Preface

Throughout 2020, the COVID-19 pandemic has wreaked havoc, inflicting widespread catastrophic loss of life in its wake. It has been a challenging and distressing year all over the world. Some countries have been hit harder than others for a range of reasons that will be important to understand in time to come.

Our own nation has much to learn, as well as much for which it can be grateful, as this dangerous and highly infectious virus continues to overshadow our lives.

As noted in the Interim Report, the movement of the virus through Victoria placed our state in sadly unique circumstances in contrast to the rest of the nation.

By May 2020, active cases in the Victorian community had fallen to 57 from a peak of 541 as of 28 March 2020. But, in the wake of breaches of containment in the Hotel Quarantine Program operating in Victoria at the time, a second wave descended upon us with devastating consequences. Hundreds of lives were lost bringing suffering, sadness and grief to so many. Due to scientific evidence inextricably linking this second wave in Victoria to the transmission of infections stemming from returned travellers detained in the Hotel Quarantine Program, this Inquiry was established by an Order in Council dated 2 July 2020.

From the outset, it was clear to me that this Inquiry must be conducted in full public view. An Inquiry team of lawyers and necessary support staff was established and quickly commenced targeting and compiling material from a range of government departments, government agencies and private entities. An Inquiry office was established and a hearing venue was sourced. An opening statement was made by Senior Counsel Assisting the Inquiry on 20 July 2020, foreshadowing public hearings that were due to commence on 6 August 2020 in hearing rooms and facilities arranged at the Fair Work Commission in Melbourne.

On 2 August 2020, a State of Disaster in Victoria was declared and, shortly thereafter, stage 4 coronavirus lockdown restrictions were introduced in Melbourne, affecting our ability to conduct the hearings in a public venue. Determined to ensure we could continue our work and do so in public, considerable effort went into reorganising and operating the Inquiry remotely. To enable this to be done, the first public hearings were shifted to 17 August 2020.

I acknowledge and thank members of the public who contacted the Inquiry team and provided information, and I acknowledge and thank media organisations for their interest in, and comprehensive reporting of, the Inquiry's work, particularly as the public hearings were underway.

I thank all witnesses who appeared before the Inquiry, acknowledging that it is a considerable strain to do so.

I recognise that the Inquiry caused significant strain on the Victorian Public Service as it was leading Victoria's response to the COVID-19 pandemic while cooperating with the Inquiry. The Inquiry found no evidence of public servants acting in bad faith in regard to the Hotel Quarantine Program and I acknowledge and appreciate the work they have done to support Victoria and Victorians. There was considerable evidence of long hours and dedication to public service demonstrated by many public servants engaged to perform roles in response to COVID-19.

I also wish to acknowledge the many hundreds of people working on-site in hotel quarantine facilities, who put themselves in harm's way to perform their work, and the thousands of people who went through the Hotel Quarantine Program, an experience reported to be quite difficult for some.

In the early weeks of the Inquiry, the impact of the increased restrictions, the need to set up remote systems to receive and examine the thousands of documents that were being provided to the Inquiry, and the work involved in the set up and conduct of live streaming remotely, made it clear that it would not be possible to meet the original reporting date of 25 September 2020. I sought, and received, an extension from the Governor to deliver the Inquiry's final report by 6 November 2020. The Inquiry

was required to conduct a significant amount of work in a very short time frame. To do so, the original estimates of staffing and support for the Inquiry expanded considerably as the scale of the task and its complications became apparent.

As noted in the Foreword to the Interim Report, following the conclusion of its public hearings, the Inquiry began work to consolidate the information and evidence received in preparation for delivery of the Final Report by 6 November 2020.

After the public hearings were completed, final submissions by Counsel Assisting were made on 28 September 2020. Written submissions in reply were received by 13 parties with Leave to Appear on 5 October 2020. In the wake of the submissions in reply, the Inquiry was put on notice that there was additional material, of potential significance to the Inquiry, that had not been produced to it.

This caused a request for a further extension to the report date to 21 December 2020 so that this material could be gathered and considered.

Notwithstanding this disruption, to assist in the timely re-opening of international points of entry to Victoria, the Interim Report was prepared and delivered to the Governor on 6 November 2020.

In presenting this Final Report I acknowledge the contribution of every staff member who worked on this Inquiry. I particularly thank and acknowledge the outstanding work of Counsel Assisting the Inquiry: Mr Tony Neal QC, Mr Ben Ihle and Ms Rachel Ellyard, Ms Jess Moir and Mr Steven Brnovic. The Counsel Assisting team was supported by a hardworking and tireless legal team ably led by Mr Will Yates, who was seconded to the Inquiry from the Victorian Government Solicitor's Office.

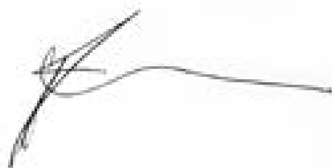
I acknowledge the excellent work undertaken by the Intake and Assessment team, led by Ruth Baker, who endeavoured to ensure that every person who contacted the Inquiry felt heard and treated with respect. The team also provided broader support to witnesses across the Inquiry.

I also acknowledge the outstanding work of Shilpa Bhim and her team to whom so much is owed in the development and delivery of both the Interim Report and this Final Report.

The Inquiry drew on a range of skillsets from 34 staff engaged in legal work and a range of other tasks, including the technical support to undertake hearings, setting up and maintaining an electronic hearing book, setting up and maintaining the Inquiry website and publishing exhibits and transcripts as they were released, responding to phone calls and emails from the public and the media, and assisting in the preparation and delivery of these two Reports. To undertake this work in six months is no easy feat, and I am grateful for the diligence and hard work undertaken by each and every Inquiry staff member who helped to make this happen. I am particularly appreciative of the support and contribution of chief executive, Jo Rainford, to the Inquiry's operation.

I thank all Victorians for their patience and understanding as the Inquiry has undertaken its work. The second wave of COVID-19 cases led to a series of restrictions in the state and had devastating impacts on peoples' lives, livelihoods and mental health. It made what was already a difficult year far more difficult. We have endeavoured to provide as much clarity as possible to all Victorians on the operation of Victoria's Hotel Quarantine Program. While we cannot turn back the clock, we hope the Inquiry's findings and recommendations provide some assistance for the road ahead.

On behalf of the entire Inquiry team, I extend condolences to the families, friends and loved ones of each individual whose life has been lost to this terrible virus.



The Honourable Jennifer Coate AO
Chairperson
Board of Inquiry into the COVID-19 Hotel Quarantine Inquiry

Executive summary*

From early this year, the World Health Organization (WHO) and governments all over the world were grappling with how to reduce the spread of COVID-19 and avoid overburdening health systems and workers in such a connected world.

Commonly used measures to reduce the spread of COVID-19 throughout 2020 have included social distancing, lockdowns and restrictions on the movement of people in the community plus, in the case of people entering a country from overseas, a period of quarantine.

These measures have been, and continue to be, used across Australia. Of significance to the work of the COVID-19 Hotel Quarantine Inquiry was the 14-day period of mandatory quarantine that was announced on 27 March 2020 and implemented for all international arrivals into Victoria from 29 March 2020.

The stated purpose of mandatory quarantine was to try to slow the spread of COVID-19, with the majority of COVID-19 cases in Australia, at the time, attributed to returned travellers.[1] Across Australia, quarantine for returned travellers was (and continues to be) almost exclusively undertaken in hotels.

Within the first week of the Hotel Quarantine Program being established in Victoria, the number of returned travellers in the Program was between 1,550[2] and approximately 2,000.[3] At any one time, there were between 1,500 and more than 4,000 individuals in quarantine across 10–16 hotels.[4]

Victoria's Hotel Quarantine Program ran for three months from 29 March–30 June 2020. In this time, a total of 21,821 returned travellers went through the Program, with a total of 236 (1.1 per cent) of those returned travellers testing positive for COVID-19 while in quarantine.[5]

Despite the relatively low number of positive COVID-19 cases in the Hotel Quarantine Program, breaches of containment in the Program, in May and June 2020, were inextricably linked to the second wave of COVID-19 cases in Victoria,[6] with devastating social and economic consequences for the State.

Due to the established link between the second wave of COVID-19 cases and the outbreaks from a Hotel Quarantine Program, this Inquiry was established on 2 July 2020 to examine a range of matters related to the Program, including:

- decisions and actions of government agencies, hotel operators and private contractors
- communication between government agencies, hotel operators and private contractors
- contractual arrangements
- information, guidance, training and equipment provided to personnel in hotels
- policies, protocols and procedures.[7]

Within the first three months of the Inquiry being established, it held public evidentiary hearings over 27 days, acquired evidence from 96 witnesses and received more than 350,000 pages of documents. On 6 November 2020, the Inquiry delivered its Interim Report, which made recommendations for a more robust Quarantine Program for Victoria as the State began re-opening to international arrivals.

This Final Report is to be read in conjunction with the Interim Report. The recommendations from the Interim Report find their evidentiary basis and rationale in the contents of this Final Report, which examines why the Hotel Quarantine Program was established, decisions made and actions taken in its establishment, what went wrong, what went well and what could, and should, be done better. The further recommendations contained in this Final Report are to be read in conjunction with the recommendations contained in the Interim Report.

* This summary has been prepared to provide an overview of the contents of the Report and its conclusions. It is not a substitute for the contents of the Report or the conclusions contained therein.

The emergence of COVID-19

Chapter 1 of this Report summarises the background to COVID-19 in the international and national context.

After emerging in late 2019 in Wuhan, China, COVID-19 rapidly proliferated across the globe, leading the WHO to declare the virus a 'pandemic' on 11 March 2020.[8]

The first Australian case of COVID-19 was reported on 25 January 2020,[9] with 12 cases confirmed by 1 February 2020.[10] Local case numbers then continued to increase with more than 3,000 confirmed cases of COVID-19 in Australia by 27 March 2020.[11]

As these numbers continued to swiftly rise, so too did concern among government, medical and scientific communities, and the general public. As highlighted by Dr Annaliese van Diemen, Victoria's Deputy Chief Health Officer (DCHO), the anticipated trajectory of the virus posed a significant risk to public health.[12]

At a state level, the Victorian response included the activation of the State Control Centre (SCC)[13] and a declaration of a State of Emergency, after which came a series of Directions prohibiting various gatherings, and Directions to returning travellers to 'self-isolate' for 14 days upon their arrival into Victoria.[14]

At the federal level, the National Cabinet was established on 13 March 2020 with the stated aim of ensuring consistency in Australia's response to the COVID-19 pandemic.[15]

Many of the National Cabinet's agreed measures were aimed at addressing the concern that international arrivals were fuelling the rise in domestic COVID-19 case numbers. These measures included imposing a self-isolation requirement for international arrivals and a ban on foreign cruise ships,[16] as well as prohibiting the entry of non-citizens and non-permanent residents.[17]

It was in this context that the National Cabinet, at a meeting on 27 March 2020, resolved to implement a mandatory 14-day quarantine period for international arrivals,[18] setting the wheels in motion for the establishment of Victoria's Hotel Quarantine Program.

The science behind COVID-19

To understand the context of the Hotel Quarantine Program, it was important to understand the nature and the science of COVID-19, as outlined in Chapter 2.

While acknowledging that there is a continuous state of learning with respect to the COVID-19 virus, the weight of the expert knowledge, at the time, was that the COVID-19 virus had an incubation period of up to 14 days for the majority of patients, with most patients being non-infectious at the end of that 14-day period. On that basis, the 14-day quarantine period, imposed for the purposes of the Hotel Quarantine Program, was a reasonable and appropriate period.

There was a general understanding among the experts of the modes of transmission of the virus as of 29 March 2020. These included that:

A. the virus primarily spread from person-to-person via droplets, aerosols and fomites (for example, transmission by contact with a contaminated surface)

B. droplet transmission occurred when a person was in close contact (within one metre) with someone who had the virus

C. airborne transmission was possible in specific circumstances and settings in which procedures or support treatments that generate aerosols were performed.[19]

These methods of transmission were of critical importance when considering the use of hotels as facilities for mass quarantine.

Asymptomatic transmission (including by way of super spreaders) led to particular complexities for infection control and testing regimes in the Hotel Quarantine Program. The public health community had a knowledge of the risk of asymptomatic transmission of the virus by March 2020.

The weight of the expert evidence to the Inquiry was that between 17–20 per cent of cases would be asymptomatic, which had flow-on impacts in terms of appropriate testing requirements. To address the risk inherent in asymptomatic spread of the virus, it was necessary to require testing of all people at the end of their quarantine period, regardless of whether they were reporting symptoms. This issue had ramifications for the testing regime in place during the Hotel Quarantine Program.

Hotel quarantine's link to the 'second wave'

The expert evidence, based on genomic testing, was that 99 per cent of Victoria's second wave of COVID-19 cases in the community came from transmission events related to returned travellers infecting people working at the Rydges and the Stamford Plaza Hotel. The movement of the virus from these infected workers into the community was characterised by high rates of local transmission.[20]

Prior to the second wave, Victoria's COVID-19 cases were largely attributed to infection acquired overseas.

Mass quarantining and the science

The conclusions that can be drawn from the scientific evidence provided to the Inquiry are that three fundamental safety features must be built into any program that seeks to house together potentially infected people in a quarantine facility. They are:

A. the importance of expert advice, input and ongoing supervision and oversight of infection prevention and control (discussed in chapters 8 and 9)

B. the importance of a rapid and effective contact tracing regime (discussed in Chapter 9)

C. the importance of an evidentiary base for the testing regime (discussed in Chapter 10).

The state of pre-pandemic planning

Victoria's Hotel Quarantine Program was established over the course of one weekend in March 2020. Chapter 3 analyses the state of pre-planning for mandatory, mass quarantine in Australia prior to the Hotel Quarantine Program.

Both the State and Commonwealth governments were aware, prior to 2020, of the possibility of a pandemic and its potentially devastating consequences.

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

Prior pandemic planning was directed at minimising transmission (for example, via voluntary isolation or quarantine at home) and not an elimination strategy. Professor Brett Sutton, Victoria's Chief Health Officer (CHO), accepted that:

> One of the issues in both the Australian Health Management Plan for Pandemic Influenza and the Victorian plan reflecting it is that there probably wasn't sufficient consideration of coronavirus as a virus of pandemic potential, nor was there such explicit consideration of a program of quarantine essentially for the purpose of keeping a jurisdiction entirely free of the virus.[21]

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

Significantly, the Commonwealth undertook a review of its health sector response in the wake of the H1N1 pandemic in 2009. The Commonwealth's *Review of Australia's Health Sector Response to Pandemic (H1N1) 2009* recommended that the roles and responsibilities of all governments for the management of people in quarantine, both at home and in other accommodation, during a pandemic, should be clarified. The Review recommended that a set of nationally consistent principles could form the basis for jurisdictions to develop operating guidelines, including plans for accommodating potentially infected people in future pandemics and better systems to support people in quarantine. Further, this review recommended an examination of the policy on quarantine and isolation, including management, support systems and communication.[22]

The Commonwealth Pandemic Plan and the Victorian Pandemic Plan were updated following the *Review of Australia's Health Sector Response to Pandemic (H1N1) 2009* in respect of evidence-based decision-making, use of existing governance mechanisms, a scalable and flexible approach and an emphasis on communication activities, with work regarding the policy on quarantine and isolation to be clarified. Despite this, the evidence to the Inquiry was that this work regarding the policy on quarantine and isolation was not undertaken following the Review being published in 2011.

Had the work proposed by the Commonwealth's *Review of Australia's Health Sector Response to Pandemic (H1N1) 2009* been done, there would likely have been, at least, a set of guiding principles and a framework to support the establishment of the Hotel Quarantine Program, thus avoiding the Program needing to be set up in an *ad hoc* manner during a pandemic.

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

The lack of a plan for mandatory mass quarantine meant that Victoria's Hotel Quarantine Program was conceived and implemented 'from scratch', to be operational within 36 hours, from concept to operation. This placed extraordinary strain on the resources of the State, and, more specifically, on those departments and people required to give effect to the decision made in the National Cabinet and agreed to by the Premier on behalf of Victoria. This lack of planning was a most unsatisfactory situation from which to develop such a complex and high-risk program.

Given the future movement of people in and out of Victoria from across the nation, it is in Victoria's interests to advocate for nationally cohesive and detailed quarantine plans, as previously recommended in the *Review of Australia's Health Sector Response to Pandemic (H1N1) 2009,* to clarify roles and responsibilities between different levels of government, management and support systems and communication protocols.

Pandemic planning exercises

Emergency incident exercises, specifically related to infectious disease pandemics, have been undertaken regularly. These exercises considered associated public health and emergency management plans and are undertaken within the Department of Health and Human Services (DHHS) and with other agencies.

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

What drove the decision for a Hotel Quarantine Program?

Chapter 4 considers the factors behind the shift to a program of mass, mandatory quarantine.

As of 15 March 2020, Victoria adopted the agreement reached at National Cabinet to make precautionary self-isolation directions for all international arrivals in order to reduce the risk of community transmission from those potentially carrying the virus into Australia from international locations. At that time, positive cases were starting to rise in Australia and in Victoria. By 15 March 2020, Australia had a total of 298, and Victoria 57, confirmed COVID-19 cases. Dr van Diemen, and other experts considered that, without effective intervention, those numbers would continue to rise exponentially.

By 27 March 2020, there was a total of 3,162 cases in Australia with 574 of those cases in Victoria. This represented a tenfold increase in Victorian cases. During this period, there had been an outbreak on the Ruby Princess cruise ship, which had docked in Sydney, with infected passengers permitted to disperse across the nation. This event was linked to 800 cases in Australia.

The view of National Cabinet, echoed by the Victorian Premier, was that the majority of cases in the community, at that time, were linked to the virus coming in via international arrivals.

Together with the considerable concern raised in relation to the Ruby Princess disembarkation, there was evidence that some returned travellers were not adhering to Directions to self-isolate at home. On closer examination during the Inquiry, as reported in Section 2 of the Interim Report, the evidence of intentional non-compliance with Self-Isolation Directions was not extensive. Further, the evidence of 'non-compliance' was, at least, partly referable to the poor dissemination of information to returning travellers who were being directed to self-isolate.

As of 27 March 2020, the Australian Health Protection Principal Committee (AHPPC) had only recommended to the National Cabinet enforced quarantine for 'high-risk' cases. Nevertheless, both the National Cabinet and, in turn, the Victorian Premier took the decision to direct the mandatory detention of all international arrivals into designated facilities which, in Victoria, were hotels. Both the CHO and the DCHO supported the decision based on the following:

A. an exponential increase in COVID-19 cases

B. a link between returned travellers and community transmission rates

C. perceived rates of non-compliance with Self-Isolation Directions

D. perceived inadequacy of the Self-Isolation Directions.

As of 27 March 2020, there was a proper and grave concern being expressed about the extent to which Victoria's health system might be overrun by COVID-19. The situation in many countries was already very grave, with substantial rates of infection and serious illness causing demand for hospital care to exceed existing medical services.

It is readily accepted that quarantining for international arrivals is likely to be required in Victoria for some time to come. In this context, the Interim Report addresses the option of a home-based quarantine program. Recommendation 58 of the Interim Report stated that, in conjunction with a facility-based model for international arrivals, the Victorian Government should develop the necessary functionality to implement a supported home-based model for those international arrivals assessed as suitable for such an option.

Section 2 of the Interim Report set out the reasons for recommendations for the development of a home-based model. One of the reasons set out in Section 2 is that a major risk of the hotel model is the daily movement of personnel in and out of the facility and then into communities in which they live. Even in a best practice model, which has dedicated personnel not moving between facilities, clinical and non-clinical personnel are, of necessity, coming in and out of a facility which, by definition, contains potentially infected people.

Minimising the numbers of people working in such environments, by only having in the facility those unable to quarantine at home, reduces this risk of transmission to the broader community.

The decisions made in establishing the Hotel Quarantine Program

Chapter 5 considers the evidence as to decisions made, and actions undertaken, in establishing the Hotel Quarantine Program over the course of a weekend, including which department was in charge and who was responsible for the decision to use private security as the enforcement model.

Initial decision-making

As a consequence of there being no pre-planning for the large-scale detention of international arrivals into a mandatory quarantine program when the Premier committed Victoria to Hotel Quarantine, those who would have to implement the program in Victoria were required to do so with very little warning and without any available blueprint for what was required. The situation was further complicated by the fact that the decision would come into effect just 36 hours later, at 11.59pm on 28 March 2020.

To put the scale in context, information provided by the Prime Minister on 27 March 2020 outlined that 7,120 people had arrived at airports around the country on 26 March 2020, the day before the announcement of hotel quarantine.

The Premier was aware there was no pre-existing plan for large scale quarantine in Victoria and there had been no discussion in the State Cabinet about the National Cabinet decision. However, he considered the Program feasible to achieve based on his knowledge of the availability of hotel rooms and the dedicated team of people at the operational level able to rise to this challenge.[23] The initial responsibility for setting up the Program was given to the Department of Jobs, Precincts and Regions (DJPR) in a telephone call made by the then Secretary of the Department of Premier and Cabinet (DPC) to the Secretary of DJPR on 27 March 2020.

Other than the sourcing of numbers of available hotel stock, DJPR had no preparation for, or relevant expertise to operate, an enforced quarantine program. The capability and capacity of the hotels in terms of the provision of security, cleaning and catering had not been a factor in the decision to allocate the lead to DJPR, nor had the capacity of the hotels to accommodate large numbers of people in a manner that would prevent transmission of COVID-19 to the community been considered.

It was not appropriate to conceive of the Hotel Quarantine Program as an extension of, or substantially similar to, existing accommodation programs, such as the COVID-19 Emergency Accommodation Program (CEA Program). The logic of tasking DJPR to source hotels on the basis of its work for the CEA Program did not extend to it sourcing hotels for quarantine purposes; the nature and purposes of the two programs were significantly different and involved different levels of risk. DJPR understood from the outset that it would need the assistance of DHHS for crafting the legal framework for the Program and arrangements for the health and wellbeing of the people in quarantine.

Within a few hours of that call to the Secretary of DJPR, and without knowledge of that call, the Emergency Management Commissioner and the State Controller — Health at DHHS were setting up a meeting at the State Control Centre (SCC) on the understanding that this Program would be operated using the emergency management framework.

By the afternoon of 28 March, at a meeting of a number of agencies at the SCC, the Emergency Management Commissioner, in conjunction with the DHHS State Controller — Health, made clear that DHHS was in charge as the control agency of the operation, which would become known as Operation Soteria, after the Greek goddess of safety, and that DJPR was a support agency.

DJPR continued to provide the contracting and organising of many logistical aspects of the Program including hotels, security, cleaning contractors and general logistics, such as transport and aspects of catering.

Notwithstanding this expressed position from the Emergency Management Commissioner, there remained an ongoing dispute between DHHS and DJPR as to who was in charge of the overall operation of the Program, which continued throughout the Inquiry. DJPR was clear that it was DHHS while DHHS was adamant that it was only responsible for parts of the Program and that DJPR was jointly responsible and accountable for its delivery. This was the source of considerable and significant problems with the way in which the Program operated. It also occupied an inordinate amount of time during the Inquiry.

The decision to embark on a Hotel Quarantine Program in Victoria involved the State Government assuming responsibility for managing the risk of COVID-19 transmission. But even though that risk was assumed by the Government, and as critical 'decisions' were made with respect to enforcement measures, there was no detailed consideration of the risks that would be involved in such a program. This was a failure in the establishment of the Program.

It is beyond doubt that many people worked incredibly hard, in extraordinary timeframes, to deal with an unprecedented set of circumstances. But that is not a total justification for the deficiencies in some of the actions taken, and decisions made, in that first 36 hours, and it does not excuse the deficiencies found in the Program.

Decisions on the enforcement model: the use of private security

This issue occupied a considerable amount of time during the Inquiry and generated a great deal of heated dispute. Somewhat ironically, it occupied a far greater amount of time and energy during the Inquiry than it did during the March 2020 meeting at the SCC. No person or agency claimed any responsibility for the decision to use private security as the first tier of security. All vigorously disputed the possibility they could have played a part in 'the decision'.

The evidence was that the use of private security did not raise any particular concerns during the weekend setup of the Program or produce any considered discussion about how the enforcement model should work. No doubt, in the wake of the evidence that has emerged as to the links between infected security guards and the second wave of COVID-19, and problems more generally with the use of that workforce, positions have hardened as to any 'ownership' of the decision to use private security.

Ultimately, the evidence did not identify that any one person decided to engage private security in the Program. However, there were clearly people who influenced the position that was found to have been adopted at the SCC meeting on the afternoon of 27 March 2020.

Chapter 5 goes through the detail of the exchanges and discussions in the lead up to this meeting.

In short, it concludes that, while no request was made to Victoria Police to provide the 'first tier' of the enforcement model for hotel quarantine, the then Chief Commissioner of Police was consulted and expressed a preference that private security perform that role and Victoria Police provide the 'back up' for that model.

That position, expressed by the senior police representative present at the SCC meeting that afternoon, was clearly persuasive to those at the meeting. There being no particular discussion or dissent, this set in motion the actions, that evening, by DJPR to commence contractual engagement with three security firms. Notwithstanding the multiple submissions from a number of agencies represented at the SCC meeting, the conclusion of Chapter 5 is that this SCC meeting was where and when the decision to engage private security was made as the first tier of enforcement, with Victoria Police as the 'back up'.

At no time on 27 March 2020 did it appear there was any consideration of the respective merits of private security versus police versus Australian Defence Force (ADF) personnel in that first-tier role. Instead, an early mention of private security rather than police grew into a settled position, adopted by acquiescence at the SCC meeting.

There was no actual consideration of whether ADF personnel would have been a better option. The assessment that ADF was not needed on the ground at the hotels was an assessment made without any proper consideration of the anterior question of what would be the best enforcement option.

As of 27 March 2020, the decision not to request the assistance of the ADF for a role in the quarantine hotels was made by the Emergency Management Commissioner. It was open to be made in the sense that, once it was agreed private security would be used at the hotels, there was no longer a 'need' for ADF but, as there had not been any proper analysis of that private security arrangement, it was an assessment that proceeded without investigation.

As noted in Chapter 5, it is important to acknowledge the haste with which these decisions were being made. However, the fact remains that not one of the more than 70,000 documents produced to the Inquiry demonstrated a contemporaneous rationale for the decision to use private security as the first tier of enforcement, or an approval of that rationale in the upper levels of government. Such a finding is likely to shock the public. Unlike the formal application through the Expenditure Review Committee process for the funding for the CEA Program, no such process was uncovered for the use of private security in the Hotel Quarantine Program.

Chapter 5 concludes that the people of Victoria should understand, with clarity, how it was that such a decision to spend millions of dollars of public money came about. The people should be able to be satisfied that the action to proceed in this way was a considered one that addressed the benefits, risks and options available in arriving at such a decision. There was no evidence that any such considered process occurred, either on 27 March 2020 or in the days and weeks that followed, until the outbreaks occurred.

Chapter 5 notes that the decision to engage private security was not a decision made at the Ministerial level. The Premier and former Minister Mikakos said they played no part in the decision. Minister Neville was aware of the proposal but not responsible for it and Minister Pakula appears not to have been told until after private security had been engaged. Enforcement of quarantine was a crucial element of the Program that the Premier had committed Victoria to adopting, but neither he nor his Ministers had any active role in, or oversight of, the decision about how that enforcement would be achieved.

In his evidence, the Premier agreed that the question of how this occurred should be capable of being answered.[24] As the head of the Victorian Public Service at the time, the then Secretary of DPC acknowledged it was a fair point that, if no one knew who made the decision, there was an obvious risk that no one would understand that they had the responsibility for revisiting the decision if time and experience showed that it was not the correct one.[25] This was what occurred here. The decision was made without proper analysis or even a clear articulation that it was being made at all.

On its face, this was at odds with any normal application of the principles of the Westminster system of responsible government. That a decision of such significance for a government program, which ultimately involved the expenditure of tens of millions of dollars and the employment of thousands of people, had neither a responsible Minister nor a transparent rationale for why that course was adopted, plainly does not seem to accord with those principles.

The conclusions contained in Chapter 5 find that the decision as to the enforcement model for people detained in quarantine was a substantial part of an important public health initiative and it cost the Victorian community many millions of dollars. But it remained, as multiple submissions to the Inquiry noted, an orphan, with no person or department claiming responsibility.

The procurement and role of private security

Chapter 6 discusses the use of private security in the Hotel Quarantine Program. It finds that there were problems from procurement through to the scope of the role of security guards.

Chapter 6 concludes that there was no a basis to find anything other than the overwhelming majority of security guards who worked in the Hotel Quarantine Program did so honestly and with goodwill. None of those workers went to work to get infected with COVID-19. However, systemic governmental failings led to problems.

Decisions were not made at the right levels and with the right information

Chapter 6 concludes that outsourcing such a critical function warranted closer scrutiny from senior public servants and the Minister. Those who negotiated the terms of the contracts, and those who 'supervised' them, were doing so without any clear understanding of the role of security in the broader Hotel Quarantine Program and had no expertise in security issues or infection prevention and control. They had no access to advice from those who had been party to the decision to use security and had limited visibility over the services being performed.

Failings in the procurement process

Chapter 6 concludes that the process by which the security firms were selected was not appropriate or sufficiently rigorous. It was made in haste and without any risk assessment, led by staff that did not have the requisite experience and knowledge, and without any public health oversight or input. The speed with which security had to be contracted was some explanation, though not a sufficient explanation, for why the initial contacts were made in the way they were.

Chapter 6 also concludes that there were failures of proper procurement practice on the part of DJPR.

The first was a failure to make use of the State Purchase Contract (SPC) for security services when making initial arrangements for security over the weekend of 28 to 29 March 2020. Those involved in procuring security firms were not aware of that SPC or the existence of publicly available details of security service providers that were regularly used by the Government via the SPC arrangements. Those involved were also unaware of the applicable critical incident procurement policy and protocols, and that an exemption from the SPC was not needed.

Procurement policies are there for a reason. The existence of procurement policies in general, and the SPC specifically, reflect principles of value for money, as well as accountability, suitability and capacity to properly provide services, transparency and probity.[26] These contracts for security services represented tens of millions of dollars; it stands to reason that decisions made to spend public money on these providers should have been consistent with practices that are based on general procurement principles. That should have involved, as far as possible, reliance on existing SPC arrangements.

While it is true that there was a critical incident procurement policy that provided DJPR with the flexibility to source services outside of the SPC Panel, it did not follow that proper procurement practices and decision-making were irrelevant. Indeed, the Department of Treasury and Finance provided evidence that the Victorian Government Purchasing Board's communication to departmental procurement teams was that, wherever possible, SPCs should continue to be used during the pandemic.[27]

The second failure noted in Chapter 6 was in DJPR contracting longer term with the private security provider, Unified Security Group (Australia) Pty Ltd (Unified), despite advice that it was preferable to use those who were part of the SPC panel of providers.

Those tasked with procuring security services for the Hotel Quarantine Program should have heeded the specific procurement advice they were given, as to the risks of informally engaging a non-panel firm to provide quarantine security. They should have considered whether Unified was suitable to remain a service provider in light of their knowledge of the SPC arrangement.

Chapter 6 concludes that the third failure in the procurement process was in not making evidence-based decisions about the allocation of work between the three contractors with whom contracts were signed.

Even allowing for the use of Unified in the short term, it was a failure of government decision-making to contract a firm that had previously been refused admission to the SPC for security services for, what became, very significant sums of money, and then to allocate so much work to that firm.

There was a preference within DJPR for Unified. The preference appears to have been based on what was seen as a willingness by Unified to do the work asked of it, despite some of that work being outside the role it was engaged to perform.

The role of private security

The role performed by private security was ill-defined from the beginning and was, ultimately, a role not suited, without close monitoring and extensive and continued training, to the cohort of guards that was engaged.

The role of security guards changed over time, from 'static guarding' at the outset, to facilitating fresh air breaks later on. The expanded roles increased the risk of security guards being infected through contact with potentially infected guests and through contact with possibly contaminated surfaces in circumstances where overall infection prevention on the site was completely inadequate.

The introduction of those additional functions should have occurred following a proper re-evaluation of the infection control measures in place and an assessment of the increased risks to staff that they posed. No such assessment occurred because no person or agency regarded themselves as responsible and accountable for either the hotel site or the decision to use private security. Responsibility for revisiting the scope of the duties to be performed by security guards lay with DJPR as the contract manager. DJPR did not see that to be the case.

Contract development and management

The conclusions on this issue in Chapter 6 are that DJPR should not have been responsible for contract management throughout the Hotel Quarantine Program. DHHS was the appropriate body to manage those contracts and should have done so as control agency with overall responsibility for the Hotel Quarantine Program.

The contracts should have made clear that security guards were subject to the direction of DHHS in supporting their enforcement functions.

Explicit provision in the contracts would have provided greater clarity and certainty as to who was in charge of security services personnel, which may have led to a greater focus on supervising the work of those personnel.

It was not appropriate that the contracts placed responsibility for training and supervision, in relation to PPE and infection prevention and control, on the contractors in the manner they did. That should have been a responsibility that remained with the State as the architect of the Hotel Quarantine Program.

The contractual requirement for security services personnel to complete the Commonwealth Government Department of Health's COVID-19 online training module was an inappropriate mechanism to properly mitigate the risk of COVID-19 transmission in a hotel quarantine context. Commendable as it was to require training to be undertaken as a precondition of engagement in the Program, it was a failure in preparing those contracts that the content of such training was not based on advice specific to the risks at hotel quarantine sites. COVID-19-related training should have been specifically tailored for non-health professionals working at the quarantine hotels. That it was not, and that it was potentially confusing, meant that it was even more important that contractual requirements as to PPE and training were clear, specific and relevant.

Not having clear, consistent training and PPE requirements led to contractors having different levels of knowledge and sophistication when it came to the use of PPE: at one end of the spectrum, Wilson Security Pty Ltd (Wilson) had a significant suite of policies, practices and supports to mitigate the risk of virus transmission, and at the other, Unified was particularly reliant on DHHS to provide training and information.

Subcontracting security services

The heavy reliance on subcontracting posed a significant risk to the success of the Hotel Quarantine Program in terms of the quality and competence of security guards actually recruited. Notwithstanding this, DJPR did not have adequate oversight of the use of subcontractors in the Hotel Quarantine Program. That was due, in part to DJPR not being aware of the extent to which the head contractors would rely on subcontracting.

DJPR should have been more vigilant and proactive in requiring the security service providers to seek written prior approval for the engagement of subcontractors, as per their respective contracts. But so, too, should the security services providers have complied with their subcontracting obligations at the required time. The consequence of this was that DJPR did not give proper oversight to those performing security services.

It is a significant deficiency that DJPR was not in a position to know the extent to which the security providers actually engaged in subcontracting throughout the duration of the Hotel Quarantine Program, let alone be confident as to who was providing the services and whether they were properly equipped to do so.

Private security guards should not have been engaged without close monitoring

Security guards were not the appropriate cohort to provide security services in the Hotel Quarantine Program without close monitoring and extensive and continued training.

Consideration was not given to the appropriateness or implications of using a largely casualised workforce in an environment where staff had a high likelihood of being exposed to the highly infectious COVID-19. This, of course, had flow on impacts in terms of the spread of the virus.

That is not to say that staff, whether those who contracted security providers or the security staff themselves, acted in bad faith. However, greater consideration ought to have been given to the environment in which security staff were working and their prior infection control knowledge and training.

As an industry, casually employed security guards were particularly vulnerable because of their lack of job security, lack of appropriate training and knowledge in safety and workplace rights, and their susceptibility to an imbalance of power resulting from the need to source and maintain work. These vulnerabilities had previously been identified by the Government.

A fully salaried, highly structured workforce with a strong industrial focus on workplace safety, such as Victoria Police, would have been a more appropriate cohort, which would have minimised the risk of outbreaks occurring and made contact tracing an easier job in the wake of an outbreak.

The use of hotels and cleaners

Chapter 7 analyses the use of hotels and cleaners in the Hotel Quarantine Program.

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

Once the decision had been made to adopt a universal quarantine program for all international arrivals within some 36 hours, the decision to use hotels as the designated facilities for the purpose of Victoria's quarantine program was an obvious enough choice.

Hotels were chosen because they were available, could be stood up quickly, would accommodate large numbers of returned travellers and would provide economic benefits. Even if afforded careful prior contemplation, hotels presented as the only readily available option in the absence of a purpose-built quarantine facility.

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

Procurement and contracting of hotels

It is beyond doubt that the organisation of the hotels and the cleaning companies for the Program involved a significant logistical undertaking. DJPR entered formal agreements with 29 hotels (20 hotels were ultimately used for the Program).[28] It engaged three professional cleaning companies for specialised cleaning, initially only for those rooms that had been used by people who were known to be COVID-positive.[29]

There is no controversy that those contracts between the State and the hotels and cleaning companies were prepared and executed, on behalf of the State, by DJPR.[30] DJPR maintained the obligation of contract management throughout the period from March until July 2020, at which time primary control of the Hotel Quarantine Program transferred to the Department of Justice and Community Safety (DJCS).[31]

While DJPR had responsibility for management of the contracts, in a number of important respects, especially in relation to infection prevention and control measures, direction and management of those contractors was based on advice from DHHS. This resulted in a situation where those responsible for ensuring compliance with the contracts (DJPR) were not the ones with sufficient expertise to understand whether the contracts were being performed as they should. This was an unnecessarily complicated and unwieldy situation, and not a safe system of infection prevention and control. It was compounded by the internal management structures and available public health resources of DHHS that are discussed in Chapter 8.

Important information directed to infection prevention and control — the cornerstone of this Program — was merely transferred to the contractors via DJPR which, in turn, was obtaining such information as was available from DHHS; as a result, it created too many opportunities for its import to be diluted or, even, lost.

Additionally, this contractual framework complicated and obscured what was the necessary and appropriate, albeit apparently lacking, 'ongoing supervision and oversight'[32] by DHHS of the operational aspects of the Hotel Quarantine Program.

Insofar as those aspects were being delivered, or, at least, were intended to be delivered, by the hotels and cleaners who had been engaged, it is apparent that the DHHS Public Health Team and the infection prevention and control (IPC) expertise available to DHHS had little direct insight into how the Program was being administered and, indeed, no oversight.[33] At most, DHHS submitted that 'the Public Health Team had responsibility for the availability of infection prevention and control and PPE advice and guidance'.[34]

DHHS accepted it could have addressed this issue by taking over responsibility for the contracts. The impact of fragmenting responsibilities in this way as between DJPR, DHHS and the private contractors added to, or increased, the vulnerabilities inherent within the Hotel Quarantine Program in Victoria. The provision of policy advice and guidance on IPC measures, such as proper cleaning standards and methods, to DJPR, which had no expertise in the area and, therefore, no ability to oversee the correct implementation of these requirements, was not a safe way to minimise the risk of infectious outbreaks in hotel quarantine sites.

Apparently, with a realisation as to the unwieldy nature of the Program, from 3 July 2020, DHHS assumed responsibility for both the selection and contracting of all hotels in the Program.[35] Existing agreements with hotels were amended to reflect this transfer of responsibility from DJPR to DHHS.[36]

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

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

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

IPC measures are essential to a successful quarantine program. It was necessary to have those with the expertise in infection prevention and control deliver that training. Nothing short of constant reinforcement, supervision and oversight from those with the necessary expertise was what was required in such a highly infectious environment.

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

DHHS witnesses made clear that knowledge about the virus and its modes of transmission was evolving.[37] Dr Simon Crouch, a senior medical adviser in the Communicable Diseases Section of the Health Protection Branch of DHHS, gave evidence that:

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

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

The importance of cleaning

There was an inadequate focus, in the design and implementation of the Hotel Quarantine Program, on the need for specialised and rigorous cleaning to address the risk of virus transmission through environmental contact.

Given that the guidance from the WHO, in March 2020, specifically identified fomite transmission as a recognised method by which infection might occur, the Program should have been informed by the development of proper and authoritative guidance that dealt specifically with rigorous 'environmental cleaning and disinfection'.

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

PROCUREMENT OF COMMERCIAL CLEANING COMPANIES FOR 'SPECIALISED CLEANING'

The requirement that hotels undertake specialised cleans of COVID-positive rooms was flawed. It was based on a presumption, upon rooms being vacated, that it would be known which people in quarantine were COVID-positive and which people were not.

Because of the possibility that people infected with COVID-19 might be asymptomatic or experience only mild symptoms, which they may not recognise or report, and because testing was initially not universal nor compulsory, it was reasonably possible that a person's COVID-positive status might not have been discovered. In such a case, a room that previously held a person infected with COVID-19 would potentially be cleaned by hotel staff or subcontractors rather than the specialised cleaners.

Irrespective of the contracting arrangements and who carried out the cleaning, it was imperative that proper auditing checks were conducted with due care, particularly given the known risk of environmental transmission.[38] There was no evidence that this was done.

CLEANING STANDARDS AND QUALITY CONTROL

There was no comprehensive, specific cleaning advice tailored to the Hotel Quarantine Program until 16 June 2020, when the document titled *Hotel Quarantine Response – Advice for cleaning requirements for hotels who are accommodating quarantined, close contacts and confirmed COVID-19 guests – Update'* was issued by DHHS.

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

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

OVERSIGHT OF SPECIALISED CLEANING IN QUARANTINE HOTELS

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

DHHS assumed the management of all cleaning contracts (other than in relation to the Brady Hotel) in quarantine hotels from 1 July 2020.[39] Had DHHS taken over that function at an earlier point in time, it would likely have been more proactive in directing and managing hotels and cleaners in relation to IPC practices. The demarcation of roles resulted in a diffusion of responsibility, and led to an absence of appropriate oversight and leadership within the Program, in respect of this central tenet of IPC.

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

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

VULNERABILITIES WERE CREATED BY THE ARRANGEMENTS WITH HOTELS AND COMMERCIAL CLEANING COMPANIES

It was not appropriate for the State to place contractual responsibility for infection prevention and control on hotels and commercial cleaners.

Contracts entered into by DJPR on behalf of the State allocated to hotels and cleaners key responsibilities for worker safety, including the need to provide PPE and to manage infection prevention and control.

It was not appropriate for the State Government to seek to impose the risk of transmission of COVID-19 onto the hotel and cleaning providers in the way in which these contracts purported to do. The Hotel Quarantine Program was not just a workplace or a private arrangement between employer and employee, or contractor and principal. It should not have been seen solely through that lens. It was, fundamentally, a measure to protect the public from a significant health threat.

There was simply too much at stake for the State to have conferred such responsibilities on private service providers, whose ordinary roles were so far removed from infection prevention and control measures.

The conclusions reached on this issue echo the evidence of the Premier, who stated that it would 'absolutely' be a concern if the relevant departments 'didn't take an active role in ensuring that there was proper infection control and prevention measures in place', especially where the State had assumed such risk by bringing members of the public into the hotels.[40]

DHHS as the control agency

What became clear through the course of this Inquiry was how complex and unclear the governance structures surrounding, and relevant to, the Hotel Quarantine Program truly were, and the intractable problems this caused throughout the Program. Indeed, the complexity of those governance structures presented like a Gordian knot that developed from the early days of the Hotel Quarantine Program. This matter is examined in detail in Chapter 8.

The commencement of the Hotel Quarantine Program in DJPR, during that March weekend, created the first fracture in the 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.

Victoria's emergency management framework contains an extensive array of legislation, documents, manuals and plans that endeavour to address the range of emergencies that could transpire, and it 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.

The emergency management framework classifies emergencies into different classes depending on the type of emergency being faced. The framework also specifies which agency will be designated as the 'control agency' depending on the expertise required to respond to that emergency. The COVID-19 pandemic is a Class 2 emergency and DHHS is designated the control agency for such emergencies.

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.

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

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.

A 'control agency' is the agency identified in the arrangements that is the **primary agency responsible** for responding to a specific form of emergency. The control agency's responsibilities are set out in the Emergency Management Manual Victoria (EMMV) and include the appointment of 'controllers' for the specific form of emergency.

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.

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 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.

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 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 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 public health expertise and it was the government department that had responsibility for the legal powers exercised to detain people in quarantine.

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.

Prior to the commencement of the Hotel Quarantine Program, the then 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 CHO's disagreement with this course of action.

This decision 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).

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. Third, it meant that those in leadership roles for the Program were not people with public health expertise.

Both the CHO and DCHO expressed concern within DHHS that people were being detained using the legal powers authorised by them in circumstances where they did not consider they had sufficient authority, oversight or awareness in respect of how the operation was being run 'on the ground'. There was also considerable disquiet expressed from some senior members of the Public Health Team inside DHHS about there being a lack of clarity in the command structures adopted by DHHS for the operation of the Program.

Inside the DHHS internal governance structures, there was not an agreed view or consistent understanding between emergency management executives and the public health senior members 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 and, apparently, tension and frustration.

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.

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.

By mid-April 2020, 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 Operations Centre, and run by DHHS 'commanders'. Unfortunately, DHHS did not take this opportunity to rethink its operation but, rather, continued to see itself as coordinating the day-to-day operation of the hotel sites without taking overall responsibility for the Program.

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.

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 these legal powers to grant leave and exemptions and discharge people from quarantine at the end of their 14-day period. Neither had any role, authority or expertise in supervising the safety of the site generally.

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 the control agency taking its leadership role, which included the need to provide on-site supervision and management. This 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, tragically illustrated the lack of proper leadership and oversight, and the perils this created.

MINISTERIAL BRIEFINGS

During the course of the Inquiry, the issue of Ministerial briefings by senior public servants arose on more than one occasion.

It was a matter 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, evidence that emerged on this issue during the Inquiry signalled that an appropriate agency or entity should undertake an examination of what occurred to assess what action may be necessary. This is addressed in Recommendation 76.

Outbreaks at the Rydges and Stamford hotels

The 'second wave' of COVID-19 cases in Victoria was linked to outbreaks in two hotels — Rydges Hotel in Carlton (Rydges) and the Stamford Plaza Hotel in Melbourne's CBD (the Stamford). Chapter 9 analyses these outbreaks.

THE DESIGNATION OF A 'HOT HOTEL'

The idea of cohorting positive COVID-19 cases together in a single location or a 'hot hotel' was a sound public health measure. If appropriately and effectively done, it would have ensured that others in quarantine, who were not infected, had a reduced chance of being infected by reason of their quarantine.

Once the decision was made to establish a hot hotel, it behoved those involved in deciding to implement that concept to pay particular attention to the IPC measures deployed at that location, to ensure that the standards and policies were appropriate and that there was appropriate compliance and adherence to them. They should have had particular regard to the make-up of the workforce and habits of those undertaking duties there.

There were no documents before the Inquiry that answered the question as to who made the decision to use Rydges as a 'hot hotel' and why that decision was made. This is yet another instance of where it could not be made clear to the Inquiry who was responsible for critical decisions in the Program.

At the time the decision was made to cohort COVID-positive cases at Rydges, insufficient regard was paid to infection prevention and control standards across the entire Program and, particularly, to that location, given the appreciable and known increased risk of transmission commensurate with concentrating positive cases in one location.

ADDITIONAL SAFEGUARDS REQUIRED IN A 'HOT HOTEL' ENVIRONMENT

IPC expertise was not sufficiently embedded in the design of Rydges as a 'hot hotel.'

As many staff working in the Hotel Quarantine Program were engaged on a rotating rostered basis until at least 28 May 2020, the provision of episodic training sessions was inadequate to mitigate against the risks posed by not only a hot hotel environment, but any quarantine hotel.

What was necessary was a comprehensive and ongoing training program for all on-site personnel that was overseen by a supervisor, and on-site monitoring for compliance.

EPIDEMIOLOGICAL AND GENOMIC EVIDENCE

Breaches of containment in the Program, in May and June 2020, contributed to the 'second wave' of COVID-19 cases in Victoria, with all of its catastrophic consequences to life, health, wellbeing and the economy of the State.

As set out in Chapter 2, around 90 per cent of COVID-19 cases in Victoria since late May 2020 were attributable to the outbreak at Rydges. Just under 10 per cent of positive cases in Victoria since were attributable to the outbreak at the Stamford in mid-June.

The evidence does not provide the basis to find, with certainty, what specific event caused the transmission from infected traveller to worker. But it does show the likely mode of transmission at Rydges was through environmental transmission, particularly in light of the evidence of poor cleaning products, poor PPE use by security guards, security guards being used to provide some cleaning services and the lack of education around cleaning practices.

The evidence does not permit a conclusive finding as to whether the Stamford outbreak was due to person-to-person contact or environmental transmission.

Issues in respect of poor IPC practices at the Stamford mirrored what had been observed during the investigation into the Rydges outbreak.

Notwithstanding the considerably higher number of frontline staff who became infected at the Stamford, measures taken, whether by way of prompt and appropriate cleaning or because of the immediate and swift quarantining of all staff, or both, were more effective in preventing the spread of the virus into the community.

THE GENESIS OF EACH OUTBREAK

Infection prevention and control measures at both hotels were inadequate, namely in terms of cleaning, PPE use, and staff training and knowledge. Those inadequacies contributed to the transmission of the COVID-19 virus from returned travellers to those working in the Program. In particular, there were pervasive issues identified with delays in deep cleans and in quarantining exposed staff that may have also contributed to the outbreaks.

The need to quickly quarantine exposed staff was significant. As DHHS was aware of the risk posed by fomite transmission, and given there was no reliable data to exclude or limit its likelihood, a more prudent, safety-based approach would have been to furlough every member of staff that had been exposed to all reasonably perceived primary and secondary sources of transmission. This was a reasonable option that would have been apparent to those with the mandate to contain the virus. That this would have required effectively shutting down the hotel or bringing in a replacement cohort of staff (with corresponding substantially increased PPE and infection prevention and control measures) ought not to have been persuasive arguments against such cautious measures. The former approach was taken merely days later without apparent adverse consequence. The delay to isolate the staff earlier resulted in a lost opportunity to curb the further spread of this virus from the exposed workforce into the community.

With respect to contact tracing, timely and accurate information is vital to efforts to contain outbreaks. Detailed information about the movements of cases and close contacts is particularly vital to contact tracers.

A ‘two way’ flow of information is important for contact tracing. Just as it is important for individuals to be forthcoming with public health authorities, it is important for health authorities to provide individuals and private entities with information that would enable those individuals and entities to take appropriate action in the event of a possible exposure.

Although the use of hotels as a setting for mass quarantine may have been unprecedented, factors that played a part in the outbreaks from Rydges and the Stamford should have been foreseen had there been an appropriate level of health focus in the Program. It was an inescapable conclusion that the second wave that hit Victoria was linked to transmission events out of both of those hotels from returned travellers to personnel on-site and then into the community.

The testing regime in the Hotel Quarantine Program

Testing of those detained in the Hotel Quarantine Program was clearly an important aspect of its stated aim, being to minimise the possibility of COVID-19 transmission into the community via returning travellers. Chapter 10 of the Report considers the testing regime.

Initially, only those who showed symptoms were offered a test, and testing in the Hotel Quarantine Program remained entirely voluntary until July 2020. The mandatory testing powers contained in the *Public Health and Wellbeing Act 2008* (Vic) were considered but not used.

A new approach was implemented, in July 2020, when an additional 10 days of quarantine was introduced for those who refused testing on Day 11. This new approach was justified and appropriate.

It is understood that this will be bolstered in the revised hotel quarantine program with mandatory testing of staff and all on-site personnel working in the program, along with voluntary testing of their families and household contacts.

Both approaches represent substantial improvements to the initial testing program that risked undermining, at least to some degree, the efficacy and intentions of the Hotel Quarantine Program and, in doing so, risked transmission of COVID-19 from those detained in the Program into the community.

To further protect against these risks, the legal basis for, and utility of, a testing regime requiring returned travellers who refuse testing at the conclusion of their 14-day quarantine period to undergo mandatory testing should be further explored.

The pivot to a health hotel model

Chapter 11 discusses the shift, in late June 2020, from the Hotel Quarantine Program run by DJPR and DHHS to a health hotel model, with sole responsibility for the Program sitting with DJCS.

Notwithstanding the various explanations and justifications given in evidence, the Government's decision to remove the operation of this public health program (Hotel Quarantine) away from the department responsible for public health, DHHS, led to the conclusion that the Government formed a view, by July 2020, that a single department needed to run the Program and that it did not have confidence that DHHS was capable of running the Program on its own at that time.

The pivot created a governance framework whereby DJCS had clear and direct supervision and control over — and accountability for — those working within the Program, compared to the fragmentation and obfuscation of responsibility in the earlier iteration of the Program.

DHHS was slow to realise it needed to bring a greater clinical focus to the Hotel Quarantine Program. It was aware of, at least, some of the deficiencies in the Hotel Quarantine Program well before June 2020; it could, and should have, remedied them sooner.

By late June, after the second outbreak, only one hotel — the Brady Hotel — was operating under a model whereby Alfred Health provided clinical and infection prevention and control services to that hotel. An approach to Alfred Health could have been made sooner and the training and clinical governance developed by Alfred Health implemented more broadly than at one hotel.

The decision made by DHHS, in late June, to seek an alternative workforce to replace private security indicated that DHHS had the power and authority to make that decision and could have done so earlier, either by consultation with DJPR or by having the contracts transferred to itself.

The 24/7 police presence at the 'health' hotels recognised the value of a trained, salaried security presence that had supervised occupational health and safety operating procedures as required by a strong industrial advocate in the Police Association, and a recognition by Victoria Police of the need for worker safety operating procedures.

The involvement of unions and industrial advocates in the planning of the new model — there were multiple references in Crisis Council of Cabinet submissions to the importance of consultation with the Community and Public Sector Union, the Transport Workers Union and the Police Association — reflected the greater degree of concern attached to workplace health and safety for those government employees than appeared to have been the case when planning for workplaces that were to be largely staffed by private contractors.

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

Chapter 12 analyses whether and how the rights and welfare of returned travellers were approached in the Hotel Quarantine Program and considers how a future quarantine program could be strengthened in this regard.

THE VICTORIAN CHARTER OF HUMAN RIGHTS AND RESPONSIBILITIES

Chapter 12 concludes that Dr van Diemen, in making mandatory detention orders, did give serious and proper consideration to her Charter obligations, in the circumstances, and she assessed her obligations with the evidence available to her at that time.

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

The recommendations made in Section 2 of the Interim Report regarding the option of a home-based quarantine model are adopted for this purpose.

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

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

PSYCHO-SOCIAL IMPACTS OF QUARANTINE ON RETURNED TRAVELLERS

The health and welfare needs of people in the Hotel Quarantine Program had a considerable impact on the manner in which the Program operated and developed.[41] These needs created many problems for those in quarantine, in circumstances where the Program had to be deployed to receive hundreds of people at great speed, with little or no information about returning travellers before they arrived.[42]

In some instances, the manner in which these needs were handled increased the risk of transmission,[43] detrimentally affected the health and wellbeing of people detained in quarantine and created considerable strain on those working in the Program.

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

The health and wellbeing needs of those in quarantine must be a central feature of a future quarantine program.

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

The fact that such advice was not obtained was likely to be attributable to factors including the speed with which the Program had to be set up, that there was no developed plan or experience for holding people in mass quarantine facilities and, what has been found to be, the disproportionate focus of those designing and implementing the Hotel Quarantine Program on logistics, when health should have been given greater attention. What this evidence showed was that there was some, but not sufficient, attention given to the mental health and overall wellbeing of returned passengers. While the focus on health and wellbeing did increase as the Program developed, there were shortcomings or systemic gaps in meeting the health and human needs of those in quarantine, including:

A. not initially understanding, or adequately addressing the fact that:
   I. being detained in quarantine in a hotel room for 14 days would be a very difficult and stressful experience for some
   II. a percentage of the people held in quarantine would have significant health needs, either physical or mental, or both, and would need particular support
   III. having no access to fresh air or exercise would be extremely difficult for some people

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

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

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

E. clear, consistent and accurate information was necessary but difficult to find or not available, or in a language that was not accessible. The system for acquiring and maintaining information on people in quarantine was inadequate

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

G. the process for accessing applications for leave and/or exemptions was not clear or consistent.

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

The Inquiry accepts that efforts were made to keep returning travellers safe and comfortable and to offer appropriate support to them. But meeting the health and wellbeing needs of such a wide range of returned travellers is a complex and nuanced task that needs proper attention. Those responsible for the welfare of people in quarantine needed to have been continuously mindful of performing their roles in a way that did not impose greater stresses than those already imposed by reason of a highly stressful and unusual situation.

Victoria's Quarantine Program: future options

This Inquiry investigated why the Hotel Quarantine Program was established and how it was managed. It identified failings in the Program's design and administration, including with respect to where focus, responsibility and accountability lay.

Fundamentally, this Inquiry highlighted that the Hotel Quarantine Program was administered without the focus on infection prevention and control that was necessary to properly contain the COVID-19 virus and the catastrophic consequences of its spread into the community.

This Inquiry has not been solely about identifying deficiencies or finding fault. To do so would be to miss opportunities for improvement in Victoria's future quarantine program.

There was evidence from some witnesses not just about what went wrong but, also, what could have been done better. Where deficiencies have been identified throughout the course of this Inquiry, it has given rise to lessons that can be learned. It has also given rise to 81 recommendations.

The Inquiry's Interim Report recommended options for the future quarantining of international arrivals. Those recommendations, which are adopted into this Final Report, set out two models that would operate concurrently: the first being a facility-based model and the second being a home-based model.[44]

Those models were proposed having taken into account, and in response to, the issues that were raised during the Inquiry.

A full list of the Inquiry's recommendations, flowing from the Interim Report and this Final Report are set out at pages 38–49.

Endnotes

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2 Exhibit HQI0135_RP Witness statement of Ms Merrin Bamert, 27 [94].

3 Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 5 [15].

4 Exhibit HQI0135_RP Witness statement of Ms Merrin Bamert, 27 [94]; Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 5 [15].

5 National Review of Hotel Quarantine, ‘Attachment A - Quarantine – National Statistics’, 34-35 <https://www.health.gov.au/sites/default/files/documents/2020/10/national-review-of-hotel-quarantine.pdf>.

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9 Federal Minister for Health, ‘First Confirmed Case of Novel Coronavirus in Australia’ (Media Release, 25 January 2020) <https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/first-confirmed-case-of-novel-coronavirus-in-australia>.

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15 Prime Minister, Minister for Health, Chief Medical Officer, ‘Advice on Coronavirus’ (Media Release, 13 March 2020) <https://www.pm.gov.au/media/advice-coronavirus>; Prime Minister, ‘Press Conference with Premiers and Chief Ministers – Parramatta, NSW’ (Transcript, 13 March 2020) <https://www.pm.gov.au/media/press-conference-premiers-and-chief-ministers-parramatta-nsw>.

16 Prime Minister ‘Coronavirus Measures Endorsed by National Cabinet’ (Media Release, 16 March 2020) <https://www.pm.gov.au/media/coronavirus-measures-endorsed-national-cabinet>.

17 Prime Minister ‘Update on Coronavirus Measures’ (Media Statement, 20 March 2020) <https://www.pm.gov.au/media/update-coronavirus-measures-0>.

18 Prime Minister ‘Update on Coronavirus Measures’ (Media Release, 27 March 2020) <https://www.pm.gov.au/media/update-coronavirus-measures-270320>.

19 Exhibit HQI0106_RP Witness statement of Dr Sarah McGuinness, 7 [27]; World Health Organization, ‘Modes of transmission of virus causing COVID-19: implications for IPC precaution recommendations: scientific brief’ (Brief, 29 March 2020) <https://www.who.int/news-room/commentaries/detail/modes-of-transmission-of-virus-causing-covid-19-implications-for-ipc-precaution-recommendations>.

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26 See Exhibit HQI0073_P Witness statement of Ms Hayley Baxter, 4 [15], 8–9 [28(c)], 12 [47].

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28 Exhibit HQI0049_RP Witness statement of Mr Unni Menon, 7 [23].

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30 Ibid; Exhibit HQI00049 Witness statement of Mr Unni Menon, 7 [21]-[23].
31 Exhibit HQI00035_RP Operation Soteria Operations Plan, DOJ.504.010.8488 (version 1.0); Exhibit HQI0126_RP Annexures to witness statement of Ms Melissa Skilbeck, DHS.0001.0001.1527 (version 2.0); DHS.0001.0001.2254 (version 3.0); Exhibit HQI0186_RP First witness statement of Ms Kym Peake, 49 [252]–[254].
32 Exhibit HQI0126_RP Annexures to witness statement of Ms Melissa Skilbeck, DHS.0001.0001.1525.
33 Exhibit HQI0160_P Witness statement of Dr Annaliese van Diemen, 4-5 [24].
34 Submission 03 Department of Health and Human Services, 31 [166].
35 Exhibit HQI0049_RP Witness statement of Unni Menon, 10 [37].
36 Exhibit HQI0041_RP Witness statement of Mr Shaun D'Cruz 4 [16].
37 Exhibit HQI0103_RP Witness statement of Dr Simon Crouch, 7 [37].
38 See Exhibit HQI0001_P Witness statement of Prof. Lindsay Grayson, 9 [42].
39 Exhibit HQI0128_RP Witness statement of Mr Michael Girgis, [13].
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41 Submission 03 Department of Health and Human Services, 59-64 [329]–[344].
42 Exhibit HQI0162_P Witness Statement of Ms Andrea Spiteri, 15 [59]; Submission 03 Department of Health and Human Services, 60 [330].
43 Exhibit HQI0191_RP Initial response to the Board of Inquiry from DHHS, 8; Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 8-9 [22(c)]; Exhibit HQI0075_P Witness statement of Mr Noel Cleaves, 14 [76(a)-(b)]; Transcript of day 13 hearing 4 September 2020, 912-913.
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COVID-19 Hotel Quarantine Inquiry Recommendations

The COVID-19 Hotel Quarantine Inquiry delivered its Interim Report and Recommendations to the Governor of Victoria on 6 November 2020.

The Interim Report underpins this Final Report with recommendations that support the development and implementation of a robust quarantine system for the State of Victoria.

The Final Report incorporates and adopts the 69 recommendations presented in the Interim Report set out below. The Final Report recommendations flow on from the Interim Report and, as such, are numbered from Recommendation 70 onwards.

Interim Report Recommendations (Recommendations 1–69)

The Quarantine Program (Section 1 of the Interim Report)

Purpose of the Quarantine Program

1. The Quarantine Program for international arrivals into Victoria be clearly defined as a public health measure to address the need to contain the transmission of COVID-19 into the community while ensuring that the health and wellbeing of those placed into quarantine is properly addressed together with the need to ensure the safety of all personnel working in the Program.

Control of the numbers

FACILITY-BASED MODEL

2. To achieve an orderly and manageable process, the Victorian Government must do all things possible to ensure appropriate and necessary processes are put in place to control the numbers of international arrivals at any given time, informed by the availability of fully operational facilities that are ready and able to receive the agreed numbers.

HOME-BASED MODEL

3. The numbers of international arrivals also be controlled to make practical and achievable the individual engagement and suitability assessments required for home-based quarantine (see Recommendation 59).

Information gathering

4. The Victorian Government takes all possible steps to obtain the co-operation and assistance of Commonwealth agencies and officials, to ensure that the best available and most relevant information is provided to State officials as far in advance as possible for each international arrival, in order to facilitate an informed suitability assessment for appropriate placement in the Quarantine Program (including suitability to quarantine at home).

Electronic record-keeping

5. The Victorian Government liaises with the Commonwealth to develop a process whereby such information about each international arrival bound for a Victorian point of entry can be placed in an electronic file made available to the state authorities as expeditiously as possible prior to the arrival, and for that file to contain targeted information for State officials to assist in the management of the necessary quarantine arrangements.
6. All necessary actions be taken to have that electronic file follow the individual from international arrival through to the completion of their quarantine obligations and include all relevant information to assist in that person's safe transition into the community.

Safe and suitable physical environment for a quarantine facility

7. Given there are currently no identified specific purpose-built quarantine facilities in Victoria, that hotels remain a reasonable and viable option for international arrivals needing to be placed into quarantine. Relevant criterion for selecting suitable locations as quarantine facilities include:
    - A. sufficient proximity to a hospital
    - B. being within commuting distance for adequate numbers of appropriately skilled personnel for the facility
    - C. the facility's:
        - I. ability to allow for the physical separation of people
        - II. ability to properly implement all necessary infection control requirements, as far as practicable
        - III. capacity to make necessary modifications and additions to minimise the risk of transmission, as far as practicable
        - IV. ability to provide safe access to outside areas for fresh air and exercise breaks
        - V. ability to provide for specific needs such as mobility issues or the need to cater for infants.

Governance structure

8. The Victorian Government ensures that at the ministerial and departmental level, clear control and accountability structures are in place for the operation of the Quarantine Program (including the facility-based program together with any home-based program),to be operated by one Cabinet-approved department, with support from other departments as necessary, but in accordance with a clear line of command vesting ultimate responsibility in the approved department and Minister.

9. The Victorian Government ensures that the Minister and department approved as the single agency to be accountable for the operation of the Quarantine Program is the department that is the sole agency responsible for any necessary contracts.
10. The responsible Minister ensures that the departmental structure for the operation of the Quarantine Program has clearly defined roles that have the necessary expertise and advice embedded at appropriate levels of seniority in the operational structure (the departmental governance structure).
11. The responsible Minister ensures that the appropriate senior members of that governance structure form a body ('Quarantine Governing Body') that meets regularly, is chaired by the Secretary to the responsible Minister, maintains records of its meetings including records of all decisions reached, and provides reports to the Minister from those meetings including in respect to decisions reached.
12. The responsible Minister ensures that the Quarantine Governing Body provides regular, timely and accurate reports to the Minister as to the operation of the Quarantine Program, across all sites, and including all aspects of the entire Quarantine Program, including full and accurate reports as to compliance, monitoring and risks measured against the Purpose (as set out in Recommendation 1).
13. The responsible Minister ensures that the Quarantine Governing Body sets clear and consistent lines of accountability across all individual sites operating as quarantine facilities.
14. The Quarantine Governing Body ensures that each individual quarantine facility site has provided role clarity to all personnel working on-site.
15. The Quarantine Governing Body ensures that each quarantine facility has a Site Manager responsible for the overall operation of that facility, who is accountable to the Quarantine Governing Body.
16. The Site Manager role should be filled by a person who has experience in the management of complex healthcare facilities.

On-site role clarity

17. The Site Manager ensures that all personnel working in the quarantine facility understand their role and responsibilities.
18. The Site Manager ensures that all personnel on-site understand to whom they report and all lines of reporting and accountability on-site.

Appropriate mix of personnel on-site

19. The model contained in paragraph 21 of Section 1 be considered an appropriate model for the operating structure of a quarantine facility.
20. The Chief Commissioner of Police be requested to provide a 24/7 police presence on-site at each quarantine facility.
21. The responsible Minister and Quarantine Governing Body ensure that infection prevention and control expertise is embedded in each quarantine facility site, together with the necessary clinical personnel, to meet the mental and physical health needs of people in quarantine. To this end, the model presented and expanded upon at paragraph 21 of Section 1 [of the Interim Report] should be considered a good basis for all quarantine facilities.

Dedicated personnel

22. Accepting the need to bring in expertise, every effort must be made to ensure that all personnel working at the facility are not working across multiple quarantine sites and not working in other forms of employment.
23. To achieve the aims of Recommendation 20,every effort should be made to have personnel working at quarantine facilities salaried employees with terms and conditions that address the possible need to self-isolate in the event of an infection or possible infection, or close contact exposure, together with all necessary supports, including the need to relocate if necessary and have a managed return to work.

Infection prevention and control unit on each site

24. The Quarantine Governing Body ensures that each quarantine facility has a properly resourced infection prevention and control unit embedded in the facility with the necessary expertise and resources to perform its work.

Training and workplace culture

25. The Site Manager be responsible for ensuring that all personnel working on-site are inducted into a culture of safety, focussed on infection prevention and control provided by those with the expertise to deliver such training.
26. The culture of safety to be fostered by the Site Manager should encourage collaboration, open discussion as to mistakes and oversights and speaking up about concerns and potential health and safety risks.
27. The Site Manager be responsible for ensuring that all personnel working on-site are engaged in ongoing training in infection prevention and control provided by those with the expertise to deliver such training tailored to the specific roles to be performed on-site.
28. The Site Manager ensures that the personnel on-site who have the expertise in infection prevention and control are engaged in ongoing monitoring and supervision of all of the requirements in place for infection prevention and control, which includes matters such as individual behaviour, the use of personal protective equipment (PPE) and cleaning practices.

Acquisition and use of PPE

29. The Site Manager ensures that the infection prevention and control experts direct the acquisition, distribution and use of PPE with specific, clear and accessible directions to all personnel on-site (acknowledging that such instructions may vary according to role).

Cleaning practices in quarantine facilities

30. The Site Manager ensures that all cleaning practices throughout the site are developed, directed and overseen by personnel with infection prevention and control expertise, and include 'swab' testing as directed by the infection prevention and control experts.

Independent safety auditing

31. The Quarantine Governing Body ensures that each quarantine facility site has regular, independent safety audits performed (as against the Purpose set out in Recommendation 1) with reports from those safety audits to be provided to both the Site Manager and the Quarantine Governing Body.

Period of quarantine

32. A 14-day period in quarantine is appropriate, unless the current state of expert opinion changes, or as otherwise directed by the Chief Health Officer or their delegate.

Cohorting of positive cases

33. Any decision to cohort known positive cases at a particular quarantine facility should only occur after proper consultation with the appropriate experts as to suitability of the facility, any necessary adjustments to the facility, and the experts being satisfied that all necessary infection prevention and control precautions are in place at that facility.

Testing

34. All people in quarantine, whether facility or home-based, should be tested on such days as directed by the Chief Health Officer or their delegate, regardless of reported symptoms.
35. For those assessed as suitable for home-based quarantine, it should be a condition of such placement that a person agrees to be tested, as directed by the Chief Health Officer or their delegate.

Clinical equipment on-site

36. On advice from the appropriate experts, adequate and readily accessible on-site clinical equipment to address the range of possible health needs of those in quarantine should be placed at each quarantine facility, together with the necessary resources to effectively sanitise any such equipment.

Safe transport arrangements

37. Given the possible COVID-19-positive status of an individual in a quarantine facility or home-based quarantine, arrangements and protocols for the safe transporting of a person for either urgent or non-urgent health reasons should be developed.

Contact tracing unit

38. That the Quarantine Governing Body ensures that each quarantine facility has a contact tracing unit embedded in the facility that can build familiarity and trust with on-site personnel and has accurate and up-to-date information for such personnel, to enable a rapid and efficient response to any possible outbreak and provide ongoing training to all personnel as to what is required in the event of potential or actual infection.

Evacuation procedure on-site

39. Each Site Manager should develop an emergency evacuation plan for the site and ensure it is well understood and regularly rehearsed by all personnel working in the facility and communicated to each of those placed in the quarantine facility.

Health and wellbeing of people in quarantine

Daily health and welfare checks

40. The Quarantine Governing Body ensures that daily health and welfare checks be embedded into the operation of each quarantine facility.
41. Site Managers arrange standard daily health and welfare checks on people in quarantine, to be conducted with the assistance of available technology, such as a visual telehealth platform, where the individual is willing and able to participate in this way or as otherwise directed by the Clinical Manager (as per the model in paragraph 21 of Section 1).
42. The Quarantine Governing Body provides direction, advice and resourcing as to the use of visual telehealth platforms to enable a case management approach to an individual's health needs, which may enable family, interpreters, existing or preferred healthcare professionals and supports to participate in case conferencing directed to the health and wellbeing of those in quarantine facilities.
43. That the daily health and welfare checks be conducted by appropriately skilled personnel who are also able to screen for any unmet needs or concerns, rather than limited to a check on COVID-19 symptoms.
44. Suitable health and welfare checks by appropriately skilled personnel should be conducted on those in home-based quarantine.

FRESH AIR AND EXERCISE BREAKS

45. The Quarantine Governing Body ensures the ability to provide daily fresh air and exercise breaks for people placed in quarantine facilities is factored into not only the physical layout, but also the staffing of the facility, to ensure there is provision for safe, daily opportunity for people in quarantine facilities to have access to fresh air and exercise breaks.

COMMUNICATION WITH AND TO PEOPLE IN QUARANTINE FACILITIES OR PRIOR TO ENTRY INTO THE QUARANTINE PROGRAM

46. The Quarantine Governing Body ensures that each facility program operates on an understanding and acknowledgment that a number of people placed in quarantine facilities will experience a range of stressors as a result of being detained in a quarantine facility for 14 days.
47. The Quarantine Governing Body ensures that all reasonable steps are taken to assist those who will be particularly vulnerable and require additional skilled support by reason of their being held in quarantine.
48. The Quarantine Governing Body ensures that every effort is made to provide multiple forms of communication of information throughout the period of quarantine to assist in reducing the distress and anxiety that some people will experience in quarantine.
49. The Quarantine Governing Body should address the need to provide accurate, up-to-date and accessible information to all people seeking to enter Victoria through international points of entry, including in community languages, to ensure best efforts at communication are made for all international arrivals.
50. Site Managers ensure that clear, accessible and supportive styles of communication should be regularly used to enable people to have consistent and accurate information about what supports are available to them and who to contact if they have a complaint, a concern or an enquiry while quarantined in a facility.
51. To assist in creating support for people in quarantine facilities and ensuring that there is information available in a range of formats and languages, Site Managers should assign a role to an appropriate person who can coordinate communications and use various platforms (for example visuals, signs, social media, etc.) to encourage those in quarantine facilities to connect with one another. These platforms can also be used to regularly communicate general and relevant information.

Exemptions and temporary leave

52. Authorised Officers ensure that each person placed in quarantine, whether facility or home-based, is made aware of the process for requesting temporary leave or an exemption and the criteria upon which such requests will be assessed.
53. Authorised Officers make decisions about whether or not to grant an exemption or temporary leave as promptly as practicable.
54. Authorised Officers ensure that any conditions or restrictions on such grants should be clearly communicated to the person making the request, address the need to manage the risk of transmission of COVID-19 while that person is in the community and is monitored for compliance.
55. To assist Authorised Officers and enhance consistent decision-making, that each Authorised Officer be provided with a checklist and guidance material on all relevant considerations when determining applications for exemptions and temporary leave applications.

Language is important

56. Language such as 'resident' rather than 'detainee' be used to reduce the risk of such language having a negative effect on the culture of the facility and to reflect that quarantine is a health measure and not a punitive measure.

Transitioning out of quarantine facilities

57. People leaving quarantine facilities should be offered an opportunity for a 'de-brief' to assist with their transition out of the facility and also to enable the opportunity for feedback to be passed to the Site Managers to assist in maintaining a culture of continuous improvement.

Home quarantine model (Section 2 of Interim Report)

Home quarantine as an option

58. In conjunction with a facility-based model program for international arrivals, the Victorian Government develops the necessary functionality to implement a supported home-based model for all international arrivals assessed as suitable for such an option.

Control on numbers arriving

59. The Victorian Government does all things possible to ensure that appropriate controls are put in place to limit the number of international arrivals at any given time to make the necessary individual engagement and assessment for a home-based model practical and achievable.

Assessment of risk factors for home quarantine

60. The Victorian Government engages the appropriate expertise to develop a list of risk and protective factors to be used in the assessment of individual suitability for the home-based model.
61. To assist the Chief Health Officer and Authorised Officers in making such assessments, the Victorian Government engages personnel with the appropriate expertise and training, supported by the necessary resources, to support the Chief Health Officer and Authorised Officers to apply those risk factors to the individual circumstances of international arrivals.
62. The Victorian Government ensures that the Chief Health Officer and Authorised Officers are provided with the capacity and necessary resources to efficiently confirm the accuracy of information being provided for individual assessments of international arrivals.

Individual engagement

63. The Victorian Government takes all necessary steps to address the language and cultural needs of all international arrivals to ensure that accurate information is both obtained for assessment purposes and received and understood by the person subject to the Home Quarantine Directions.
64. The Victorian Government takes all reasonable steps to assess and provide any reasonable supports that may assist an individual or family to quarantine at home.

Conditions of Home Quarantine Direction accepted in the form of a personal undertaking

65. Accepting the need to do all things necessary to mitigate against the risk of non-compliance with a Home Quarantine Direction made by the Chief Health Officer or Authorised Officer, the Chief Health Officer or Authorised Officer could consider making the Home Quarantine Direction conditional upon the eligible person entering into a written undertaking, which could contain specific requirements that they must agree to, including (but not limited to):
    A. to submit to such COVID-19 testing during the period of home quarantine as is specified by the Chief Health Officer or Authorised Officer
    B. to allow such people as are required to carry out such testing to enter the premises at which the person is detained to conduct such testing
    C. to provide during the period of detention such information as is reasonably required by the Chief Health Officer or Authorised Officer in order to review whether their detention continues to be reasonably necessary.
66. Further, to underscore the gravity of any non-compliance, such an undertaking or agreement could also include an assurance from each person (over the age of 18 years) that they understand and agree to comply with each of the conditions of their quarantine and have understood the penalties that apply to any breaches.

Monitoring and compliance

67. The Victorian Government considers enhancing the range of methods for monitoring compliance with Home Quarantine requirements, such as electronic monitoring using smart phone technology and the use of ankle or wrist monitoring systems.

Penalties for non-compliance

68. The Victorian Government, in recognition of the risks to public health associated with any non-compliance with the Home Quarantine Directions, considers whether the current penalty regime is sufficiently weighted to enforce compliance.
69. The Victorian Government, in recognition of the risks to public health associated with any non-compliance with the Home Quarantine Directions, considers whether an offence should be created to apply to any person who knowingly enters a place where a person has been directed to Home Quarantine, unless that person has been authorised by the Chief Health Officer or Authorised Officer to do so.

Additional Final Report Recommendations (Recommendations 70–81)

Pre-pandemic planning (Chapter 3)

70. The Victorian Government, through the various national structures available to the Premier, the Minister for Health, the Secretary to DHHS and the Chief Health Officer, advocates for necessary action to be taken to address the recommendations from the *Review of Australia's Health Sector Response to Pandemic (H1N1) 2009* as to clarity on roles and responsibilities between different levels of government, management, support systems and communication and policy on quarantine and isolation.
71. The Secretary of DHHS engages with the appropriate representative bodies from the medical profession with a view to developing agreed plans as to the availability of medical expertise and resources in the event of a public health emergency and the need for future surge demands.
72. The Secretary of DHHS ensures that future pandemic planning exercises should specifically address the need for clarity of roles, structures and accountabilities to ensure the necessary detailed focus and preparedness as to the importance of these issues is widely understood and well-rehearsed.
73. The Secretary of DHHS, in consultation with representative bodies from the broader health sector, reviews the range of participants currently invited to pandemic planning exercises to assess how the range of representative participants could be expanded to include the broader health sector.

Role of the control agency and Ministerial accountability (Chapter 8)

74. 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. 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).

Testing regime (Chapter 10)

78. To provide clarity to the Chief Health Officer and his delegates on the circumstances in which mandatory testing powers may be exercised and, to further minimise the risks of community transmission arising from the revised hotel quarantine program:

    A. the Responsible Minister should obtain detailed legal advice from the Solicitor-General on the range of circumstances in which ss 113 and 200(1)(d) of the *Public Health and Wellbeing Act 2008* (Vic) may be exercised to require that those refusing testing at the conclusion of their quarantine period undertake mandatory testing

    B. the request for such advice should provide a detailed list of practical scenarios that commonly arise, or are expected to arise, in the context of returned travellers refusing to undergo testing in the Hotel Quarantine Program

    C. recognising that it will not be possible to provide absolute certainty on the range of circumstances in which these powers may be available, the advice should provide practical guidance to the Chief Health Officer and Authorised Officers in their exercise of the powers under ss 113 and 200(1)(d) and consider matters including those listed above in paras 41.a–41.h

    D. the request for advice should also include a request for a ‘checklist’ to be developed in order to assist those working in the Hotel Quarantine Program to determine when mandatory testing powers and/or the option of imposing an additional 10 days’ quarantine should be exercised

    E. to accompany this advice, the Responsible Minister should identify an appropriate person who will be available to provide legal advice, at short notice and when required, to the Chief Health Officer and delegates, on the exercise of mandatory testing powers and/or the option of imposing an additional 10 days’ quarantine.

79. To protect against the risk of infection spreading to the community via staff or personnel working in the program who have contracted the virus from returned travellers, the Responsible Minister should ensure, or continue to ensure, that:

    A. all on-site staff and personnel, including frontline workers and cleaners, are required to undergo daily saliva testing and weekly nasal swab testing

    B. family and household members of such frontline staff and personnel are provided with, and given support to access, voluntary testing on, at least, a weekly basis.

Returned travellers' rights and welfare (Chapter 12)

TRANSITIONING INTO QUARANTINE FACILITIES

80. The Quarantine Governing Body (called COVID-19 Quarantine Victoria) should ensure proper infection prevention and control measures are applied in the transit of returned travellers to their quarantine facility, in the same manner as those measures are applied at hotels. Those measures should include proper social distancing, cleaning and PPE practices.
81. To further reduce the risk of transmission during transit, the Quarantine Governing Body should require that:
    - A. buses used to transport returned travellers to quarantine facilities must be used only for that purpose and not to provide non-quarantine related transport services to members of the public
    - B. every effort be made to ensure that drivers of buses used to transport returned travellers to quarantine facilities are not permitted to work in other forms of employment (or to drive buses for any other purpose), consistent with Recommendation 22.

About this Report

The COVID-19 Hotel Quarantine Inquiry was established on 2 July 2020 to examine matters related to Victoria's Hotel Quarantine Program.

Specifically, the Inquiry was tasked with looking into decisions by, actions of and communication between government agencies, hotel operators and private contractors involved in the Hotel Quarantine Program, along with associated contractual arrangements, information, guidance and training, and policies, protocols and procedures.

The Inquiry's Final Report examines the workings of Victoria's Hotel Quarantine Program and provides associated findings and recommendations based on evidence and information tendered to the Inquiry.

The Final Report is to be read in conjunction with the Inquiry's Interim Report, which was delivered on 6 November 2020 and contained 69 recommendations that supported the development and implementation of a robust quarantine system for the State of Victoria. As explained in the Interim Report, those recommendations were based on the evidence and information before the Inquiry at that time. The Interim Report was delivered to the Governor to assist in developing and implementing a future quarantine program for the proposed re-opening of international points of entry into Victoria.

The Final Report incorporates and adopts the 69 recommendations presented in the Interim Report, as set out in the previous section. The Final Report recommendations flow on from the Interim Report and, as such, are numbered from Recommendation 70 onwards.

Evidence and information contained in this Report

To inform its work, the Inquiry received evidence from 96 witnesses (with 63 of these witnesses appearing at hearings to give evidence) and sat for 27 hearing days, during which 263 exhibits were tendered into evidence. There were 30 parties with Leave to Appear, from whom 414 pages of closing written submissions were received.

While all of this material has been considered, only those parts of the evidence or submissions necessary to explain reasoning or findings or recommendations are referred to in the body of the Report. The fact that a piece of evidence or a submission is not referred to in this Report does not mean that regard was not had to it.

Intake and Assessment Team received a considerable range of information

From 15 July 2020, the public was able to make contact with the Inquiry via telephone and email channels as per details provided on the website (see Chapter 14: How we went about our work).

The Inquiry had an Intake and Assessment Team whose role it was to receive and respond to those who contacted the Inquiry. In this way, the Inquiry received information from a range of people involved in the Hotel Quarantine Program, including returned travellers, nurses and security guards.

Information provided to the Inquiry from some of these sources has been included in the Report in the form of narratives and quotes. Some of the narratives contain the full story of a person's experience in the Hotel Quarantine Program as reported to the Intake and Assessment Team; some of the quotes in the Report are a snippet of an experience.

The information provided to the Inquiry and included in the narratives and quotes is important and valuable. However, it is noted that, generally, this information was not provided to the parties with Leave to Appear to respond to or test. As such, these narratives and quotes are not referenced as 'evidence' but are, instead, referenced as 'information provided to the Inquiry'.

Terms of Reference

You are required to inquire into, report and make any recommendations considered appropriate in relation to the following terms of reference:

1. The decisions and actions of Victorian government agencies, hotel operators and Private Service Providers, including their staff/contractors and any other relevant personnel involved in the Quarantine Program (each Relevant Personnel), relating to COVID-19 Quarantine Containment;
2. Communications between Victorian government agencies, hotel operators and Private Service Providers relating to COVID-19 Quarantine Containment;
3. The contractual arrangements in place across Victorian government agencies, hotel operators and Private Service Providers to the extent they relate to COVID-19 Quarantine Containment;
4. The information, guidance, training and equipment provided to Relevant Personnel for COVID-19 Quarantine Containment and whether such guidance or training was followed, and such equipment was properly used;
5. The policies, protocols and procedures applied by Relevant Personnel for COVID-19 Quarantine Containment; and
6. Any other matters necessary to satisfactorily resolve the matters set out in paragraphs 1 to 5.