Rostering arrangements meant that, often, Authorised Officers would work at different hotels and not at the same hotel over a period, leading to a lack of continuity at each hotel. As new Authorised Officers came into a new hotel, they would be faced with different situations and different experiences.[473] There were inconsistencies throughout hotels, particularly with handovers between shifts, in respect of walk-lists and temporary leave arrangements for compassionate leave.[474]

361. The evidence of Mr Cleaves was that Authorised Officers did not have operational control over security teams.[475] Similarly, Mr Cleaves stated he did not recall personally giving direct instructions to security guards regarding operational matters such as cleaning or the appropriate use of PPE, except when carrying out a specific Authorised Officer function.[476] He was clear that security did not report to Authorised Officers, nor did Authorised Officers supervise security or their teams.[477]

362. But they were not the views held by those providing security services at hotels. Evidence from security guards and security companies was that they saw Authorised Officers as 'in charge' at hotels. For example:

    A. The security guard known as Security 1 understood that Authorised Officers were in charge of quarantine at the site.[478] Similarly, the security guard known as Security 2 understood that 'DHHS [was] the ultimate authority, as the Authorised Officer'.[479]

    B. Greg Watson, from Wilson Security Pty Ltd, understood that Authorised Officers were in charge of the site, on the basis that they were mentioned in detention orders, mentioned as a point of escalation, and in correspondence where it is identified that the decision rested with Authorised Officers.[480]

C. Jamie Adams, from MSS Security Pty Ltd, understood that each hotel would have an Authorised Officer and that security would report to them at a site on a day-to-day operational level.[481]

D. Mo Nagi, from Unified Security Group (Australia) Pty Ltd, gave evidence that he understood the responsibilities of Authorised Officers at hotels included dealing with guest issues and managing fresh air walks.[482] He saw Authorised Officers as the 'overlay of any issues and concerns that were required where any authority needed to occur …' [483] Mr Nagi accepted that Authorised Officers could give directions to, or make requests of, security staff.[484]

E. Ishu Gupta, one of the directors of The Security Hub Pty Ltd, was critical of Authorised Officers whom he saw as 'running the program' without necessarily having relevant training and knowledge or a background in health.[485]

F. Commander Tim Tully of Victoria Police gave evidence that he observed that security guards would look to Authorised Officers for guidance on what could actually be undertaken in the hotel quarantine environment; however, his evidence was also that Authorised Officers were saying 'well, we're not in a position to empower you to do it'.[486]

363. It is understandable that many perceived that Authorised Officers were 'in charge' as they did represent the legal power to detain people in their rooms as well as grant fresh air breaks and leave and, ultimately, authorise the discharge of people from their mandatory quarantine period.

364. However, Authorised Officers on-site at the hotels had no role in overseeing IPC.[487] Mr Smith (Commander of COVID-19 Enforcement and Compliance) espoused the view that the Commander of Operation Soteria had overall responsibility for IPC and that DHHS Team Leaders were their representatives on-site. It was his understanding that this included responsibility for PPE but only for DHHS staff — as opposed to the other staff — working at the hotels.[488]

365. The evidence as to the perceptions and confusion, in particular from non-DHHS people about who was 'in charge' on-site, was a completely understandable and human response to this situation. Putting to one side the question of having the right expertise on-site, at a minimum, such a challenging and dangerous environment that mandated people into a 14-day detention demanded that the control agency provide an on-site supervisor whose role it should have included monitoring safety on-site and understanding and intervening when risks and dangers emerged on-site.

366. In her statement, Ms Spiteri, when asked what could have been done differently, sensibly and helpfully stated that '[e]arlier strengthening of the role of rostering of the Department's team leaders in hotels, as well as clearer communications about the roles of the Department's team leaders, Authorised Officers and DJPR site managers, would have assisted all staff working in the quarantine hotels to understand who to report to for escalation and resolution. A clear, consistent and communicated unified command structure at each hotel, with consistent staffing of key management positions, could have ensured all staff working in quarantine hotels knew who was in charge of which aspects of the operation'.[489] Ms Spiteri went on to explain that 'The ongoing challenge to resource Departmental Team Leader and Authorised Officer roles, given the speed with which the program was initially stood up and then the pace of standing up new quarantine hotels, was a key factor in preventing this from occurring'.[490]

367. Setting up this Program, bringing all of the disparate agencies together and not having a coherent on-site supervising presence was always going to fall short of what best practice required of such a dangerous site. It was not enough to provide advice and guidance and policies to a disparate group of people and rely on the various agencies to oversee themselves. Each site needed a supervisory role to ensure that the site operated safely and according to best practice.

368. This is why I recommended that the Quarantine Governing Body ensures that each facility has a Site Manager responsible for the overall operation of that facility, who is accountable to that Body, and who possesses experience in the management of complex healthcare facilities.[491] That Site Manager must ensure that all personnel working in the quarantine facility understand their role and responsibilities and to whom they report and are accountable.[492]

8.3.10 Clinical guidance and governance on-site

369. Having found that such a complex and dangerous site needed on-site supervision from the control agency, the next question was what skills and background people filling such roles should have had. The nature of the virus and constant and inherent dangers of transmission required nothing short of IPC expertise on-site, to embed best practice infection and control processes, oversee the induction and training of all personnel on-site, and maintain vigilant oversight and monitoring to minimise the risk of transmission of the virus.

370. As has been stated throughout this Report, the supply and use of PPE, cleaning procedures and IPC procedures are areas of expertise that cannot be left to chance, or, merely, to posters put up on-site or one-off pieces of training from time-to-time. Nothing short of constant on-site vigilance from those with the right expertise is what is required. For this reason, I have recommended that the Site Manager be responsible for IPC measures, including with respect to training and supervision arrangements.[493]

371. Dr van Diemen conceded that priority should have been given to ensuring there was oversight from clinically-trained personnel.[494] She observed that 'we all could have treated the hotel quarantine program more as a health program than a logistics or compliance exercise and viewed the overarching principles more from a health lens than occurred at the time, including standards of care and infection control'.[495] She also reflected that, in line with a greater health focus, there could have been regular external auditing and reporting on adherence to standards.[496]

372. On this issue, it was the evidence of Mr Helps that there was no overall risk register created across the Program.[497] Mr Helps noted that the risks and issues were such that they required immediate action and resolution. No argument can be taken with that, but it misses the value and importance of capturing what is happening at and across sites, and the value of having a central repository for this information to ensure that a risk addressed on one site is analysed and addressed to assess whether there may be a systems-wide issue to address. The maintenance of a risk register is a proper and necessary practice at each quarantine facility. It should be made available for the purposes of safety audits that should be undertaken by independent experts.[498]

373. Mr Helps was unaware if agencies working in the Program maintained a risk register,[499] but whether they did or did not, the agency with overall site responsibility, DHHS, should have maintained such a register to enable the necessary system-wide overview.

374. Incorporated into the safe operation of sites should be regular safety audits, which would include inspection of the risk registers. This would have assisted in a more cohesive and Program-wide view of the emerging risks across the hotel sites.[500]

375. The evidence was that there was public health guidance provided from time-to-time[501] to Operation Soteria. This guidance, which the Public Health Team had input into, included PPE advice for healthcare workers, security staff and Authorised Officers, advice about cleaning requirements, and guidelines for the health and welfare of the detainees.[502]

376. A number of witnesses from DHHS gave evidence about the various policies and procedures relating to infection control and welfare that were drafted and disseminated. But the process was *ad hoc*, fragmented and reactive.

377. Advice in respect of cleaning provides a useful illustration. I have described cleaning policies in more detail in Chapter 7 of this Report. Suffice to say, there were several iterations of cleaning advice provided at different times, to different people and entities and on a variety of different topics.[503] The process by which specific and tailored cleaning guidance was disseminated is an example. The document entitled *Cleaning and disinfecting to reduce COVID-19 transmission: Tips for non-healthcare settings* (dated 20 March 2020: pre-dating the set-up of Hotel Quarantine) was initially used as guidance for cleaning of quarantine hotels. According to that document '[t]he principles in this guide apply equally to domestic settings, office buildings, small retail businesses, social venues and all other non-healthcare settings'.[504]

378. By email, dated 2 April 2020, Ms Febey of DJPR wrote to the State Emergency Management Centre, asking for 'some advice which is more tailored to the context that we're operating in' and noting that quarantine hotels 'are running essentially health services'.[505] However, as at 27 April 2020, cleaning contractors were still being directed to that document as guidance for the cleaning of quarantine hotels.[506] Eventually, specific guidance was prepared that set out advice for cleaning requirements for hotels that were accommodating quarantined, close contacts and confirmed COVID-19 guests.[507]

379. Prof. Sutton explained that the Public Health Incident Management Team provided guidance and advice and policies to the Hotel Quarantine Program regarding the use of PPE and cleaning and other matters relevant to IPC but had no awareness of the level of compliance with those policies;[508] that is, at least until the outbreaks occurred and were the subject of investigation and scrutiny. Dr van Diemen also said that her team's lack of operational oversight meant that the Public Health Command was not aware of significant IPC issues plaguing the Program until after the outbreaks.[509] Indeed, the Public Health Team did not regard itself as responsible for the implementation or supervision of those policies on-site. That meant that there was no one on-site with the expertise to maintain the necessary vigilance and supervision required. That this gap in the Program existed was a serious danger inherent in the Program.

380. Certainly, public health expertise from within the Public Health Command was called upon during the Program. So, too, was external expertise from Infection Prevention Australia. However, from a control and governance perspective, that public health advice was developed and on-shared to other agencies and their contractors to implement. These other agencies and contractors did not have expertise in IPC.

381. There was no evidence presented of any overarching plan, oversight or accountability within the Program for IPC on-site. While there were obvious aspects of the Program designed to meet these ends, they were largely reactive and lacking in cohesion of plan and purpose. The evidence demonstrated that the need for overarching clinical governance was not identified in the initial planning and implementation of the Program. It was apparently not until after the first outbreak from Rydges that thought was given by DHHS senior management to instituting a system of a clinical governance framework with a clinical governance lead.[510] It had no real effect until the engagement of Alfred Health, on 27 June 2020, when it took over clinical governance and clinical leadership of the Program[511] to provide 'streamlined clinical governance and oversight functions at the COVID Positive hotel with clinical staff and auxiliary and security staff all being drawn from individuals experienced in the IPC requirements of hospital environments'.[512]

382. It is now clear that the expert guidance that was provided, by way of advice and policies, did not extend to the level of operational oversight that was essential to the minimising of risk to the operation of the Hotel Quarantine Program.

383. There were others within the SCC structure that had the relevant expertise in emergency planning and logistics, most notably, the Emergency Management Commissioner, Victoria Police and the Australian Defence Force. In a Class 2 health emergency, health should be the focus of DHHS. That is the expertise that DHHS was expected to bring to the emergency response, and the Department's decision-making should have reflected that focus.

8.3.11 Ministerial briefings

384. During the course of the Inquiry, the issue of the briefing of Ministers by senior public servants arose on more than one occasion. In the DHHS context, Ms Peake acknowledged that, as Secretary to DHHS, she was accountable to her Ministers, including the Health Minister.[513] She was also accountable to the Premier in her role as Mission Lead — Secretary for the COVID-19 response.[514] In each role, she was specifically accountable for keeping those Ministers informed of significant issues within their portfolios.[515]

385. In response to questions by Counsel Assisting about the set up and structure and lines of accountability for the Hotel Quarantine Program, former Minister Mikakos gave evidence that she was not consulted nor did she receive any advice as to the operational plan or the initial decisions taken in the setup of the Program.[516]

386. Former Minister Mikakos agreed that DHHS's involvement in the Hotel Quarantine Program, even initially, was a substantial undertaking and a significant issue that fell within her portfolio.[517]

387. Her evidence was that she did not 'approve' of the plan in the sense of signing off on it. She stated that she considered that to be the role of the Emergency Management Commissioner.[518]

388. Similarly, the evidence of former Minister Mikakos was that she was not consulted or involved in the decision to move to the emergency management framework in which DHHS was the control agency for the Program.[519] Neither was she consulted with respect to the decision not to appoint the CHO as the State Controller — Health in the face of the looming COVID-19 pandemic, although, it was the former Minister's evidence that she would not expect to have been briefed on that issue.[520]

389. Former Minister Mikakos did, however, express 'surprise' that she was not delivered copies of Safer Care Victoria reports that investigated two serious incidents in the Hotel Quarantine Program.[521] The reports contained recommendations about a range of matters that should be addressed to improve safety for people being detained in quarantine hotels.[522]

390. While the Premier became aware of the control agency arrangements early on in the Hotel Quarantine Program, he could not point to a specific document or briefing as to precisely when he became so aware.[523] He was aware, in general terms, of the concept of control agency and support agency for emergency management purposes, and the significance of those terms.[524] He stated that he may have had some sense of departmental arrangements, but not much awareness as to the agencies involved. He thought that he would have had a briefing on the operational structure of the Program ahead of the announcements he made at his press conference on 28 March 2020, but could not recall the specifics.[525] However, in the ordinary course of his duties, he said, he would not expect to see operational documents.[526]

391. DHHS submitted that 'there was very regular and appropriate briefing of Ministers, their offices, the Premier, his office and the Crisis Council of Cabinet on … the operation of the hotel quarantine program'.[527] This submission is at odds with aspects of the evidence of both the Premier and former Minister Mikakos.[528]

392. Another example of information that was significant to the operation of the Hotel Quarantine Program being provided to a senior public servant but not being passed on to a Minister can be found in an email exchange in early April 2020. That exchange was between Phil Gaetjens, Secretary to the Department of Prime Minister and Cabinet, and his Victorian counterpart, Mr Eccles.[529] Mr Eccles gave evidence that he had asked the Commonwealth to assist with the cost of private security at hotels.[530] Mr Gaetjens responded that NSW had been provided with support in the form of Australian Defence Force personnel and that the same support might be available to Victoria if it were to reconsider its model of operating the Hotel Quarantine Program.[531]

393. Mr Eccles did not, so far as the documentary evidence reveals, respond, other than by return email to say 'thanks'.[532] His oral evidence was that he could not recall taking any other action in response to this email.[533] In its submissions, DPC accepted that the evidence established that Mr Eccles did not draw the contents of Mr Gaetjens's email to the attention of the Premier. DPC further accepted that it was open to me to find that Mr Eccles should have drawn the contents of Mr Gaetjens's email to the attention of the Premier, because its contents concerned a significant issue.[534] These concessions are properly made. Apart from anything that has later been learned about the issues that arose with respect to the use of private security, their use in the Hotel Quarantine Program was at a cost of many millions to the public purse.

394. Similarly, Minister Pakula, as the Minister for DJPR, gave evidence that, while he received verbal briefings from time to time about the work of DJPR in the Hotel Quarantine Program, he only became aware of issues and concerns his department was having about such things as whether there should be a police presence at hotels or whether people should be allowed out of their rooms, as a result of evidence to this Inquiry.[535] Further, his evidence was that he was not aware that contracts were going to be entered into for the provision of private security services or cleaning services, or how those contracts were constructed.[536] Minister Pakula was unable to recall how he became aware that his department had entered into contracts with private security companies for the provision of services at quarantine hotels. He thought it may have been 'from media reportage' or 'a conversation'.[537] Minister Pakula thought it was 'usual' that he would not know about his department being engaged in these multimillion dollar contracts.[538] Indeed, the estimate given from DPC for the amount spent by DJPR for its part in the Hotel Quarantine program was $133.4 million to 30 June 2020.[539]

395. As can be seen from these examples taken from the evidence, the issue of the information that does or does not get passed on by senior public servants to Ministers responsible to Victorians for the operation of their portfolios came up in several significant ways across several departments. Ensuring that Ministers are thoroughly and properly briefed is part of our system of responsible government, in place to create checks and balances on bureaucratic decision-making. It is also in place to, thereby, confirm that the Minister for the department is performing the important function of maintaining oversight of his or her department's actions for which he or she is answerable to the people of Victoria.

396. It is beyond the remit of this Inquiry to engage in an examination of the Westminster system of ministerial and public service lines of accountability and responsibility. However, the evidence on this issue that emerged in the Inquiry dictates that an appropriate agency or entity should undertake an examination of what has occurred to assess what action may be necessary in response. Given the role and responsibilities of the Public Sector Commissioner, as set out in the *Public Administration Act 2004* (Vic), I am satisfied that this is the appropriate place to direct a recommendation.

397. For the above reasons, I make the following Recommendation:

Recommendation 76: That the Public Sector Commissioner examines the evidence that emerged in this Inquiry as to the lines of accountability and responsibility as between Departmental heads and Ministers to give guidance across the public service as to the obligations on heads of departments and senior public office holders, both in law and in practice.

8.3.12 Appropriateness of EMMV and Class 2 emergency

398. The evidence was that this was the first time that the EMMV framework was used in a large-scale health emergency. Mr Helps stated '[t]he complex structure did at times raise challenges as State controller-health with navigating the various governance structures and establishing if a response activity was tasked through EM arrangements, public health command or through other national and state government departments "business as usual" arrangements.[540] At times, because of this structure, it was difficult to track the origin of a decision, the role or position responsible and information, data or plans'.[541]

399. Given this evidence, together with the evidence of the layers of confusion and complexity that emerged as to the interaction between the emergency management framework and the statutory roles and responsibilities under the PHW Act of those in public health, a review and reconsideration is warranted as to whether the EM framework, in its current structure, is suitable for Class 2 public health emergencies. I note that both Mr Helps and Ms Spiteri considered such a review is called for.[542]

Recommendation 77: The Emergency Management Commissioner, in collaboration with the Chief Health Officer, Secretary DHHS and other relevant agencies, reviews the suitability of the emergency management framework to Class 2 public health emergencies, including how the framework intersects with the *Public Health and Wellbeing Act 2008* (Vic).

8.4 — Summary of conclusions

400. During that March weekend, the commencement of the Hotel Quarantine Program in DJPR created the first fracture in lines of accountability and governance from which aspects of the operation did not recover. Even though the Program was quickly reset within Victoria's emergency management framework, that DJPR held the contracts for hotels, security guards and aspects of cleaning contributed to the firmly-held view in DHHS that it was in a model of 'shared accountability' with DJPR for the operation of the Hotel Quarantine Program.

401. Victoria's emergency management framework contains an extensive range of documents, manuals and plans that endeavour to address the range of emergencies that could transpire, and sets out structures by which to respond to those various types of emergencies. One of the aims of the emergency management framework is to establish efficient governance arrangements that clarify roles and responsibilities of agencies and to facilitate co-operation between agencies.

402. The emergency management framework classifies emergencies into different classes depending on the type of emergency being faced. The framework also designates which agency will be designated as the 'control agency' depending on the expertise required to respond to that emergency. A pandemic is classified as a Class 2 emergency and designates that DHHS is the control agency.

403. The use of the emergency management framework to respond to the COVID-19 pandemic was the first time it had been used in Victoria for a large-scale Class 2 emergency.

404. While there was a range of plans in place in this framework, none of those plans contemplated mass mandatory quarantining of people in response to a Class 2 emergency.

405. While there was no controversy about the appointment of DHHS as the control agency for this Class 2 emergency, there was considerable controversy that persevered throughout the Inquiry as to what it meant to be the control agency.

406. The meaning of the term 'control agency' is defined in the emergency management framework as the agency with the **primary responsibility** for responding to a specific form of emergency. The control agency's responsibilities are set out in the EMMV and include the appointment of 'controllers' for the specific form of emergency.

407. The importance of having a control agency in emergency management is to ensure clear lines of command and control, as this is critically important to lead and manage the emergency, coordinate the response and ensure there is no ambiguity about who is accountable for the management of the emergency.

408. Notwithstanding that DHHS acknowledged it was the control agency, it characterised its role in the Hotel Quarantine Program as one in which it had a 'shared accountability' with DJPR. It relied on several lines of reasoning to characterise its role in this way. First and foremost, it relied on the concept that the overall response to the pandemic and the Hotel Quarantine Program, as part of that response, fell within the meaning of a *complex emergency* as contained in the EMMV. In such circumstances, the need for 'shared accountability' is referred to but the reference goes on to make clear that, in these collaborative responses as between agencies, there is a need for a single agency to be responsible as the lead agency.

409. To the detriment of the operation of the Hotel Quarantine Program, DHHS did not accept that role or responsibility of being the single lead agency, either during the running of the Program or, indeed, even on reflection, during this Inquiry. This left the Hotel Quarantine Program without a government agency taking leadership and control and the overarching responsibility necessary to run such a complex and high-risk program. DHHS was the government agency that had this responsibility. Not only was it the control agency in emergency management terms, but it was the repository of the public health expertise and was the government department that had responsibility for the legal powers exercised to detain people in quarantine.

410. Notwithstanding this fundamental mischaracterisation of its role and function, adopting the structure and language of the emergency management framework, DHHS appointed a range of 'controllers' and 'commanders' inside complex and, at times, inexplicable internal governance structures that served to complicate and obfuscate reporting lines and accountabilities rather than create clarity of role definition and lines of command.

411. Prior to the commencement of the Hotel Quarantine Program, the Secretary to DHHS, on the advice of one of her deputy secretaries, departed from the expectation of the emergency management framework that the CHO would be appointed State Controller for a public health emergency and, instead, appointed two emergency management experts as State Controllers. This was despite the disagreement of the CHO with this course of action. (Note that at 8.3.3 paragraphs 275 to 278, it appeared that Prof. Sutton was formally appointed as one of four State Controllers – Health but that he was not made aware of this.)

412. The decision to not (apparently) appoint Prof. Sutton was taken on the basis that the CHO would not have the 'bandwidth' to fulfil all of the functions he had in the context of the state-wide emergency, and on the basis that the role required emergency management logistics (hence, the appointment of two such experts).

413. The impact of this decision had three important ramifications. First, it contributed to the mischaracterisation of the operation of the Hotel Quarantine Program as a 'logistics' and 'compliance' exercise rather than a public health program. Second, it created another fragmentation in governance of the Program, as it removed the head of the DHHS Public Health Team from much-needed operational oversight of the Program and, third, it meant that those in leadership roles for the Program were not people with public health expertise.

414. It concerned both the CHO and the DCHO that people were being detained using the legal powers authorised by them and yet they did not consider they had sufficient authority or oversight or awareness as to how the operation was being run 'on the ground'. Further, there was considerable disquiet expressed from the senior members of the Public Health Team inside DHHS that there was a lack of clarity about the command structures inside DHHS.

415. Inside DHHS's internal governance structures, as between emergency management executives and the public health senior members, there was not an agreed view or consistent understanding as to who was fulfilling what functions and roles and who was reporting to whom. In the context of the operation of the Hotel Quarantine Program, this created confusion and fragmentation in governance structures.

416. The mischaracterisation of the Hotel Quarantine Program as a 'logistics' and 'compliance' exercise meant that focus did not fall on the need for expert infection and prevention oversight to be embedded into the Program.

417. The impact of the pandemic and its demands on the Public Health Team inside DHHS revealed, among other shortages, a significant lack of much-needed public health infection prevention expertise employed by DHHS.

418. By mid-April, it was recognised that the Hotel Quarantine Program would likely be in place for 12–18 months and, therefore, needed to be taken out of an emergency management response structure and run as a departmental program. To that end, a centre was set up, ironically called the Emergency Operation Centre, and run by DHHS 'commanders'. Unfortunately, DHHS did not take this opportunity to rethink its operation but, rather, continued to see itself as co-ordinating the day-to-day operation of the hotel sites but not taking overall responsibility for the Program.

419. DHHS executives continued to see DHHS as responsible for providing 'broad' policy support, supporting the health and wellbeing of people being held in quarantine, obtaining advice and guidance from the public health arm of DHHS and passing that on to various agencies on-site, including DJPR, hotel operators and private security firms, in the firm view that each agency was responsible for its own operation on-site.

420. The on-site presence that DHHS did have was through its Team Leaders and Authorised Officers. Neither of these roles had functions of oversight or direction or supervision. The Team Leaders were seen as problem solvers or liaison points on-site. The Authorised Officers were responsible for the exercise of legal powers to detain people in quarantine. They exercised the legal powers to grant leave and exemptions and discharge people from quarantine at the end of their 14-day period. Neither had any role or authority or expertise in supervising the safety of the site generally.

421. Just as DHHS did not see itself as the control agency responsible for the Program, it did not see itself as 'in charge' on-site. This left brewing the disaster that tragically came to be. This complex and high-risk environment was left without on-site supervision and management, which should have been seen as essential to an inherently dangerous environment. That such a situation developed and was not apparent as a danger until after the two outbreaks was the ultimate evidence of the perils of the lack of proper leadership and oversight.

422. Ultimately, the intractable problems of governance and control and leadership in the Hotel Quarantine Program presented like a 'Gordian knot' that was only 'cut'" after the outbreaks in July when the responsibility for the Program was removed from DHHS.

8.4.1 Summary of Recommendations

74. That the Emergency Management Commissioner clarifies the language used in the Emergency Management Manual Victoria to ensure that there is no possibility of any ambiguity about the role and responsibility of the control agency, including a more fulsome definition of what constitutes a complex emergency and the role of the designated control agency in a complex emergency.

75. That the Secretary of DHHS engages in discussions with the President of the Australian Medical Association to address the availability of medical expertise to meet current and future surge and planning demands for public health emergencies.

76. That the Public Sector Commissioner examines the evidence that emerged in this Inquiry as to the lines of accountability and responsibility as between Departmental heads and Ministers and gives guidance across the public service as to the obligations, both in law and in practice, on heads of departments and senior public office holders.

77. The Emergency Management Commissioner, in collaboration with the Chief Health Officer, the Secretary of DHHS and other relevant agencies, reviews the suitability of the Emergency Management Manual Victoria framework to Class 2 public health emergencies, including how the Emergency Management Manual Victoria intersects with the *Public Health and Wellbeing Act 2008* (Vic).

Endnotes

1 Exhibit HQI0130_RP Witness Statement of Ms Pam Williams, 40 [106].
2 Exhibit HQI0135_RP Witness Statement of Ms Merrin Bamert, 27 [94].
3 Transcript of day 15 hearing 10 September 2020, 1153–1154.
4 Exhibit HQI0135_RP Witness statement of Ms Merrin Bamert, 27 [94].
5 Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 5 [15].
6 Ibid.
7 *Emergency Management Act 2013* (Vic) (EM Act), s. 3.
8 Exhibit HQI0140_P Witness statement of Mr Craig Lapsley, 2 [4].
9 EM Act, s. 5.
10 Ibid s. 5(b)(i), (ii).
11 Ibid s. 24(1).
12 Ibid s. 32(1)(a).
13 Ibid s. 32(1)(b).
14 Ibid s. 32(1)(e)(ii).
15 Ibid s. 32(1)(mb).
16 Ibid s. 3; Exhibit HQI0145_RP Annexure to first witness statement of Commissioner Andrew Crisp, DOJ.600.001.0275-0276.
17 Exhibit HQI0145_RP Annexure to first witness statement of Commissioner Andrew Crisp, DOJ.600.001.0275–0276.
18 Ibid DOJ.600.001.0719.
19 EM Act, s. 53(1)(a).
20 Transcript of day 15 hearing 10 September 2020, 1212.
21 EM Act, s. 54(a).
22 Ibid s. 54(b).
23 Ibid s. 54(c). See Part 7 for agencies' roles with respect to a specified emergency.
24 Ibid s. 54(d).
25 Ibid s. 54(ea)–(ec).
26 Exhibit HQI0145_RP Annexures to first witness statement of Commissioner Andrew Crisp, DOJ.600.001.0501.
27 Part 3 provides the State Emergency Response Plan; Part 7 describes Emergency Management Agency Roles; Part 8 sets out Response and Recovery Regions (Appendix 8).
28 Exhibit HQI0145_RP Annexures to first witness statement of Commissioner Andrew Crisp, DOJ.600.001.1026.
29 Ibid DOJ.600.001.1032.
30 Ibid DOJ.600.001.0325.
31 Ibid DOJ.600.001.0446.
32 Ibid DOJ.600.001.0239.
33 Ibid DOJ.600.001.0276.
34 Ibid DOJ.600.001.0735.
35 Ibid DOJ.600.001.0313.
36 Ibid DOJ.600.001.0319–0320.
37 Exhibit HQI0186_RP First witness statement of Ms Kym Peake, 3 [10.6].
38 Exhibit HQI0145_RP Annexures to first witness statement of Commissioner Andrew Crisp, DHS.600.001.0719.
39 Ibid.
40 Ibid DOJ.600.001.0279.
41 Ibid DOJ.600.001.1058.
42 Ibid DOJ.600.001.0288.
43 Exhibit HQI0140_P Witness statement of Mr Craig Lapsley, 21 [17].
44 Ibid.
45 Ibid 19 [14].
46 Exhibit HQI0145_RP Annexures to first witness statement of Commissioner Andrew Crisp, DOJ.600.001.0717.
47 Ibid.
48 Transcript of day 15 hearing 10 September 2020, 1212.
49 Transcript of day 19 hearing 17 September 2020, 1581.
50 Exhibit HQI0144_P First witness statement of Commissioner Andrew Crisp, 3 [11(c)].
51 Transcript of day 17 hearing 15 September 2020, 1355.
52 Exhibit HQI0145_RP Annexures to first witness statement of Commissioner Andrew Crisp, DOJ.600.001.1054.
53 Ibid.

54 Ibid DOJ.600.001.0317.
55 Transcript of day 17 hearing 15 September 2020, 1352.
56 *Public Health and Wellbeing Act 2008* (Vic) (PHW Act), s. 200(1)(a).
57 Transcript of day 17 hearing 15 September 2020, 1366.
58 Exhibit HQI0186_RP First witness statement of Ms Kym Peake, 38 [191]; Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 5 [14].
59 Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 5 [14].
60 Exhibit HQI0186_RP First witness statement of Ms Kym Peake, 2 [9].
61 Ibid 3 [10.6].
62 Exhibit HQI0186_RP First witness statement of Ms Kym Peake, 2 [8].
63 Transcript of day 18 hearing 16 September 2020, 1454.
64 The Hon. Daniel Andrews MP, Premier of Victoria, 'New Departments to deliver a healthier, fairer Victoria' (Media Release, 30 November 2020) <https://www.premier.vic.gov.au/new-departments-deliver-healthier-fairer-victoria>.
65 Exhibit HQI0186_RP First witness statement of Ms Kym Peake, 8 [36].
66 Ibid 8 [38].
67 Ibid 8 [37].
68 Exhibit HQI0126_RP Annexures to witness statement of Ms Melissa Skilbeck, DHS.0001.0001.0013.
69 Ibid DHS.0001.0001.0016.
70 Ibid DHS.0001.0001.0017.
71 Ibid DHS.0001.0027.0909-0910.
72 Exhibit HQI0125_RP Witness statement of Ms Melissa Skilbeck, 4 [20]–[21].
73 Ibid 4 [25].
74 Exhibit HQI0186_RP First witness statement of Ms Kym Peake, 12 [50].
75 Exhibit HQI0125_RP Witness statement of Ms Melissa Skilbeck, 4 [21].
76 Exhibit HQIO153_RP Witness statement of Prof. Brett Sutton, 15 [74]; Exhibit HQI0155_RP Annexures to witness statement of Prof. Brett Sutton, DHS.5000.0056.3664.
77 Exhibit HQI0186_RP First witness statement of Ms Kym Peake, 12 [51].
78 Ibid 12 [52].
79 Exhibit HQI0162_P Witness statement of Ms Andrea Spiteri, 2 [7].
80 Exhibit HQI0098_RP Annexures to witness statement of Dr Clare Looker, DHS.5000.0056.3655.
81 Exhibit HQI0113_P Witness statement of Dr Finn Romanes, 3 [11].
82 Exhibit HQI0160_RP Witness statement of Dr Annaliese van Diemen, 4 [20].
83 Exhibit HQI0144_P First witness statement of Commissioner Andrew Crisp, 5 [12(c)].
84 Ibid 16 [34]; Exhibit HQI0164_RP Witness statement of Mr Jason Helps, 11 [44].
85 Exhibit HQI0144_P First witness statement of Commissioner Andrew Crisp, 19 [46].
86 Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 4 [11]; Exhibit HQI0144_P First witness statement of Commissioner Andrew Crisp, 10 [16(c)].
87 Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 4 [9]–[10].
88 Ibid; Transcript of day 16 hearing 11 September 2020, 1267.
89 Exhibit HQI0126_RP Annexures to witness statement of Ms Mellissa Skilbeck DHS.0001.0001.1449.
90 Exhibit HQI0153_RP Witness statement of Prof. Brett Sutton, 8 [34].
91 Transcript of Day 18 hearing 16 September 2020, 1454.
92 Exhibit HQI0103_RP Witness statement of Dr Simon Crouch, 1 [5]; Exhibit HQI0113_P Witness statement of Dr Finn Romanes, 2 [8].
93 Exhibit HQI0153_RP Witness statement of Prof. Brett Sutton, 8 [35]; Exhibit HQI0113_P Witness statement of Dr Finn Romanes, 2 [8]. The Public Health Incident Management Team also had two functions fulfilled by Executive Leads who report to the PHC, these were Strategic Communication and Public Health Operation Coordination (see, Exhibit HQI0153_RP Witness statement of Prof. Brett Sutton, 8 [36]; Exhibit HQI0113_P Witness statement of Dr Finn Romanes, 2 [9].
94 Exhibit HQI0151_P Witness statement of Ms Jacinda de Witts, 2 [7].
95 Previously titled Public Health Emergency Operation and Coordination until 1 July 2020 (see Ibid 1 [5]; [7(b)]).
96 Exhibit HQI0151_P Witness statement of Ms Jacinda de Witts, 1 [5].
97 Ibid 1 [4].
98 Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 4 [11].
99 Ibid 4 [10].
100 Ibid.
101 Exhibit HQI0135_RP Witness statement of Ms Merrin Bamert, 6 [18].
102 Ibid 5 [17].

103 Exhibit HQI0126(1)_RP Annexures to witness statement of Ms Melissa Skilbeck, DHS.0001.0001.0812–0817.
104 Exhibit HQI0186_RP First witness statement of Ms Kym Peake, 3 [12].
105 Ibid 3 [13].
106 Transcript of day 23 hearing 23 September 2020, 1965.
107 Exhibit HQI0177_RP First witness statement of Mr Christopher Eccles, 21 [82].
108 Ibid.
109 Exhibit HQI0193_P Letter from the Hon. Daniel Andrews MP to Ms Kym Peake, DHS.0001.0031.0004.
110 Ibid.
111 Exhibit HQI0186_RP First witness statement of Ms Kym Peake, 4 [16].
112 Ibid.
113 Exhibit HQI0193_P Letter from the Hon. Daniel Andrews MP to Ms Kym Peake, DHS.0001.0031.0004–0005; Exhibit HQI0186_RP First witness statement of Ms Kym Peake, 4 [15]–[16]; Transcript of day 22 hearing 22 September 2020, 1910.
114 Exhibit HQI0193_P Letter from the Hon Daniel Andrews MP to Ms Kym Peake, DHS.0001.0031.0004.
115 Ibid.
116 Transcript of day 22 hearing 22 September 2020, 1909.
117 Exhibit HQI0193_P Letter from the Hon. Daniel Andrews MP to Ms Kym Peake, DHS.0001.0031.0004.
118 Transcript of day 22 hearing 22 September 2020, 1903.
119 Ibid.
120 Exhibit HQI0193_P Letter from the Hon. Daniel Andrews MP to Ms Kym Peake, DHS.0001.0031.0004–0005.
121 Transcript of day 22 hearing 22 September 2020, 1910.
122 Ibid.
123 Ibid 1912.
124 Ibid 1910.
125 Ibid 1911–1912.
126 Ibid.
127 Ibid 1915.
128 Ibid.
129 Ibid.
130 Ibid 1903.
131 Ibid 1915.
132 Ibid 1916.
133 Ibid 1918.
134 Exhibit HQI0153_RP Witness statement of Prof. Brett Sutton, 7 [30].
135 Ibid 6 [28], 7 [32(a)–(b)], [fn 6].
136 Exhibit HQI0125_RP Witness statement of Ms Melissa Skilbeck, 2 [10].
137 Ibid; Exhibit HQI0151_P Witness statement of Ms Jacinda de Witts, 2 [7].
138 Exhibit HQI0194_RP Mission Implementation Plan, DHS.0001.0013.0414.
139 Exhibit HQI0153_RP Witness statement of Prof. Brett Sutton, 6 [26].
140 Exhibit HQI0151_P Witness statement of Ms Jacinda de Witts, 2 [8]; Transcript day 18 hearing 16 September 2020, 1453.
141 Exhibit HQI0125_RP Witness statement of Ms Melissa Skilbeck, 1 [5]–[6]; Exhibit HQI0152_P Annexures to witness statement of Ms Jacinda de Witts, DHS.1000.0004.0001.
142 Transcript day 18 hearing 16 September 2020, 1453.
143 Ibid 1455.
144 Ibid 1454.
145 Exhibit HQI0162_P Witness statement of Ms Andrea Spiteri, 2 [7].
146 Exhibit HQI0166_P Class 2 State Controller responsibilities, DHS.0001.0027.0196.
147 Transcript of day 19 hearing 17 September 2020, 1583–1584.
148 Ibid 1583.
149 Ibid 1583-1584.
150 Ibid 1584.
151 Ibid 1584–1585.
152 Ibid 1595.
153 Ibid 1595–1596; Exhibit HQI0162_P Witness statement of Ms Andrea Spiteri, 12 [40].
154 Ibid 1596.
155 Ibid.
156 Ibid 1596–1597.
157 Exhibit HQI0164_RP Witness statement of Mr Jason Helps, 12 [51].

158 Exhibit HQI0144_P First witness statement of Commissioner Andrew Crisp, 10 [16(c)].
159 Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 4 [11].
160 Transcript of day 17 hearing 15 September 2020, 1375.
161 Ibid.
162 HQI0149_RP Witness statement of Mr Christopher Eagle, 4 [18].
163 Transcript of day 17 hearing 15 September 2020, 1438.
164 Ibid 1375.
165 Ibid 1438–1439.
166 Ibid 1439, 1441.
167 Ibid 1439.
168 Ibid 1440.
169 Ibid 1441.
170 Ibid 1437.
171 Exhibit HQI0164_RP Witness statement of Mr Jason Helps, 13 [53].
172 Ibid; Exhibit HQI0162_RP Witness statement of Ms Andrea Spiteri, 21 [92]–[93].
173 Exhibit HQI0164_RP Witness statement of Mr Jason Helps, 13 [53].
174 Exhibit HQI0162_RP Witness statement of Ms Andrea Spiteri, 21 [92]; Transcript of day 19 hearing 17 September 2020, 1591.
175 Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 6–7 [18]; Exhibit HQI0135_RP Witness statement of Ms Merrin Bamert, 6 [18].
176 Transcript of day 19 hearing 17 September 2020, 1590.
177 Ibid.
178 Ibid 1591–1592.
179 Exhibit HQI0135_RP Witness statement of Ms Merrin Bamert, 6 [18].
180 Ibid.
181 Transcript of day 16 hearing 11 September 2020, 1269.
182 Ibid 1280–1281.
183 Exhibit HQI0126_RP Annexures to witness statement of Ms Melissa Skilbeck, DHS.0001.0001.1444, DHS.0001.0001.1450 (at [2.3]).
184 Transcript day 18 hearing 16 September 2020, 1553.
185 Exhibit HQI0153_RP Witness statement of Prof. Brett Sutton, 8 [34]–[35].
186 Transcript of day 18 hearing 16 September 2020, 1455.
187 Exhibit HQI0252_P Second affidavit of Prof. Brett Sutton, 2 [10].
188 Exhibit HQIO153_RP Witness statement of Prof. Brett Sutton, 5 [15]–[16].
189 Ibid 5 [17].
190 Transcript of day 18 hearing 16 September 2020 1523–1524.
191 Exhibit HQIO153_RP Witness statement of Prof. Brett Sutton, 6 [25].
192 Transcript of day 18 hearing 16 September 2020, 1523.
193 Ibid.
194 Exhibit HQI0151_P Witness statement of Ms Jacinda de Witts, 3 [10].
195 Exhibit HQI0126_RP Annexures to witness statement of Ms Melissa Skilbeck DHS.0001.0001.0814.
196 Exhibit HQI0160_P Witness statement of Dr Annaliese van Diemen, 2 [9].
197 Ibid 3 [15]–[16], 4 [20].
198 Ibid 3 [17].
199 Transcript of day 18 hearing 16 September 2020, 1522.
200 Exhibit HQI0126(1)_RP Annexures to witness statement of Ms Melissa Skilbeck, DHS.0001.0027.0912.
201 Submission 03 Department of Health and Human Services, 6 [28].
202 See, e.g. Exhibit HQI0167_RP EMV State Operational Arrangements, DHS.5000.0032.1862; Exhibit HQI0187_RP Annexures to first witness statement of Ms Kym Peake, DHS.0001.0001.0814.
203 Exhibit HQI0160_P Witness statement of Dr Annaliese van Diemen, 4 [20].
204 Ibid 4 [21].
205 Transcript of day 18 hearing 16 September 2020, 1515.
206 Exhibit HQI0249_RP First affidavit of Prof. Brett Sutton, 6 [33].
207 Exhibit HQI0203_RP Witness statement of 'DHHS Infection Control Consultant', 5 [18]–[20]; Exhibit HQI0160_P Witness statement of Dr Annaliese van Diemen, 22 [97].
208 Exhibit HQI0203_RP Witness statement of 'DHHS Infection Control Consultant', 5 [22]–[23].
209 Transcript of day 18 hearing 16 September 2020, 1524–1525; Exhibit HQI0203_RP Witness statement of 'DHHS Infection Control Consultant', 4 [17].
210 Transcript of day 18 hearing 16 September 2020, 1531.

211 Exhibit HQI0203_RP Witness statement of 'DHHS Infection Control Consultant', 6 [26]–[28].
212 Transcript of day 18 hearing 16 September 2020, 1456.
213 Exhibit HQI0186_RP First witness statement of Ms Kym Peake, 41 [207].
214 Ibid; Transcript of day 23 hearing 23 September 2020, 2004.
215 Transcript of day 18 hearing 16 September 2020, 1525.
216 Exhibit HQI0103_RP Witness statement of Dr Simon Crouch 1 [5]; Exhibit HQI0097_RP Witness statement of Dr Clare Looker, 2–3 [13].
217 Exhibit HQI0105_RP Annexures to witness statement of Dr Simon Crouch, DHS.0001.0003.0054.
218 Ibid DHS.0001.0003.0054–0058.
219 Ibid DHS.0001.0003.0054; Exhibit HQI0103_RP Witness statement of Dr Simon Crouch, 5 [25].
220 Exhibit HQI0106_RP Witness statement of Dr Sarah McGuinness, 1 [5].
221 Transcript of day 14 hearing 8 September 2020, 1063.
222 Ibid 1063.
223 Ibid.
224 Ibid 1063-1064.
225 Exhibit HQI0113_P Witness statement of Dr Finn Romanes, 3 [10].
226 Ibid 3 [12].
227 Transcript of day 18 hearing, 16 September 2020, 1515.
228 Exhibit HQI0113_P Witness statement of Dr Finn Romanes, 6–7 [30].
229 Ibid 9 [45], 14 [70].
230 Ibid 14 [70].
231 Ibid 5 [23]; Exhibit HQI0114_RP Annexures to witness statement of Dr Finn Romanes, DHS.5000.0123.3241.
232 Exhibit HQI0113_P Witness statement of Dr Finn Romanes 8 [38]; Exhibit HQI0114_RP Annexures to witness statement of Dr Finn Romanes, DHS.5000.0126.1658.
233 Exhibit HQI0113_P Witness statement of Dr Finn Romanes, 6–7 [30].
234 Transcript of day 16 hearing 11 September 2020, 1285–1286.
235 Ibid 1308.
236 Ibid 1286.
237 Ibid.
238 Ibid
239 Exhibit HQI0135_RP Witness statement of Ms Merrin Bamert, 24 [81].
240 Transcript day 16 hearing 11 September 2020, 1285.
241 Ibid 1286.
242 Ibid 1286–1287.
243 Ibid 1287.
244 Ibid.
245 Ibid.
246 Ibid 1307.
247 Exhibit HQI0075_RP Witness statement of Mr Noel Cleaves, 22–23 [117].
248 Transcript of day 13 hearing 4 September 2020, 915.
249 Ibid.
250 Transcript day 15 hearing 11 September 2020, 1189.
251 Exhibit HQI0085_RP Witness statement of Ms Janette Curtain, 6 [35(c)].
252 Exhibit HQI0090_RP Witness statement of Mr Eric Smith, 11 [27.1].
253 Compare with New South Wales. See Transcript of day 12 hearing 3 September 2020, 877.
254 PHW Act, s. 168, s. 175.
255 Ibid s. 169.
256 Ibid s. 200(6).
257 Ibid s. 203 prescribes a penalty of 120 penalty units for a natural person. Up until 30 June 2020, the value of a penalty unit under s 6 of the *Monetary Units Act 2004* (Vic) was $165.22: see *Victorian Government Gazette*, No. G16, 23 April 2020 <http://www.gazette.vic.gov.au/gazette/Gazettes2020/GG2020G016.pdf>.
258 Transcript of day 13 hearing 4 September 2020, 897.
259 Ibid 904.
260 Exhibit HQI0122_RP Witness statement of Mr Murray Smith 13 [57(a)(iii)–(iv)]; Exhibit HQI0124_RP Annexures to witness statement of Mr Murray Smith, DHS.5000.0025.4759 .
261 Exhibit HQI0124_RP Annexures to witness statement of Mr Murray Smith DHS.5000.0025.4775.
262 Ibid.
263 Ibid DHS.5000.0025.4778.

264 Exhibit HQI0122_RP Witness statement of Mr Murray Smith, 2–3 [8].
265 Ibid 3 [10].
266 Transcript of day 15 hearing 10 September 2020, 1187–1188.
267 Ibid 1188–1189.
268 Ibid 1187–1188.
269 Exhibit HQI0032_P Witness statement of Ms Claire Febey, 13 [56].
270 Transcript of day 8 hearing 27 August 2020, 416, 419.
271 Transcript of day 15 hearing 10 September 2020, 1188–1189; Exhibit HQI0122_RP Witness statement of Mr Murray Smith, 4 [14].
272 Transcript of day 15 hearing 10 September 2020, 1188.
273 Exhibit HQI0145_RP Annexures to the first witness statement of Commissioner Andrew Crisp, DOJ.502.003.1765.
274 Transcript of day 15 hearing 10 September 2020, 1211.
275 Exhibit HQI0211_P First witness statement of the Hon. Jenny Mikakos, former MP, 4 [18]; Transcript of day 22 hearing 22 September 2020, 1892.
276 Transcript of day 22 hearing 22 September 2020, 1892; Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 5 [16].
277 With regard to the Hotel Quarantine Program, Ms Peake acknowledged that the role of DHHS was not entirely informed by the emergency management framework. It was required to contribute capabilities, skills, legal powers and resources 'some of which fit within the scope of [the EMMV] and an emergency multiagency response, some of which are just relevant to the normal functions of each Department administered under the Public Administration Act and Financial Management Act': Transcript of day 23 hearing 23 September 2020, 1991.
278 Exhibit HQI0186_RP First witness statement of Ms Kym Peake, 23 [115].
279 Ibid 32 [164].
280 Ibid 32 [162].
281 Transcript of day 23 hearing 23 September 2020, 1990.
282 Ibid 1991.
283 Transcript of day 15 hearing 10 September 2020, 1211.
284 Transcript of day 24 hearing 24 September 2020, 2064.
285 Exhibit HQI0211_P First witness statement of the Hon. Jenny Mikakos, former MP, 4 [19]–[21] .
286 Transcript of day 16 hearing 11 September 2020, 1287.
287 Transcript of day 19 hearing 17 September 2020, 1586.
288 Exhibit HQI0162_P Witness statement of Ms Andrea Spiteri, 9 [31].
289 Exhibit HQI0032_P Witness statement of Ms Claire Febey, 15 [63].
290 Exhibit HQI0033(1)_RP Annexures to witness Statement of Ms Claire Febey, DJP.101.004.4572–4573.
291 Transcript of day 22 hearing 22 September 2020, 1905.
292 Submission 03 Department of Health and Human Services, 10 [51], quoting Exhibit HQI0145(1)_RP Annexures to first witness statement of Commissioner Andrew Crisp, DOJ.600.001.0717.
293 Submission 03 Department of Health and Human Services 10 [54].
294 Ibid 10–11 [56]–[57].
295 Ibid 10 [51], quoting Exhibit HQI0145(1)_RP Annexures to first witness statement of Commissioner Andrew Crisp, DOJ.600.001.026.
296 Exhibit HQI0140_P Witness statement of Mr Craig Lapsley, 21 [18].
297 Ibid 19 [14].
298 Transcript of day 17 hearing 15 September 2020, 1373.
299 Exhibit HQI0143(3)_RP, Transcript of audio recording of Operation Soteria meeting 6.00pm 28 March 2020, 20.
300 Transcript of day 17 hearing, 15 September 2020, 1374.
301 Exhibit HQI0218_P Witness statement of the Hon. Daniel Andrews MP, 1 [1].
302 Ibid 2 [8].
303 Exhibit HQI0211_P First witness statement of the Hon. Jenny Mikakos, former MP, 11 [56].
304 Exhibit HQI0184_RP Witness statement of Mr Simon Phemister, 19 [91].
305 Transcript of day 23 hearing 23 September 2020, 1942.
306 Ibid 1949.
307 Exhibit HQI0169_RP Witness statement of Chief Commissioner Shane Patton, 11 [6.2].
308 Exhibit HQI0145(1)_RP Annexures to first witness statement of Commissioner Andrew Crisp, DOJ.600.001.0501, 0717.
309 Exhibit HQI0177_RP witness statement of Mr Christopher Eccles, 19–20 [77]–[78].
310 Ibid 16–17 [65].

311 Transcript of day 24 hearing 24 September 2020, 2064; Exhibit HQI0211_P First witness statement of the Hon. Jenny Mikakos, former MP, 4 [18], 6 [28], 11 [56], 12 [62]; Transcript of day 23 hearing 23 September 2020, 1989–1990.
312 Exhibit HQI0186_RP First witness statement of Ms Kym Peake, 62 [329].
313 Exhibit HQI0145(1)_RP Annexures to first witness statement of Commissioner Andrew Crisp, DOJ.600.001.0717.
314 Exhibit HQI0032_P Witness statement of Ms Claire Febey, 16–17 [65].
315 Ibid 17 [27]; Transcript of day 8 hearing 27 August 2020, 405–406, 426–427.
316 Exhibit HQI0032_P Witness statement of Ms Claire Febey, 17 [66].
317 Ibid 17 [68].
318 Ibid 17 [67]; Exhibit HQI0080_RP First witness statement of Ms Rachaele May, 3 [10].
319 Transcript of day 8 hearing 27 August 2020, 410.
320 Exhibit HQI0080_RP First witness statement of Ms Rachaele May, 5 [24].
321 Ibid 5 [22].
322 Transcript of day 13 hearing 4 September 2020, 962.
323 Exhibit HQI0080_RP First witness statement of Ms Rachaele May, 4 [16]–[17].
324 Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 6 [19].
325 Transcript of day 23 hearing 23 September 2020, 2012; Transcript of day 24 hearing 24 September 2020, 2081.
326 Transcript of day 17 hearing 15 September 2020, 1357.
327 Submission 03 Department of Health and Human Services, 1 [3(c)].
328 Exhibit HQI0186_RP First witness statement of Ms Kym Peake, 3 [10.6].
329 Exhibit HQI0215_RP Initial response to the Board of Inquiry from DHHS, 3.
330 Ibid.
331 Exhibit HQI0186_RP First witness statement of Ms Kym Peake, 23 [111]–[113]; HQI0162_P Witness statement of Ms Andrea Spiteri, 9 [29]; Transcript of day 19 hearing 17 September 2020, 1587.
332 Submission 03 Department of Health and Human Services, 3 [11]; HQI0162_P Witness statement of Ms Andrea Spiteri, 9 [29]; Transcript of day 19 hearing 17 September 2020, 1587.
333 Exhibit HQI0186_RP First witness statement of Ms Kym Peake, 38 [191].
334 Exhibit HQI0160_P Witness statement of Dr Annaliese van Diemen, 22 [100].
335 Transcript of day 18 hearing 16 September 2020, 1532.
336 Exhibit HQI0160_P Witness statement of Dr Annaliese van Diemen, 22 [97].
337 Ibid 22 [101]; Transcript of day 18 hearing 16 September 2020, 1563; Exhibit HQI0151_P Witness statement of Ms Jacinda de Witts, 11 [40].
338 Exhibit HQI0095_RP Witness statement of Dr Nathan Pinskier, 1 [7].
339 Transcript of day 19 hearing 17 September 2020, 1603.
340 Transcript of day 18 hearing 16 September 2020, 1531.
341 Exhibit HQI0092_RP Witness Statement of Dr Julian Rait, 5.
342 Transcript of day 23 hearing 23 September 2020, 1967.
343 Ibid.
344 Exhibit HQI0164_RP Witness statement of Mr Jason Helps, 3 [16].
345 Exhibit HQI0162_P Witness statement of Ms Andrea Spiteri, 2 [7].
346 Ibid.
347 Exhibit HQI0186_RP First witness statement of Ms Kym Peake, 12 [53].
348 Transcript of day 15 hearing 10 September 2020, 1217.
349 Ibid 1219.
350 Exhibit HQI0126_RP Annexures to witness statement of Ms Melissa Skilbeck, DHS.0001.0001.0840.
351 Ibid.
352 Transcript of day 15 hearing 10 September 2020, 1219.
353 Transcript of day 18 hearing 16 September 2020, 1485.
354 Ibid 1486.
355 Ibid 1533.
356 Ibid.
357 Exhibit HQI0125_RP Witness statement of Ms Melissa Skilbeck, 6 [30].
358 Transcript of day 17 hearing 15 September 2020, 1364–5.
359 Transcript of day 15 hearing 10 September 2020, 1219; Transcript of day 23 hearing 23 September 2020, 1971.
360 Transcript of day 23 hearing 23 September 2020, 1981.
361 Exhibit HQI0113_P Witness statement of Dr Finn Romanes, 17 [84].
362 Transcript of day 18 hearing 16 September 2020, 1489.
363 Transcript of day 23 hearing 23 September 2020, 1972–1973.
364 Ibid.

365 Ibid 1973.
366 Exhibit HQI0162_P Witness statement of Ms Andrea Spiteri, 8 [27].
367 Ibid 8 [28].
368 Ibid 9 [30].
369 Ibid 9 [31].
370 Transcript of day 19 hearing 17 September 2020, 1583.
371 Ibid 1584.
372 Exhibit HQI0164_RP Witness Statement of Mr Jason Helps, 5 [24].
373 Transcript of day 19 hearing 17 September 2020, 1586.
374 Ibid 1595–1597.
375 Exhibit HQI0198_RP Advice re appointment of DHHS Class 2 Controllers.
376 Ibid DHS.0001.0011.1101.
377 Transcript of day 23 hearing 23 September 2020, 1982.
378 Exhibit HQI0253_RP Exhibits to second affidavit of Prof. Brett Sutton, DHS.9999.0032.0145.
379 Transcript of day 19 hearing 16 September 2020, 1487.
380 Exhibit HQI0164_RP Witness Statement of Mr Jason Helps, 6 [29].
381 Ibid 6 [30].
382 Ibid.
383 Exhibit HQI0167_RP EMV State Operational Arrangements COVID-19, DHS.5000.0032.1856.
384 Transcript of day 18 hearing 16 September 2020, 1522–1523.
385 Ibid 1523.
386 Ibid 1524.
387 Ibid 1523.
388 Ibid 1524.
389 Transcript of day 15 hearing 10 September 2020, 1219; Exhibit HQI0113_P Witness statement of Dr Finn Romanes, 18 [84].
390 Transcript of day 16 hearing 11 September 2020, 1328.
391 Transcript of day 18 hearing 16 September 2020, 1527.
392 Ibid 1487–1492; Exhibit HQI0153_P Witness statement of Prof. Brett Sutton, 29 [159]–[160]; Exhibit HQI0113_P Witness statement of Dr Finn Romanes, 17–18 [84].
393 Exhibit HQI0113_P Witness statement of Dr Finn Romanes, 17–18 [84].
394 Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 4 [11].
395 Exhibit HQI0162_P Witness Statement of Ms Andrea Spiteri, 21 [93].
396 Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 37–38 [98].
397 Ibid 37 [95].
398 Ibid 37 [97].
399 Ibid 37 [95].
400 Transcript of day 14 hearing 8 September 2020, 1024.
401 Exhibit HQI0135_RP Witness statement of Ms Merrin Bamert, 6 [18].
402 Transcript of day 23 hearing 23 September 2020, 1972.
403 Exhibit HQI0164_RP Witness statement of Mr Jason Helps, 31 [143].
404 Transcript of day 19 hearing 17 September 2020, 1584.
405 Ibid.
406 Ibid 1585.
407 Exhibit HQI0255_RP Affidavit of Mr Jason Helps, 8 [30].
408 Transcript of day 18 hearing 16 September 2020, 1504.
409 Exhibit HQI0249_RP First affidavit of Dr Brett Sutton, 7 [43].
410 Ibid 8 [48].
411 Exhibit HQI0257_RP Affidavit of Mr Braedan Hogan, 7 [43].
412 Exhibit HQI0229_RP DHHS email chain re 'Information – Chain of Command' and other ending 2 July 2020, DHS.5000.0133.6518.
413 Exhibit HQI0152(2)_RP Annexures to the witness statement of Ms Jacinda de Witts, DHS.5000.0001.3588.
414 Exhibit HQI0259_RP Affidavit of Dr Finn Romanes, 4 [26].
415 Exhibit HQI0158_RP Email from Dr Finn Romanes to Ms Andrea Spiteri and Mr Chris Eagle, DELW.0001.0011.2116.
416 Exhibit HQI0256_RP Documents referred to in affidavit of Mr Jason Helps, DHS.0001.0131.0027.
417 Ibid.
418 Ibid.
419 Exhibit HQI0253_RP Exhibits to the second affidavit of Prof. Brett Sutton, DHS.5000.0165.7865–6.
420 Ibid DHS.5000.0165.7865.

421 Exhibit HQI0120_RP Email from Mr Euan Wallace to Ms Melissa Skilbeck.
422 Exhibit HQI0256_RP Documents referred to in affidavit of Mr Jason Helps, DHS.0001.0131.0065. For further evidence of concerns raised about governance, see Exhibit HQI0258_RP Documents referred to in affidavit of Mr Braedan Hogan, DHS.0001.0132.0152–DHS.0001.0132.0158; DHS.0001.0132.0147; Exhibit HQI0256_RP Documents referred to in affidavit of Mr Jason Helps, DHS.5000.0072.9118–DHS.0001.0131.0077.
423 Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 6 [18].
424 Exhibit HQI0135_RP Witness statement of Ms Merrin Bamert, 6 [18].
425 Exhibit HQI0137_RP Email from Ms Merrin Bamert to DHHS and Safer Care Victoria, SVC.0001.0002.0056.
426 Exhibit HQI0117_R Annexures to first witness statement of Prof. Euan Wallace AM, DHS.0001.0002.0058, DHS.5000.0089.2744.
427 Transcript of day 16 hearing 11 September 2020, 1312.
428 Exhibit HQI0256_RP Documents referred to in affidavit of Mr Jason Helps, DHS.0001.0131.0065.
429 Exhibit HQI0160_P Witness statement of Dr Annaliese van Diemen, 4 [21].
430 Ibid.
431 Ibid 4–5 [24].
432 Ibid 32 [146].
433 Exhibit HQI0252_P Second affidavit of Prof. Brett Sutton, 1 [8].
434 Ibid 2 [10].
435 Exhibit HQI0160_P Witness statement of Dr Annaliese van Diemen, 15 [68].
436 Exhibit HQI0145 Annexures to first witness statement of Commissioner Andrew Crisp, DOJ.501.001.9230.
437 Transcript of day 18 hearing 16 September 2020, 1492–1493.
438 Ibid; Exhibit HQIO153_RP Witness statement of Prof. Brett Sutton, 29 [160]
439 Transcript of day 18 hearing, 16 September 2020, 1530.
440 Ibid 1534; Exhibit HQI0160_P Witness statement of Dr Annaliese van Diemen, 18 [83].
441 Ibid.
442 Transcript of day 18 hearing 16 September 2020, 1535.
443 Transcript of day 16 hearing 11 September 2020, 1308 and 1328; Exhibit HQI0161_RP Annexures to witness statement of Dr Annaliese van Diemen, DHS.5000.0053.6652.
444 Exhibit HQI0135_RP Witness statement of Ms Merrin Bamert, 24 [80(a)].
445 Exhibit HQI0116_RP First witness statement of Dr Euan Wallace, 11 [39(d)].
446 Exhibit HQI0256_RP Documents referred to in affidavit of Mr Jason Helps, DHS.0001.0131.0073.
447 Ibid.
448 Transcript of day 19 hearing 17 September 2020, 1603.
449 HQI0161(1)_RP Annexures to witness statement of Dr Annaliese van Diemen, DHS.5000.0053.6653; Transcript of day 18 hearing 16 September 2020, 1530.
450 Exhibit HQI0255_RP Affidavit of Mr Jason Helps, 8 [30].
451 Submission 03 Department of Health and Human Services, 19 [104].
452 Exhibit HQI0135_RP Witness statement of Merrin Bamert, 23 [74].
453 Transcript of day 18 hearing 16 September 2020, 1533.
454 Submission 03 Department of Health and Human Services, 23 [123].
455 Transcript of day 19 hearing 17 September 2020, 1596.
456 Ibid.
457 Ibid.
458 Ibid.
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460 Ibid 27 [56].
461 Transcript of day 16 hearing 11 September 2020, 1286–1287.
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464 Exhibit HQI0009_RP Witness statement of 'Nurse Jen', 17 [143].
465 Transcript of day 6 hearing 20 August 2020, 264–265.
466 Ibid 264; Exhibit HQI0023_P Witness statement of Mr Luke Ashford, 1 [5].
467 Transcript of day 6 hearing 20 August 2020, 263–265.
468 Ibid 265.
469 Ibid 267.
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471 Transcript of day 13 hearing 4 September 2020, 898.
472 Ibid 915.
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478 Transcript of day 6 hearing 20 August 2020, 298.
479 Transcript of day 7 hearing 24 August 2020, 350.
480 Transcript of day 11 hearing 2 September 2020, 795.
481 Transcript of day 12 hearing 3 September 2020, 821.
482 Ibid 863.
483 Ibid.
484 Ibid.
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486 Transcript of day 13 hearing 4 September 2020, 964–965.
487 Transcript of day 15 hearing 10 September 2020, 1188.
488 Ibid.
489 Exhibit HQI0162_P Witness statement of Ms Andrea Spiteri, 25 [109].
490 Ibid.
491 See Recommendations 15 and 16.
492 See Recommendations 17 and 18.
493 See Recommendations 27 and 28.
494 Exhibit HQI0160_P Witness statement of Dr Annaliese van Diemen, 32 [147].
495 Ibid.
496 Ibid 32 [148].
497 Exhibit HQI0164_RP Witness statement of Mr Jason Helps, 21 [80].
498 See Recommendation 65.
499 Exhibit HQI0164_RP Witness statement of Mr Jason Helps, 21 [80].
500 See Recommendation 63.
501 Exhibit HQI0151_P Witness statement of Ms Jacinda de Witts, 8 [27].
502 Ibid 8–9 [28].
503 Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 11–16 [26]–[39]; Exhibit HQI0113_P Witness statement of Dr Finn Romanes, 4–5 [19]–[21].
504 Exhibit HQI0152_RP Annexures to witness statement of Ms Jacinda De Witts, DHS.0001.0015.0323.
505 Exhibit HQI0033_RP Annexures to witness statement of Ms Claire Febey, DJP.102.008.3855.
506 Exhibit HQI0152_RP Annexures to witness statement of Ms Jacinda De Witts, DHS.5000.0023.0395.
507 Ibid DHS.5000.0069.8348–8353.
508 Transcript of day 18 hearing 16 September 2020, 1455–1456.
509 Ibid 1534–1536.
510 Exhibit HQI0135_RP Witness statement of Ms Merrin Bamert, 24 [80].
511 Ibid.
512 Exhibit HQI0130_RP Witness Statement of Ms Pam Williams, 24 [51].
513 Exhibit HQI0186_RP First witness statement of Ms Kym Peake, 2–3 [8], [12].
514 Transcript of day 22 hearing 22 September 2020, 1909.
515 Ibid; Transcript of day 23 hearing 23 September 2020, 1966.
516 Transcript of day 24 hearing 24 September 2020, 2065.
517 Ibid 2065–2066.
518 Ibid 2071; Exhibit HQI0211_RP First witness statement of the Hon. Jenny Mikakos, former MP, 6 [29].
519 Transcript of day 24 hearing 24 September 2020, 2063.
520 Ibid 2055, 2057.
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525 Ibid 2138.
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531 Exhibit HQI0180_RP Annexures to second witness statement of Mr Christopher Eccles, DPC.0014.0001.0004.
532 Ibid.
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