COVID-19
Hotel Quarantine Inquiry

COVID-19 Hotel Quarantine Inquiry Final Report and Recommendations

VOLUME II

DECEMBER 2020

COVID-19 HOTEL QUARANTINE INQUIRY

Final Report and Recommendations

Volume II

The Hon. Jennifer Coate AO
Board of Inquiry

ORDERED TO BE PUBLISHED

Victorian Government Printer
December 2020

PP No 191, Session 2018–2020
(document 2 of 2)

COVID-19 HOTEL QUARANTINE INQUIRY
FINAL REPORT AND RECOMMENDATIONS VOLUME II

Published December 2020

ISBN 978-0-6450016-2-4
Suggested citation: COVID-19 Hotel Quarantine Inquiry, Final Report and Recommendations, Volume II
Parl paper no. 191 (2018–2020)

Contents

CHAPTER 9

Outbreaks at Rydges and Stamford hotels

1. Following the commencement of mandatory quarantine at 11.59pm on 28 March 2020, the Hotel Quarantine Program ran 24 hours a day, seven days a week, up until the time that Victoria ceased accepting international arrivals on 30 June 2020.[1] Over that period, in excess of 20,000 returned travellers[2] were accommodated across approximately 20 contracted hotels.[3] From 17 June 2020, Alfred Health was engaged to provide quarantine services in the newly established facility at the Brady Hotel under the 'Health Hotel' model.[4] Alfred Health later expanded its service delivery to a number of other quarantine sites.[5]
2. Prior to the involvement of Alfred Health, there were outbreaks of COVID-19 from two of the 20 hotels; the Rydges Hotel in Carlton (Rydges) and the Stamford Plaza Hotel in Melbourne's CBD (Stamford).
3. Before turning to the details of those outbreaks, I make the observation, again, that best practice in running a healthcare facility, be it a hospital or a quarantine facility, does not guarantee that no infection transmission will occur. But what best practice does provide is that the risk of such transmission is minimised to the greatest extent possible.

What were the outbreaks?

4. The outbreaks of the COVID-19 virus from Rydges and Stamford were described in Chapter 2. But before any analysis of the outbreaks as to why and how they happened, their consequences and lessons of those outbreaks, I shall briefly set out the facts of the outbreaks here.

Rydges outbreak

5. The genesis of the Rydges outbreak was as follows:
    A. On 9 May 2020, a family of four returned from overseas and commenced mandatory quarantine at the Crown Promenade hotel, staying together in the same room.[6] On that same day, one family member became symptomatic and subsequently tested positive to COVID-19 on 14 May 2020. The other three family members became symptomatic between 10 and 12 May 2020, and tested positive for COVID-19 on 14, 17 and 18 May respectively.[7]
    B. On 15 May 2020, following the two initial COVID-19 diagnoses, the entire family was relocated to Rydges.[8]
    C. On 25 May 2020, three people who worked at Rydges began to experience COVID-19 symptoms.[9] This included one member of hotel staff and two security guards.[10] They were each, subsequently, diagnosed with COVID-19.[11] As at 18 June 2020, 17 confirmed cases were linked to Rydges.[12] This included eight individuals who had worked at Rydges[13] (including one hotel worker, a nurse and six security guards),[14] as well as household and social contacts of those staff.[15]

Stamford outbreak

6. And for the Stamford outbreak, it happened thus:

   A. On 1 June 2020, a traveller returned from overseas and commenced a 14-day period of mandatory quarantine at Stamford. On the same day, that person became symptomatic. The traveller was tested for COVID-19 on 3 June 2020 and was subsequently diagnosed with COVID-19 on 4 June 2020.[16]

   B. A security guard, who had been working at Stamford, became symptomatic on 10 June 2020 and tested positive for COVID-19 on 14 June 2020.[17]

   C. On 11 June 2020, a couple returned from overseas and commenced mandatory hotel quarantine at Stamford. On the same day, one of them became symptomatic. On 12 June 2020, the other became symptomatic. Both underwent testing on 14 June 2020 and both were diagnosed with COVID-19, on 15 and 16 June 2020 respectively.[18]

   D. By 13 July 2020, a total of 46 cases of COVID-19 had been epidemiologically linked to the Stamford outbreak.[19] This included 26 security guards and one healthcare worker,[20] as well as social and household contacts of staff members.[21]

7. These outbreaks led to disastrous consequences for the Victorian community. The transmission of COVID-19 from returned travellers to those working within the program and its subsequent proliferation into the community were underwritten by a considerable range of contributing factors.

8. Identifying factors that led to each outbreak, as well as understanding the epidemiological and genomic evidence of the consequences of those outbreaks is the work of this chapter. However, what is contained here is not to be read in isolation from other contributing factors identified in other chapters of this report.

9.1 The designation of a 'hot hotel'

9. Within the Hotel Quarantine Program, certain premises were used exclusively to accommodate returned travellers who had tested positive to COVID-19.[22] Those designated hotels were referred to as 'red hotels' or 'hot hotels'. According to Dr Finn Romanes, Deputy Public Health Commander with the Department of Health and Human Services (DHHS) public health team, the idea of a hot hotel 'is a manifestation of the concept of "cohorting", which is the practice of isolating individuals with an infectious disease together, and separate from others who do not have that disease'.[23]

10. In the initial phase of the Program, there was no designated hot hotel. Instead, hotels accommodating returned travellers as part of the Program had 'red floors' set aside for confirmed COVID-19 cases.[24] In the event that a returned traveller tested positive for COVID-19 during the course of their mandatory quarantine period, they could be relocated to a red floor.[25]

11. During April 2020, returned travellers who had been diagnosed with COVID-19 (and their close contacts) were moved to a single site, Rydges. It appears that it was determined that this site was to be used as a 'hot hotel' because it had been the hotel that received a large number of known COVID-positive returned travellers who had previously been on a cruise ship off the coast of South America.

Support for the idea of establishing a hot hotel

12. On 30 March 2020, Dr Romanes raised a policy proposal of moving positive COVID-19 cases to a 'dedicated hotel for people found to be positive'.[26] On 31 March 2020, he advised Merrin Bamert, Director of Emergency Management at DHHS and later the Commander of Operation Soteria, and others, of Public Health Command's recommendation to cohort positive COVID-19 cases. He noted Prof. Sutton's advice that this should 'ideally be in one hotel only, or if necessary, on one floor of one hotel'.[27]

13. Dr Annaliese van Diemen, Deputy Chief Health Officer (DCHO) confirmed, in her evidence before the Inquiry that she had recommended cohorting positive guests and indicated that the approach had been endorsed by the CHO.[28]

14. Jason Helps, State Controller — Health, stated in his affidavit of 4 November 2020 that the CHO's advice about the use of a single COVID-positive hotel as contained in Dr Romanes's email of 31 March 2020, 'initiated planning for hot hotels'.[29]

15. Notwithstanding the evidence of Dr Romanes, Dr van Diemen and Mr Helps, Prof. Sutton stated that, while he agreed that cohorting guests was a generally sound public health measure, he 'was not consulted about moving positive cases into one hotel floor or to a specific hotel'.[30] In this regard, his evidence is at odds with the content of the contemporaneous email of Dr Romanes (31 March 2020).

Rationale for hot hotels

PUBLIC HEALTH RATIONALE

16. According to Dr van Diemen, cohorting of positive cases, preferably in a single location (in this case, a hotel), is a recognised public health preventative measure.[31] The benefits of doing so include that it:

    A. creates less risk across the system, in this case the Hotel Quarantine Program, because the measure separates unwell or infectious people from those who are susceptible and, therefore, decreases the number of susceptible people to whom the infection can spread

    B. decreases the number of staff who are potentially exposed to infectious people

    C. allows for a higher concentration of medical and support staff to be allocated to the cohort in light of their higher risk of deterioration and potential need for medical attention.[32]

17. On 7 April 2020, Dr Romanes, in an email to Braedan Hogan, Agency Commander of DHHS, endorsed the idea of using the Novotel South Wharf (Novotel) hotel to cohort COVID-positive guests. He noted, in particular, that the approach:

> … has many advantages from a public health risk management perspective and is — as long as logistics can be handled — the favoured public health model. This approach reduces the low (but material) risk that, as a result of detaining well individuals in a hotel, we then create a risk that they acquire COVID-19 from the environment of the hotel …[33]

18. Dr Simon Crouch, Senior Medical Advisor, Communicable Diseases Section at DHHS, gave evidence that, in his opinion, it was 'not unreasonable' to have a hot hotel in order to minimise the risk of further transmission to others in quarantine.[34] While any returned traveller should be managed as a suspected positive case, he explained that cohorting offered the best option for oversight and public health management.[35]

19. In his statement to the Inquiry Prof. Sutton agreed that, from a public health perspective, 'combining positive cases into one location is generally a sound approach from an IPC [infection prevention and control] perspective as it minimises the risk of transmission created by positive cases being accommodated with people who have not been exposed'.[36]

20. Professor Lindsay Grayson, Professor of Infectious Diseases at Austin Health, also gave evidence to the Inquiry about the approach to cohorting taken in hospitals. He gave evidence that, ideally, and even within a ward of known positive cases, all cases would be kept separate due to the potential risk of exposing a patient to a different strain of the same virus, however, in some instances, this is not possible. In these cases, the hospital will attempt to cohort, 'that is, we cluster known infected cases together, where as best as we can tell they have an identical infection and so they are not going to pose a risk to each other'.[37]

OPERATIONAL RATIONALE

21. Prof. Sutton also gave evidence that the establishment of a hot hotel had operational benefits.[38] He noted this:[39]

> Creating a COVID-19-positive hotel, or a 'hot hotel' was intended to mitigate the current circumstances where COVID-19-positive people occupy a floor of each hotel, so that other rooms cannot be used for persons not COVID-19-positive.

22. Mr Hogan observed, in email communication to Dr Romanes on 7 April 2020, that the current model of using 'red floors [was] taking out hotel capacity from the overall system' and that they were proposing the Novotel as a hot hotel at that time in order to 'release capacity in the system, stand up a suitable model of care in one location to support these positive cases and negate issues with exiting'.[40]

23. Kym Peake, former Secretary to DHHS, gave evidence that it made sense, rather than having hot floors dispersed across multiple hotels, 'to have a hotel where there was clear knowledge … about the positivity [sic] of the clientele'.[41]

Designation of Rydges as a hot hotel: whose decision was it?

24. On 27 March 2020, agreement was reached for 95 rooms at Rydges to be allocated for use in the Hotel Quarantine Program.[42] On or around 30 March 2020, that agreement was formalised in writing and executed.[43] On 1 April 2020, the Department of Jobs, Precincts and Regions (DJPR) received information from staff at Rydges about its service offering, in particular its food offering, staffing levels and security practices.[44] This communication did not include any information about the suitability of Rydges to accommodate a concentration of COVID-19-positive guests.

25. On 31 March 2020, Andrea Spiteri, State Controller — Health at DHHS, contacted Claire Febey, Executive Director for Priority Projects at DJPR, in search of a hotel that could accommodate a homeless person who had tested positive for COVID-19. She was advised, on the same date, that the request was beyond the scope of the current contracts and that the hotels had refused to accommodate the homeless man.[45] Ms Spiteri told the Inquiry:

> On 1 April 2020, [DHHS] worked further with DJPR who subsequently advised that the Rydges Carlton would be stood up as a COVID positive hotel from 2 April 2020. I do not know who decided Rydges Carlton would be the best option to be designated the COVID-19-positive hotel.[46]

26. On 2 April 2020, Ms Febey confirmed, by email to Mr Hogan and Ms Spiteri, that Rydges had been 'activated' to take confirmed COVID-19 cases from that evening, including a person who needed immediate accommodation.[47] She noted that 'this hotel is set up to receive confirmed cases from the general community that are expected to comply with their isolation'.[48]

27. On 4 April 2020, in an email to the State Control Centre (SCC), Mr Hogan, Mr Helps and Ms Spiteri, Ms Febey wrote:

> We had some great conversations with Andrea [Spiteri] and Braeden [Hogan] this week and activated Rydges as a property that will take confirmed COVID-19 cases from the community (e.g. family violence context, no other appropriate place to self-isolate).[49]

28. By 7 April 2020, DHHS had become aware of the repatriation flight from Uruguay that may be arriving in Australia carrying cruise ship passengers.[50]

29. On 8 April 2020, Ms Febey (by email to Mr Hogan, the SCC, Ms Spiteri and others) stated that agreement had been reached that Rydges would, that day, take its first confirmed COVID-19 case and 'it will be kept for the purpose of accommodating confirmed cases from both Operation Soteria and the community'.[51]

30. On 8 April 2020, Mr Hogan sent an email to Denise Ferrier, Executive Lead, DHHS, and staff, including those officers at the State Emergency Management Centre (SEMC), stating:

> [W]e have agreed with Public Health Command to stand up a hotel to contain COVID positive cases to streamline the care needed — instead of spreading it out across 14 hotels.[52]

This email, which was only produced to the Inquiry in early November 2020, suggests that the public health team was, in fact, involved in the decision to stand up a hot hotel.

31. By 9 April 2020, it was identified that the cohort of travellers from Uruguay was from the Greg Mortimer cruise ship, that a significant proportion of the group had contracted COVID-19 or were close contacts of people who had tested positive for COVID-19[53] and that they were predominantly older Australians.[54]

32. On the same day, there was correspondence between senior DHHS officials as to how to accommodate these returning travellers. Ms Peake indicated, by email, that the Premier had expressed a preference that they use a hotel near the airport to accommodate the returning travellers, rather than a hotel in the CBD.[55]

33. Melissa Skilbeck, Deputy Secretary Regulation, Health Protection and Emergency Management at DHHS, responded:

> We have one contracted hotel who is ready willing and able to accept COVID-positive guests — Rydges Swanston Street. At this late stage of planning, it would be risky to seek to convince another hotel to contract to take such guests.[56]

34. Ms Peake gave evidence that, following these emails, she had conversations with both Ms Skilbeck and Simon Phemister, Secretary of DJPR, about the risks of establishing and staffing a new hot hotel at short notice. Her evidence was that Mr Phemister agreed to advise the Premier's Private Office that it would not be prudent to try and contract a different hotel at that late stage.[57]

35. Pam Williams, Commander Operation Soteria, DHHS, also explained that there was a general reluctance among a number of participating hotels to accommodate a concentration of COVID-positive returned travellers. She stated that only two hotels indicated a willingness to accommodate such a cohort. Rydges was one of those hotels.[58]

36. According to Dr van Diemen, the decision to use Rydges as a 'hot hotel' was made by the Emergency Operations Centre.[59] The Emergency Operations Centre was, of course, a facility set up by DHHS to manage Operation Soteria.[60] She told the Inquiry that she was first informed that Rydges had been selected as the designated hotel by Ms Skilbeck in the email of 9 April 2020.[61]

37. On 10 April 2020, Mr Hogan noted, during the Operation Soteria meeting at the SCC, that 'Rydges will be a COVID-19 positive [sic] with the Uruguay flight.'[62] In the same meeting, Ms Febey observed:

> In terms of the Rydges Hotel taking the Uruguay passengers, which consists of some COVID-19 confirmed cases. DHHS will lead this service, DJPR will not have the usual on-ground presence but will provide advice on what it can help with.

38. Ms Peake gave evidence that DJPR provided advice to DHHS about Rydges being available to be used as a hotel for COVID-positive returned travellers.[63] However, she also acknowledged that the successful quarantine of the Greg Mortimer cohort impacted the decision to thereafter use Rydges as a hot hotel.[64]

39. However, documents provided to the Inquiry following the conclusion of public hearings demonstrate that, on 27 April 2020, Ms Williams sought assistance with coordinating the movement of COVID-positive passengers to Rydges and that it was at that time she had formed a plan to move all guests to Rydges to 'provide a better more coordinated service to them'.[65]

40. The evidence demonstrated that Rydges was, initially, identified as a site that could be used to house members of the community who needed support to self-isolate. However, with the influx of COVID-positive cases and their close contacts from the Greg Mortimer, Rydges became a convenient option for that group as well.

41. This was not necessarily because it was considered a particularly suitable site for the purpose, but due to a number of factors that developed gradually. It seems that it was of critical importance that Rydges had indicated a willingness to take on those guests. It was available in early April to accommodate the group of returned travellers from the Greg Mortimer cruise ship, many of whom were known to have tested positive for COVID-19. This group was accommodated at Rydges.

Implications of uncertainty about the decision-making chain: Rydges chosen as a 'hot hotel'

42. As outlined above, there were several documents that indicated the decision to use Rydges for COVID-positive returned travellers, as well as other members of the community, was a decision made between 8 and 10 April 2020.[66] However, Ms Williams gave evidence that the DCHO only 'agreed' to house all COVID-positive guests in a single hotel (to improve operational efficiencies and focus support for those guests) much later, on 22 April 2020.[67]

43. Ms Williams's email of 27 April 2020 supported this, demonstrating that it was only at that time that a plan was being formulated to move all current COVID-positive guests housed in other hotels to Rydges.[68] That plan was being conveyed to Dr Crouch of the public health team but it does not appear from the correspondence that his input was being specifically sought.[69] Rather, Ms Williams was seeking information from him to support the logistics of the exercise.

44. There were no documents before the Inquiry that clearly documented the decision, the reasons for it or the identity of who made the decision to use Rydges to cohort returned travellers who had tested positive for COVID-19 (as opposed to people from within the community).[70] The uncertainty about the decision and the basis on which it was made suggested a lack of clarity about responsibility for decision-making in respect of hotels: what hotels were to be used, and for what purposes, or by which designation?

45. Given the public health consequences of concentrating, in a single location, people who were known to have tested positive for COVID-19, the decision to select Rydges for that purpose was a critical one. It required careful thought, and a weighing up of the criteria for making such a decision that should have included, as a minimum, an expert opinion as to the infection prevention and control aspects of the facility.[71] The responsibility for that decision and reasons for taking it ought to have been clear and capable of being produced to the Inquiry.

Consultation regarding infection prevention and control at Rydges

46. Dr van Diemen gave evidence about the measures taken, generally, to ensure that hotels and staff had adequate infection control measures in place across the Hotel Quarantine Program. Chapter 7 provides more detail as to the policy documents developed by DHHS. Dr van Diemen identified that DHHS had provided infection prevention and control advice that was in line with the nationally agreed standards set by the Australian Health Protection Principal Committee (AHPPC).[72] She also gave evidence that, in late March 2020, she formed the view that the Hotel Quarantine Program policy on personal protective equipment (PPE) and infection prevention and control (IPC) needed to be more coordinated and systemised. And so she established a new Infection Prevention and Control Cell (IPC Cell) led by a public health physician and comprising infection control consultants.[73] This represented an expansion from the single infection prevention consultant available earlier in 2020, at the start of the pandemic.[74] The structure of the IPC Cell is introduced in Chapter 7 and discussed in greater detail in Chapter 8.

DEVELOPING A MODEL OF CARE FOR RYDGES

47. On 1 April 2020, during an Operation Soteria meeting at the SCC, DJPR requested guidance from DHHS about cleaning practices for quarantine hotels.[75] That same day, Mr Hogan sent an email to Ms Febey indicating that he would collate the questions DJPR had about cleaning standards in the hotels, including whether there were different standards required for cleaning when a guest was known to have tested positive for COVID-19, and 'seek advice from Public Health if needed'.[76] Mr Hogan subsequently escalated questions and sought guidelines from Public Health Command (PHC), via Dr Crouch, on cleaning requirements for quarantine accommodation.[77]

48. On 2 April 2020, and in response, Dr Clare Looker, Deputy Public Health Commander, DHHS, provided the SEMC with a link to the Commonwealth's publicly available guidance on COVID-19 for hotels and hotel staff.[78] In her witness statement, Dr Looker noted that she had copied the DHHS infection prevention and control consultant in this email, on the basis they may have been able to provide additional resources to guide the hotels.[79] There was no evidence that the deployment of additional resources was, in fact, prompted by this email.

49. On 7 April 2020, in the context of seeking endorsement for the idea of a 'hot hotel', Mr Hogan sought input from Dr Romanes, asking: 'are there any key considerations about the model of care we need to stand up? Or preferences — do we link in with a single hospital to support etc?'[80] Dr Romanes did not respond to that question.[81]

50. However, Ms Bamert responded, saying, 'we have done this work already' and went on to discuss arrangements that were in place to transfer unwell people from hotels to hospitals.[82] In her oral evidence, Ms Bamert elaborated on her response to the email. She indicated that, by her response, she had wanted to convey to Mr Hogan that there was a process in place to escalate the movement of people from the hotel to hospital if required.[83] It was apparent from her evidence that she had not intended to convey to Mr Hogan that a model of care for a hot hotel had been identified, or that the work as to 'key considerations' had been done already.

51. On 8 April 2020, via the COVID-19 Project Management Office and its executive lead, Denise Ferrier, Mr Hogan, again, made enquiries about establishing a model of care for guests in the hot hotel. He initially stated, 'I am keen to develop and implement a model of care for these patients that will adequately support them and also link into a hospital for escalations if required'.[84] In a later email he elaborated on the matters he thought the model need to cover, stating:

> From my perspective we need to ensure adequate level of care for the COVID positive patients
>
> • Resolve who the primary physician over seeing there [sic] care is
>
> • Requirements for support in the hotel and systems to support this
>
> • Escalation points and support from which hospital
>
> • Supplies and consumables preferable from a hospital so cuts us out of the supply chain [85]

52. There were no documents before the Inquiry that showed what response, if any, Mr Hogan received to this request. I, therefore, infer there was no documented response. While Mr Hogan's affidavit notes that he sought to have a model of care developed as identified in the emails, it is silent as to whether that actually occurred.[86]

53. On the same day, 8 April 2020, Ms Febey sought information about the specific practices to be put in place at Rydges. Ms Febey asked whether there would be 'any additional requirements for the service model (e.g. additional security, people housed on different floors)' and sought confirmation about cleaning requirements as follows:[87]

> • Cleaning requirements for rooms once vacated, specifically those that have had confirmed COVID-19 cases.
>
> • Whether the disposal of rubbish should be treated any differently in hotels that are housing quarantined or isolated guests. We have been advised through hotels that in NSW this is treated as medical grade waste.
>
> • Any other steps that are required from a DHHS perspective before rooms are returned to general stock.

54. Mr Hogan replied to this email and noted 'DHHS is developing a more robust model of care for this hotel and linked in with a Hospital'[88] and provided two documents with information, but that was limited to information about cleaning requirements only. Mr Hogan referred Ms Febey to page 25 of the *Guidelines for health services and general practitioners* (v 17 5 April 2020), which provided information on 'environmental cleaning and disinfection in an outpatient or community setting (for example a general practice.)'[89] He also included DHHS guidelines on *Cleaning and disinfecting to reduce COVID-19 transmission — Tips for non-health care settings* (20 March 2020). Mr Hogan indicated this information would 'work for every space **aside from those with COVID positive people in the rooms** (emphasis added)'.[90]

55. Mr Hogan's email to Ms Febey was copied to Ms Spiteri, Deputy State Controller Chris Eagle, Ms Williams and Director Health and Human Services Regulation and Reform, Meena Naidu. However, it was not copied to any members of PHC or the IPC Cell.

56. It was unfortunate that Mr Hogan's prompting on the model of care did not draw substantive responses from those to whom it was directed. For those responsible for the standing-up and operating of the hot hotel, this was an opportunity lost. Had minds turned — collectively or individually — to the types of considerations commensurate with concentrating known cases in the one location, the model may have had the necessary improvements to it prior to the outbreaks. What was subsequently observed, in the wake of the Rydges outbreak, demonstrated obvious shortcomings, especially around infection prevention and control measures and practices at that location.

57. This decision to implement a cohorting model at a dedicated hot hotel provided a distinct opportunity to reflect on the systems that were then in play across the Program, with a focus specifically on the known risk posed by confirmed positive cases (as opposed to merely presumed positive cases, as should be the case in any quarantine program). Mr Hogan seemed, at least in part, alive to that issue. Notwithstanding his raising it expressly, it appears to have passed others by.

58. The evidence leads me to the conclusion that there was no meaningful response by anyone within Operation Soteria or the public health team to the issues raised by Mr Hogan or Ms Febey, specifically key considerations about the model of care needed in the context of cohorting COVID-positive travellers in the one place. Indeed, it would appear that, beyond the question being posed by Mr Hogan, and raised again in correspondence with the COVID-19 Project Management Office and Ms Febey later in April, that no further consideration was given to that question until, at the earliest, the advent of the health hotel model with the involvement of Alfred Health in mid-June.

59. There was no evidence available to the Inquiry that a 'model of care' specific to Rydges was ever established or implemented despite this having been the intention of both DHHS and DJPR staff at early points in the process of identifying and standing up a hot hotel.

INFECTION PREVENTION AND CONTROL ADVICE

60. Ms Peake gave evidence that, around the time that it had been determined that Rydges would be a hot hotel, an IPC expert was engaged to provide advice and that the IPC Cell gave assurances that what had been recommended was appropriate.[91] She went on to explain that DHHS commissioned advice from Infection Prevention Australia (IPA) that, in her view, involved:[92]

> … a risk assessment about operationalising health and wellbeing services and entering and exit and the IPC measures that were important for that hotel and that was the advice that we relied on.

61. DHHS's Infection Prevention Consultant provided evidence that, on 10 April 2020, she was copied into an email from the Deputy Manager, Emergency Operations at DHHS, explaining that Rydges had been designated as the COVID-positive site. It was requested that an Infection Prevention Consultant from DHHS attend Rydges on Sunday 12 April 2020 to provide a briefing to nurses and General Practitioners working on-site.[93]

62. DHHS's own Infection Prevention Consultant gave evidence that she did not have capacity, at that time, to meet the request and instead provided the contact details of a private IPC consultant from IPA.[94]

63. The IPC consultant from IPA subsequently conducted a site visit to Rydges on 11 April 2020.[95] The visit resulted in a number of recommendations being made.[96] Those recommendations were circulated to the IPC Cell, the SEMC, Dr Romanes and Coralie Hadingham, Acting Manager Emergency Operations at DHHS. They included recommendations that: [97]

A. passengers disembark in groups of two and undertake the check-in and medical history process over the phone once in their rooms to reduce risk of exposure for healthcare workers and staff

B. there be a donning and doffing station on each floor

C. all staff, on entering the building, be required to change into their provided uniforms

D. there be no movement of clients out of their room for the 14 days as this created a high-risk of exposure to healthcare workers and other staff.

64. Email correspondence between operational staff, including Mr Helps, on 12 April 2020, confirmed that the IPA consultant had been engaged to 'support the onboarding of Rydges hotel' and had informed operational staff that 'all nurses are feeling confident and comfortable with the current arrangements (from an infection control perspective). Nurses are clear on the process of physical distancing, donning and doffing of PPE, and process for undertaking health assessments'.[98]

65. On 5 May 2020, IPA provided a further document titled *Summary of findings — Review of Hotel accommodation for OS travellers in quarantine*. This included a review of PPE practices across the quarantine hotels and a discussion of a subsequent visit to Rydges to 'ensure staff are well prepared for the quarantine of any future confirmed cases of COVID-19'.[99] It is not clear when the subsequent site visit was undertaken. The document noted concern among staff about the allocation of healthcare workers at the site and included concerns that staff were not rostered to work at the same hotel during a 14-day period and that some staff were junior and had not worked in the Hotel Quarantine Program previously or were inexperienced in donning and doffing.[100]

66. IPA made two further recommendations, which focused on ensuring nursing staff be allocated to the same hotel for a minimum of 14 days to cover the entire quarantine period and that only staff who demonstrated competence in donning and doffing be rostered. IPA's review concluded:[101]

> ... there are no other recommendations that I could make to improve the position of the hotel in accepting confirmed cases. **It does however rely on all staff working in the service to comply with policy and procedure** (emphasis added).

67. Ms Bamert gave evidence that, on receipt of IPA's report, DHHS met with security services provider, Unified, and provided it with a copy of the document *PPE advice for hotel security personnel for COVID-19 quarantine clients*.[102] DHHS also contacted Your Nursing Agency and requested that it 'attempt to reduce the movement of staff across hotels' but this was to be 'balanced with ensuring we were able to staff the hotels'.[103]

68. Given the decision to cohort positive cases at Rydges, IPC expertise should have been embedded at the hotel to oversee the necessary measures and monitor what was happening. That was not done. I note, in particular, evidence from the following witnesses in this regard:

A. Dr Stuart Garrow, Clinical Lead Medical Practitioner for Onsite Doctors, who provided clinical services at various hotels, including Rydges, gave evidence that 'a clear line of command for infection control was not available' and that relevant policies, standards and arrangements were adapted from hospitals and general practice where doctors and nurses had worked outside the hotels.[104]

B. Dr van Diemen, who gave evidence that, while she had responsibility for the availability of IPC advice and guidance, she did not have accountability for or any direct understanding of its implementation.[105]

C. Dr Romanes, who gave evidence that, despite his role in developing policies and procedures for the Hotel Quarantine Program, he was not involved in overseeing IPC and, therefore, was unaware of whether specific control measures were in place, generally, or at Rydges.[106]

D. The Infection Control Consultant, DHHS, who gave evidence that while she was involved in the preparation of IPC practices and procedures they held no formal role in the Hotel Quarantine Program and were not involved in the implementation of infection control policies on the ground.[107]

Training was not sufficient

69. Ms Peake gave evidence that, on 11 April 2020, the Department decided that all hotel staff at Rydges, including security, would do a 'short tutorial on infection prevention, organised by DHHS'.[108] Ms Bamert's evidence was that a PPE briefing had been arranged 'for GPs and nurses working at the Rydges Hotel'.[109] However, the email of 12 April 2020, referred to above at paragraph 61, indicated that any briefing carried out by the IPA consultant was only provided to nursing staff. Further, the evidence was that the nurses were supplied via agencies and, consequently, were not necessarily being present for episodic training.

70. It was, therefore, unclear whether Ms Peake and Ms Bamert were speaking of the same training in these parts of their evidence. If so, it would seem to be incongruent that Ms Bamert would describe the training being delivered to GPs and nurses only, while Ms Peake thought that it was delivered to 'all staff' including security and hotel staff. In any event, for the reasons that follow, it is not necessary to resolve this discrepancy. It was clear from the findings of the outbreak squad's investigations that the training was not sufficient in the initial phase[110] of the Program, or thereafter, at Rydges or Stamford. Given there were no general safety audits being conducted across the quarantine sites, it is not possible to know how widespread the issues were.

71. Email correspondence from 10 April 2020 suggested that the PPE briefing for GPs and nurses was arranged at their, and not DHHS's, request.[111] Another email about the arrangements for that PPE briefing on around 11 April 2020 said 'Training was raised in our conversation but I have left that with the [DHHS Team Leader] and the [IPA Consultant] to work through'.[112]

72. Rosswyn Menezes, General Manager at Rydges, gave evidence that, on 11 and 12 April 2020, DHHS IPC staff visited the site and showed him, as well as a limited number of his staff, how to don and doff PPE and told them to pass this information on to other staff.[113] He gave evidence that, in the following weeks, there were ad hoc occasions when on-site nurses would provide refreshers on how to don and doff PPE but that, to his knowledge, the only training the hotel staff received from DHHS was in relation to donning and doffing.[114]

73. It was Ms Spiteri's evidence that there were 'ongoing reminders' and there was 'ongoing training' for staff in the hotels. She said that the staff in the hotels were 'occasionally refreshed' but that the IPC consultant 'had spent quite a bit of time in the Rydges Hotel retraining new security staff in particular, that had come into that environment'.[115]

74. Ms Spiteri observed:

> So, while I was satisfied that the appropriate and most up-to-date infection prevention and control measures were in place, it was a constant education process. We have seen that in hospitals and in other settings as well, that you need to continually refresh that education and training to keep it at the forefront of people's minds, particularly when they are working in environments for a long period of time.[116]

75. IPA's review of Rydges, dated 5 May 2020, noted that '[o]n entry to the hotel, security staff were not wearing PPE as is the recommendation. This is a major improvement'.[117] It went on to say, 'the Health care teams compliance with PPE and HH [hand hygiene] has been excellent, and they are working to educate the security and AO [Authorised Officer] staff about appropriate PPE and HH'.[118]

76. Ms Peake described the review as being 'generally positive' while drawing attention to 'overuse of PPE and gaps in hand hygiene by security guards'.[119]

77. On 13 May 2020, the head contractor for security at Rydges stood down its entire security team.[120] It was Ms Peake's evidence that the impetus for this was complaints from healthcare workers and departmental staff at Rydges that security guards were overusing PPE and not observing social distancing requirements.[121] It was unclear whether the IPA consultant, or anyone else, was brought in at this time to provide training to the new cohort of security guards at Rydges. Ultimately, it was noted in the Outbreak Management Report for Rydges that the risk of transmission the site posed was due to 'inadequate education and cleaning procedures' in place.[122]

78. On 17 June 2020, three days after the first reported diagnosed case in a worker from Stamford,[123] Outbreak Squad nurses attended Stamford and prepared an interim report.[124] There were a number of matters raised, including that hotel personnel and security were not adequately educated in simple things such as hand hygiene and PPE use.[125] Dr Sarah McGuinness, Outbreaks Lead at DHHS, said that those matters, as identified in the outbreak squad report, would have increased, or, at least, would not have sufficiently guarded against, the risk of COVID-19 transmission at Stamford.[126]

79. There was also evidence that (notwithstanding the outbreak at Rydges on 25 May 2020)[127] it was only following the outbreak at Stamford on 14 June 2020[128], that face-to-face training was provided to 87 security guards. A summary report of the training session, conducted on 24 June 2020, noted:

> … for most this was their first face-to-face training in this area, some who had been working for several weeks had only just completed online training of which they indicated to me personally that they did not totally comprehend the learning.[129]

80. It was apparent that infection prevention control advice and PPE training provided to those staffing the Hotel Quarantine Program (including at the 'hot hotels') was insufficient to guard against the risk posed by those environments, particularly at the time of their establishment. It was also apparent that more appropriate training was only provided after the outbreaks had occurred at Rydges and Stamford.

81. The evidence before the Inquiry did not provide a clear picture of what training was provided to who and when at Rydges as there were no documents provided to make it clear, and conflicting evidence from witnesses. Even accepting that training was provided to security and hotel staff, as well as nurses and GPs, at about 11 April 2020, the benefit of any such training was quickly lost. As noted above, the evidence plainly established that, by 13 May 2020, the head contractor at Unified, responsible for staffing the security guards at Rydges, stood down the entire security team that had been working there.[130] If any security guards had received the 'short tutorial on infection prevention organised by DHHS'[131] or benefitted from follow-up visits by the IPC consultant, the benefits of such training were lost to Rydges almost immediately.

82. In any event, and as Ms Peake said when asked, based on what transpired in the Hotel Quarantine Program, it would be prudent to have an IPC expert at each premises used for quarantine in the future.[132]

83. Furthermore, as many staff and personnel working in the Hotel Quarantine Program were engaged on a rotating rostered basis until at least 28 May 2020, the provision of a single training session, provided on a single date, was inadequate to mitigate against the risks posed by not only a 'hot hotel' environment, but any quarantine hotel. I described the particular challenges that security guards, as a cohort, posed to implementing proper infection control measures within a quarantine environment in Chapter 6 of this Report. The casualised nature of security guards, the manner in which large numbers of security guards could be sourced and stood up quickly, meant that there could be a different set of guards at each hotel each day. Every guard rostered on from time to time, should have had the benefit of that training.

84. While the matters described above specifically relate to the training and advice provided at Rydges and Stamford, there was evidence of systemic issues in the delivery of training and guidance to security guards and others working on other hotel quarantine sites.

85. There was evidence that indicated that even nurses and GPs working in the hotels were not given adequate infection prevention advice and guidance. On 8 June 2020, Dr Garrow noted that there was 'some debate amongst the doctors and nurses around PPE practices'. He requested a copy of DHHS policy on PPE and infection control procedures for use in the hotels and asked that an IPC officer meet with the doctors to discuss those issues.[133] He was subsequently provided with a copy of the *PPE Advice for Health Care Workers Policy*. It was unclear whether a member of the IPC Cell or the IPA consultant ever attended a meeting with the doctors as was requested.

86. Further, the DHHS Infection Control Consultant gave evidence that it was not until 16 June 2020 that updated cleaning advice, specifically for hotels accommodating quarantined close contacts and confirmed COVID-19 guests, was prepared and issued.[134] It was, then, not until 20 June 2020 that the DHHS IPC Cell prepared version 0.1 of the *DHHS COVID-19 Infection Prevention and Control Training — Security Guards*.[135] This training program was described in email correspondence from the time as being an 'interim measure (pending Alfred coming on board) to address an immediate identified need.'[136]

87. This evidence combined to demonstrate that there was little specific attention paid to developing and implementing sound IPC practices at Rydges during the set-up phase, that there was insufficient contribution by PHC or infection control experts to the design of Rydges as a 'hot hotel' and that there was insufficient training provided by DHHS to relevant security and hotel staff and personnel working in these high-risk environments.

Additional safeguards required in a 'hot hotel' environment

88. Prof. Grayson explained that quarantine environments are self-evidently 'dangerous spaces'. He opined that 'the rigour and processes in place need to reflect and reinforce this'.[137]

89. The 'danger' is increased in a cohorted, 'hot hotel'.

90. Following the outbreaks, Prof. Sutton formed the view that a COVID-positive hotel 'clearly represented a risk of transmission from quarantined individuals to contracted staff'[138] and agreed that the risk was greater than that posed by a 'pure quarantine hotel'.[139]

91. There was a general consensus among (both medical and lay) witnesses that they understood the concentration of positive cases in one location posed a greater infection risk, in particular to staff, than was posed at other quarantine hotels.[140]

92. Prof. Grayson identified the quantum of risk by reference to a broadly analogous setting: a COVID ward of a hospital.[141]

93. Dr Crouch noted that the starting premise for people in hotel quarantine was that they should all be treated as being potentially positive,[142] and 'therefore the precautions being taken in those environments should be essentially the same'.[143] This comparison can only be sensibly understood to mean that infection controls across all quarantine facilities should be as required for a known COVID-positive environment.

94. Dr Crouch expected that hot hotels (and by logical extension, all quarantine sites) would have appropriate cleaning practices[144] and that staff would not work across multiple sites.[145] He stated that 'having a hot hotel wouldn't negate the fact that you need to be doing suitable environmental cleaning or whatever measures as appropriate for that potential for environmental transmission'.[146]

95. Dr Crouch said that had he been consulted, he would have agreed that the establishment of a hot hotel 'was a good idea'.[147] He concurred with this idea, in theory, assuming that:

    A. staff managing those in quarantine were trained appropriately to manage the confirmed cases

    B. those staff members have the knowledge and skills to do that effectively.[148]

96. When asked about the set-up of a hot hotel, Prof. Sutton outlined that, while not an IPC expert himself, he would have sought 'the input of the IPC team and the broader groups that they engage with around what step-up level of infection prevention and control might be required'.[149] He would have expected the implementation of the following appropriate measures:

    A. increased requirements for PPE because staff are dealing with a high number of known positive cases or suspected cases[150]

    B. the establishment of infrastructural and structural elements to minimise the risk of transmission, which include:

        I. creating a greater distance between those staff supporting the program and anyone who was a client of the program

        II. stratifying, separate to staff, the zones where those positive individuals were located

        III. addressing ventilation and air[151]

    C. the oversight of all of those elements, in terms of training, auditing, review and revision.[152]

97. Ms Williams's evidence was that safeguards at Rydges were 'designed to minimise any time that people spent in common areas'.[153] She explained that specialised or limited forms of access were intended to ensure that people had a rapid means of ingress and egress.[154] Nevertheless, as evidenced by the Outbreak Report, the common areas, including lifts that were required to transport COVID-positive guests in and out of the hotel, were not cleaned appropriately or by specialist cleaners.[155] This increased the risk of environmental transmission.

98. In relation to PPE, Prof. Grayson stated that all staff working with COVID patients should have been required to undertake training in infection control procedures and PPE usage.[156] He specified that the **minimum** PPE required in **any** hotel quarantine setting should be a Level 2 surgical mask, eye protection, long-sleeved single-use disposable gown and appropriate hand hygiene measures (using a TGA-approved hospital-grade alcohol-based hand rub or soap/water handwashing). He would expect those minimum standards to apply to staff undertaking duties such as patrolling hotel corridors to 'enforce' quarantine by non-contact measures. He added that, if there was a likelihood of patient contact, gloves should also be worn.[157]

99. In order to ensure that people were wearing their PPE effectively and otherwise complying with infection control protocols, Prof. Grayson explained that regular monitoring and enforcement, similar to a hospital setting, was imperative.[158] He provided a useful summary of the ways in which monitoring and enforcement was implemented at the Austin Hospital, including:

    A. regular reinforcement to staff about COVID-19 infection control measures through weekly CEO-led webinar presentations with the Infectious Diseases Department

    B. direct monitoring of adherence by the Nurse Unit Manager in each clinical area

    C. regular visits by infection control staff to observe behaviour

    D. widely displayed infection control signage throughout the hospital

    E. biannual re-credentialing in hand hygiene.[159]

100. He further outlined that educational signs alone have 'limited value in reinforcing behaviour, unless they are updated frequently, since they quickly become ignored. In addition, if the signs are only in English, they may not be fully understood by people where English is not their first language'.[160]

101. This evidence typifies the point that effectively managing transmission risks in these environments requires that communication to staff and guests be accessible and clear to all. Ms Williams acknowledged that DHHS 'were really struggling to get the message across' to security guards who 'wanted as many barriers as they could between them and what they perceived as this invisible threat'.[161] Ms Skilbeck gave evidence that the poor adherence to physical distancing policies and hand hygiene observed at Rydges and Stamford indicated that neither the policies in place nor the extensive community messaging on these issues was getting through to workers on the ground.[162] This prompted DHHS, on 17 June 2020, to engage the Behavioural Insights Unit at the Department of Premier and Cabinet for the purpose of 'better engaging the security companies and the security personnel around why it was that we were giving this advice and how it would protect them'.[163]

102. Additional safeguards implemented in the hot hotels, as discussed in Ms Bamert's oral evidence, included:

    A. a higher ratio of nurses to returned travellers, with those nurses having effective training and experience to deal with COVID-positive patients, including an understanding of the rapid nature in which a COVID patient can deteriorate[164]

    B. introducing staff with specific skills and qualifications, including an emergency nurse [165]

    C. linking the hot hotel with a range of metropolitan hospitals, depending on the demographics of the cohort, in order to support the escalation of care for people who may require hospitalisation.[166]

103. According to Ms Bamert, there was no consideration, at the time the decision was made to nominate a COVID-positive hotel, of linking that hotel in with a health service for expert guidance and direction, including around IPC.[167] As mentioned earlier in this chapter, that suggestion was raised by Mr Hogan on 7 April 2020, but it appeared that suggestion fell away.[168]

Subsequent 'hot hotel' arrangements

104. Although not immediately, the outbreak at Rydges resulted in the hotel being temporarily closed from around 1 June 2020. It was, therefore, necessary to establish an alternative COVID-positive site for returned travellers.[169] Novotel South Wharf was designated as the replacement hot hotel.[170]

105. Separately, and prompted by the outbreak, DHHS contracted Alfred Health for the management of a 'health hotel' at the Brady, which commenced operation as such from 17 June 2020.[171] Alfred Health's role within the Hotel Quarantine Program then expanded to encompass the running of all quarantine hotels. This resulted in the 'health hotel' model discussed in Chapter 11 of this report.

9.2 Epidemiological and genomic evidence

106. In order to appreciate the full impact and effect of the outbreaks at the Rydges and Stamford Plaza hotels, it was necessary to consider the epidemiological and genomic evidence. This evidence offered an insight into how the virus spread, initially within the hotel quarantine environment and then beyond into the community at large.

107. For a more comprehensive exploration of the epidemiological methods and the science of genomic sequencing as touched upon below, see Chapter 2.

Rydges outbreak

108. By 31 July 2020, DHHS had received the final genomic sequencing reports for 14 of the 17 cases epidemiologically linked to the outbreak at Rydges, although the preliminary results making the link were available in mid-June.[172] Those final reports revealed that all 14 of those cases clustered genomically together and uniquely[173] with the family of returned travellers.[174] At the time of the outbreak, there were only a few other Victorian cases of COVID-19 that had been acquired in Australia, none of which had any known links to the cases at Rydges.[175]

109. In light of the genomic and epidemiological evidence available to him, Dr Charles Alpren, an expert epidemiologist within DHHS, concluded that it was highly likely that all 17 cases epidemiologically linked to Rydges, including those for which no genomic sequence was available, belonged to the same transmission network and could be traced to the family of returned travellers that was transferred to Rydges on 15 May.[176] In short, those 17 cases could be 'sourced' back to the identified family of returned travellers.

Stamford outbreak

110. Unlike the Rydges outbreak, where all cases were linked to one family, the genomic sequencing performed by MDU PHL showed that the Stamford outbreak consisted of two distinct chains of transmission.[177] This was indicated by two genomic clusters among the cases linked to the outbreak. One of the clusters was connected with the returned traveller who arrived on 1 June 2020, while the other was linked to the couple who returned on 11 June 2020.[178]

111. By 4 August 2020, DHHS had received genomic sequencing reports for 35 of the 46 cases linked to the Stamford outbreak. All 35 of those cases clustered genomically within one of the two chains of transmission identified above.[179] At the time of the Stamford outbreak, there were no other Victorian cases of COVID-19 acquired in Australia other than those linked to the Rydges outbreak. By the time that Dr Alpren gave evidence before the Inquiry, on 18 August 2020, no epidemiological or genomic links between the cases in the Rydges outbreak and the cases in the Stamford outbreak had been identified.[180] The Inquiry is not aware of any links having been made subsequently.

112. In his evidence, Dr Alpren explained that he had concluded that it was **highly likely** (emphasis added) that all 46 cases epidemiologically linked to Stamford, including those for which no genomic sequence was then available, belonged to one of the two transmission networks and can, therefore, be traced to the three returned travellers identified above.[181]

Genomic clustering since Rydges and Stamford outbreaks

113. Since the time of the initial outbreak at Rydges, with only two exceptions, all subsequent reported genomic sequences for Victorian cases of COVID-19 have clustered with transmission networks emanating from the returned travellers observed as the sources for the Rydges and Stamford outbreaks.[182] The first exception involved a returned traveller whose symptoms started on 29 June 2020. The returned traveller clustered genomically with a resident of metropolitan Melbourne who began to experience symptoms on 28 June 2020.[183] The second exception involved a healthcare worker who clustered genomically with a returned traveller who the worker had cared for following their admission to hospital with COVID-19 for the period 19 June to 9 July 2020.[184] Further on-spreading of those clusters had not been reported or observed.[185]

114. As of 29 July 2020, DHHS had received reports of sequences pertaining to 827 currently active cases. Of those, 817 (99 per cent) sequenced with Rydges-associated genomic clusters[186] and 10 (1 per cent) sequenced with the Stamford-associated genomic clusters.[187] As of 31 July 2020, of the 2,109 sequenced cases since 26 May 2020 (the date of the first confirmed case from the Rydges outbreak), 1,996 clustered with Rydges-associated genomic profiles and 96 clustered with those from Stamford.[188]

115. At the time of Dr Alpren giving evidence to the Inquiry (18 August 2020), further sequencing had been performed so he was able to provide updated figures. In total, sequencing had been successfully performed for 4,981 cases. Of those cases, 3,594 cases clustered with Rydges-associated genomic clusters and 110 clustered genomically with Stamford-associated genomic clusters.[189]

116. From the 12,000 cases within the previous month (as at 18 August 2020), sequence data was available for 3,234 cases. Of those, 3,183 were genomically linked to the Rydges-associated cluster.[190] Of cases with symptom onset in the previous month (again, as of 18 August 2020), 1,589 cases had been sequenced. Of those, 1,577 cases (99.2 per cent) clustered genomically with Rydges and the other 12 cases (0.8 per cent) clustered genomically with Stamford.[191]

117. Given the level of genomic sequencing that had occurred by that time, Dr Alpren agreed that he would have expected to see some evidence if there were any other independent clusters occurring.[192] He had not seen any such evidence. Dr Alpren was therefore of the opinion, based on the genomic sequencing and epidemiological investigation, that there was '**high level of certainty that almost all current COVID-19 cases in Victoria can be traced to the outbreaks at the Rydges and Stamford Plaza hotels** (emphasis added)'.[193]

118. Dr Alpren noted that he could not precisely indicate the number or proportion of cases that had separately arisen from each outbreak. However, he stated that it was likely that the large majority (approximately 90 per cent or more) of COVID-19 infections in Victoria at that time could be traced to the Rydges outbreak, while a smaller proportion (approximately 10 per cent or less) of COVID-19 infections in Victoria at that time could be traced to the Stamford outbreak.[194]

119. I accept the validity of the genomic and epidemiological evidence, and the conclusions drawn from that evidence by Dr Alpren, and note that it was not the subject of any challenge or contradiction.

120. As of 15 June 2020, Victoria had recorded 1,732 confirmed cases of COVID-19.[195] As of 24 November 2020, that number had increased to 20,345.[196]

121. On 23 May 2020, Victoria's COVID-19 death toll was 19.[197] There were no deaths attributed to COVID infection between 23 May and 24 June 2020.[198] The latter date was just under a month after the first cases were identified in connection with the Rydges outbreak and about a week after the first cases were identified in connection with the Stamford outbreak.[199]

122. According to publicly available information, the overall death toll attributed to Victoria's second wave was 801 people at the time of writing. Further, the publicly available information estimated that about 80 per cent of those deaths related to Victoria's aged care homes.[200]

9.3 The genesis of each outbreak

123. The movement of COVID-19 from hotel quarantine into the community can be understood as having been transmitted from returned travellers being held in quarantine to people working on-site in hotel quarantine and then into the community via those infected workers.

124. While the epidemiological and genomic sequencing evidence provided the scientific basis for the link between the workers who became infected and the returned travellers who were the original sources of the virus, the state of the science, together with the available evidence, did not allow for specific transmission 'events' to be identified at either Rydges or Stamford as to the actual moment that transmission happened, either as between returned travellers and workers or from worker to worker.[201] For example, the state of the science was not able to give a sequence as to which worker became infected first and then may have transmitted to another worker or workers on-site.

125. Importantly, however, there was evidence of environmental and behavioural factors that were likely to have contributed to the outbreaks at both hotels.

Transmission events

RYDGES

126. The epidemiological and genomic evidence provided the basis for a conclusion that a transmission event (or multiple transmission events) occurred at Rydges during the Hotel Quarantine Program.[202] However, and notwithstanding investigation, as set out above, the state of the science and the expert evidence did not allow a finding as to a specific occurrence of the virus moving from infected traveller (either directly or indirectly) to worker in the Program.[203]

127. In her statement, Dr McGuinness said the following: 'Ultimately, the Deputy Public Health Commanders and I were unable to draw a firm conclusion about the transmission event(s) that precipitated the outbreak'.[204] Similarly, Dr Alpren's position was that no specific transmission event was able to be identified in respect of the Rydges outbreak.[205]

128. The investigations at Rydges revealed several opportunities for transmission to have occurred at different times.[206] By way of example, records of the outbreak response team investigation indicated that an episode of likely environmental contamination occurred in the family's room on 18 May 2020, which required assistance from nursing staff to rectify.[207] There was also a suggestion that the index family walked outside its room and through common areas of the hotel, on which occasion they were accompanied by security guards.[208] It is possible a transmission event or events occurred at this point.[209]

STAMFORD

129. From the epidemiological and genomic data presented above, Dr Alpren concluded that at least two transmission events occurred at Stamford during the Hotel Quarantine Program.[210] However, as with Rydges, the expert evidence and the available information was unable to pinpoint the specific transmission events.[211]

Mode of transmission?

RYDGES

130. While the mode of transmission could not be categorically determined, there was evidence before the Inquiry, as detailed below, which makes environmental transmission a more likely explanation for the Rydges outbreak than person-to-person transmission.

131. It is acknowledged that it could not be definitively ruled out that the virus was spread from person-to-person. In his evidence, Dr Crouch was unable to say which was the most likely form of transmission from the returned traveller.[212]

132. However, in her evidence, Dr Looker referred to the tightly clustered symptom onset date for the first six cases at the Rydges, and the common work shift times, as supporting a 'point-source' transmission event, rather than a staggered person-to-person transmission.[213] There was also information that the person who was assessed as the index case at Rydges was involved in cleaning common areas at the hotel.[214] Both these factors, along with the patent risks identified by the inadequate cleaning practices adopted at Rydges, added to the possibility of environmental transmission.[215]

133. In her statement, Dr McGuinness said the following:[216]

> In my opinion, the possibility that the outbreak was precipitated by person-to-person transmission **is less likely** than the outbreak being precipitated by an environmental source (emphasis added).

134. Although the evidence does not conclusively establish the mode of transmission to the degree to which scientists would be satisfied, I accept the reasoning and conclusion arrived at by Dr McGuinness. The possibility that the outbreak was precipitated by person-to-person transmission is 'less likely' than the outbreak being precipitated by an environmental source.

135. That finding draws upon the observations made in the Outbreak Management Report, which was expressly adopted by Dr Crouch:[217]

> [T]here is a **high likelihood** of fomite spread from poor cleaning products being utilised, poor PPE used by security staff, and a lack of education surrounding cleaning practices (emphasis added).[218]

136. The findings of that report are discussed in greater detail below.

STAMFORD

137. In respect of the Stamford outbreak, the evidence established the equal possibility that there was environmental or person-to-person transmission.[219]

138. Dr McGuinness stated that, in her opinion, person-to-person transmission was more of a possibility in the context of the Stamford outbreak compared with the Rydges outbreak.[220] This was due to the various opportunities for person-to-person transmission to have occurred, including large gatherings of up to 70 security guards in a single room and instances of car-pooling by security guards.[221]

139. Being unable to distinguish the respective probabilities of person-to-person transmission versus environmental transmission, Dr McGuinness concluded in respect of the Stamford outbreak that:[222]

> Transmission from a COVID-19-positive case in quarantine may have occurred directly (through person-to-person transmission) or via fomites. There is insufficient evidence to support one mode of transmission over the other and both are possible.

140. Based on the expert opinions, I am unable to prefer one method of transfer over another. In respect of the Stamford outbreak, I find that it is not possible to say that one mode of transmission was more likely than the other. What I can conclude, based on the expert evidence, is that both possible modes of transmission were a source of danger.

Contributing factors

141. Despite the fact that specific transmission events were not identified, and the mode of transmission could not be pinpointed with scientific certainty,[223] there was ample evidence that highlighted specific environmental and behavioural factors that likely contributed to the outbreaks at both hotels.

142. This evidence largely comes from the Outbreak Management Plan reports as prepared by the Outbreak Management Teams (OMTs), a subset of DHHS Case Contact and Outbreak Management Team (CCOMT), which had overall responsibility for managing and investigating the outbreaks.[224] Each OMT directed an outbreak squad that deployed specialists, including IPC nurses, to the sites.[225] According to Dr Crouch, outbreak squads facilitated rapid testing, IPC, isolation of close contacts and generally supported the containment of a public health risk.[226]

143. The Inquiry received evidence from key DHHS personnel involved in investigating the outbreaks in Drs Crouch, Looker and McGuinness. The overall picture that emerged from their evidence (which was also reflected in other evidence) was that IPC measures at both hotels were ad hoc and inadequate, and that those inadequacies led 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 **cleaning, PPE use, and staff training and knowledge**.[227]

144. There was also evidence that, despite the identification of these issues in the investigation of the Rydges outbreak in late May 2020, similar inadequacies were identified at Stamford up until mid-June 2020.[228] Indeed, the failure to heed the lessons from the Rydges outbreak was expressly cited as a factor in the decision by DEWLP to withdraw its entire staff from the Program.[229]

RYDGES

145. Investigation of the Rydges outbreak by the OMT revealed several significant problems with IPC practices, including inappropriate cleaning, inappropriate use of PPE and deficits in staff knowledge about hand hygiene and social distancing.[230]

146. The Outbreak Management Plan report from Rydges, authored by the OMT,[231] concluded that:

> There is a high risk of transmission from COVID positive cases being detained in the hotel to the staff members working at the hotel. This is due to the inadequate education and cleaning procedures that are currently in place. The cleaning duties of communal areas were the responsibility of the security staff; specifically, for the elevators used to transport COVID positive cases. Because of this, there is a high likelihood of fomite spread from poor cleaning products being utilised, poor PPE used by security staff, and a lack of education surrounding cleaning practices. At risk populations include staff members from the hotel, DHHS staff, nurses, and various other HCWs that were onsite to attend to the people in hotel detention.[232]

147. As discussed in Chapter 2, fomite transmission involves infection via surfaces or objects (including hands) that have become contaminated.[233] The evidence was that there was clearly an increased risk in a hot hotel that staff may come into contact with potentially infected surfaces or environments.

148. Considering Dr Alpren's evidence that '(i)t is likely that the large majority, approximately 90% or more, of current COVID-19 infections in Victoria can be traced to the Rydges Hotel,'[234] it is abundantly clear that effectively managing this transmission risk was paramount.

149. In respect of cleaning, a number of issues of concern were highlighted.

150. First, the hotel had no dedicated cleaning staff. As a result, general hotel staff and security staff were undertaking cleaning of common and thoroughfare areas of the hotel, [235] notwithstanding it was known that COVID-positive guests were travelling through those areas. This included evidence that one of the first security guards to contract COVID-19 had been performing a range of cleaning duties, including cleaning of the elevators used by COVID-positive guests, and evidence that a hotel staff member had removed likely contaminated rubbish from rooms occupied by COVID-positive guests.[236]

151. Secondly, and in addition to the absence of specialist trained cleaners, cleaning products and cleaning methods were inappropriate. The evidence from Dr McGuinness was that the cleaning products identified as being used by the OMT were unlikely to be effective against COVID-19.[237] Further, it was unclear whether cleaning cloths were being disposed of and replaced after use.[238] This evidence was not the subject of challenge or cross-examination when the witnesses who adopted the reports were called.

152. It should be noted, however, that Rydges Hotels Ltd sought to impugn this evidence, for the first time, in its written submissions, asserting:

> [T]he 'Environmental Investigation' within [the Rydges Outbreak Management Plan] contains both assumptions and clear errors. One significant error is the conclusion that cleaning products used were 'unlikely to be effective against SARS-CoV-2'. The author names two cleaning products. One of those products is specifically confirmed by the Therapeutic Goods Administration to be a 'disinfectant for use against COVID-19 in the ARTG for legal supply in Australia'.[239]

153. The website entry relied upon by Rydges in its final submission was not put in evidence before the Inquiry nor were its contents put to any witness. In any event, it does not stand for the evidential foundation in respect of which, I infer, it is called in aid. Rather, the website lists a range of products that have specific permission for the purposes of advertising claims.[240] I do not, therefore, accept Rydges' submissions in this regard and rely upon the evidence given by Dr McGuinness.

154. A third key area of concern identified was the inappropriate use of PPE. In particular, observations were reported to the OMT of security staff using vinyl gloves and unapproved masks.[241] There were also concerns that masks were not being changed as regularly as required.[242]

155. Finally, linked to the above, it was identified that comprehension was poor among hotel and security staff around hand hygiene, PPE, social distancing and other IPC measures.[243]

156. According to Dr Crouch, each of these factors would increase the risk of transmission.[244]

157. As well as the factors that increased the risk of transmission of the virus from those in quarantine at Rydges to those working in the Program, I find there were further issues that likely contributed to the spread and growth of the outbreak more generally into the community. They included the delays in undertaking deep cleaning, delays in quarantining staff and issues with contact tracing.

Delays in cleaning

158. Despite direction being given on 26 May 2020, with a clarification on 27 May 2020 that a full commercial bioclean was required, that clean was not thoroughly completed until the afternoon of 28 May 2020.[245] On 26 May 2020, the OMT identified that an immediate thorough clean of the site was to be undertaken as an initial control measure.[246] Some cleaning to common areas of the hotel was undertaken between 26 and 27 May 2020, however, it was not done to the satisfaction of the OMT, leaving the site 'uncontrolled' for longer than it may have otherwise been.[247]

159. On the afternoon of 27 May 2020, a request was made to IKON Services Australia Pty Ltd (IKON), at that time the only provider of specialist contract cleaning services to the Program.[248] It was requested to clean the common areas of Rydges,[249] but was not informed why this clean was being requested or what had precipitated this change to the areas it was being engaged to clean.[250]

160. Michael Girgis, General Manager of IKON, gave evidence that agreement was reached to conduct the clean the next day as IKON was unable to complete it that night.[251] The clean was subsequently undertaken on the afternoon of 28 May 2020.[252] According to Dr McGuinness, it was only after that had occurred that she could be confident the site no longer posed a risk of environmental transmission to staff.[253] Moreover, it was not until 1 June 2020 that quarantined guests at Rydges were relocated to the Novotel South Wharf.[254]

Delays in isolating staff

161. There was also a delay in quarantining or isolating people who had worked — and, thus, may have been exposed to the source of the outbreak — at the hotel. By 27 May 2020, only those staff identified as positive cases of COVID-19 and people deemed close contacts were told to quarantine. Other staff who had been on-site for 30 minutes or more from 11 May 2020, but who were not considered close contacts, were notified and asked to undergo testing.[255] Eventually, a decision was taken by the OMT to direct people who were not deemed close contacts, but who had attended the site for 30 minutes or more between 18 May 2020 and 28 May 2020, to quarantine for 14 days.[256] However, this direction did not occur until 30 May 2020.[257]

162. In her evidence, Dr McGuinness agreed that the delay between 27 and 30 May 2020 in deciding to quarantine staff may have had an impact on controlling the outbreak.[258] Dr Crouch also agreed that if a broader group had been quarantined at that time it may have helped.[259]

163. In light of the awareness of the significant risk of environmental transmission, those exposed to the site should have been quarantined immediately. The risk of fomite or environmental transmission had been flagged by the World Health Organization (WHO) in late-March 2020.[260] Ostensibly, it was this advice, and the advice from peak national bodies, that informed the policies and protocols that applied to the Hotel Quarantine Program.

164. In its final submissions to this Inquiry, DHHS stated that '… while fomite transmission was considered possible in late March 2020, the evidence from Dr Crouch, consistent with the position of WHO, is that it was considered secondary (WHO) and rare (Dr Crouch) and droplet transmission was considered more likely'.[261] While environmental transmission may not have been observed to have been responsible for significant transmissions in Victoria prior to late May 2020,[262] knowledge of the possibility of fomite transmission existed at the time of the Program's inception. That risk should have been given due attention.

165. Indeed, DHHS personnel in the public health team who wrote the policies were aware of the possibility of fomite transmission, even as early as the time of inception of the Hotel Quarantine Program. Appendix 2 of DHHS's Physical Distancing Plan (last updated on 27 March 2020) included the following:

> Early evidence suggests that SARS-CoV-2 (the virus that causes COVID-19) is primarily transmitted via respiratory droplets transmitted during close contact, **and via fomites**[263] (emphasis added).

Contact tracing

166. As explained by Dr Alpren, contact tracing refers to the identification, assessment and management of people who potentially have been exposed to disease (and so at higher risk of developing and spreading it) and working with them to interrupt the spread of the disease.[264] It allows the contact tracers to identify people who could have been exposed to the disease and to advise them to isolate.[265] The CCOMT was responsible for contact tracing.[266]

167. The efficacy of contact tracing relies on a number of factors, including good quality information being given to contact tracers. Contact tracers work with people to ascertain information from them, but they are limited to obtaining information that people are prepared to divulge.[267] Dr Alpren identified a challenge to contact tracers where a person interviewed had 'competing priorities', that is, they want to limit others from getting sick, but they also want to remain in a position where they can meet their financial obligations, such as the need to keep working and earning an income.[268] These 'competing priorities' may affect how forthcoming people are with the information about their health status or with whom they have been in contact.

168. The OMT encountered difficulties in performing effective contact tracing in these outbreaks. This was partly due to poor record-keeping, which created difficulty in obtaining reliable and timely information about security guards' and other staff movements within the hotel. Staff records and rosters made available to the OMT did not identify, for example, which guards accompanied guests on breaks, including the family of four that clustered genomically with the subsequent staff cases. This complicated (and inhibited) the tracing of close contacts.[269]

169. Further complications can arise from households of those who are infected by the COVID-19 virus. The Inquiry heard evidence that contact tracing is made much more difficult when people are living in the same household and are not well known to each other.[270] This challenge was particularly evident in the context of security guards. Dr Looker, for example, gave evidence about security guards, as a cohort, being likely to impede contact tracing efforts by nature of their employment and living arrangements. I have considered the vulnerabilities of security guards as a cohort earlier, in Chapter 6, but suffice to say that according to Dr Looker: '[c]ontact tracing efforts were impeded by a workforce [that is, the security workforce] that often worked in multiple jobs and in many cases lived in large or dense housing'.[271]

170. In addition, the OMT noted that there were issues with the provision of reliable and truthful information. Dr Crouch said that a number of those who tested positive were less than forthcoming about their close contacts.[272] For example, one of the cases linked to the Rydges outbreak failed to disclose that they had been in close contact with a housemate during the infectious period. The housemate subsequently travelled to Queensland where they became symptomatic and tested positive.[273] In Dr Crouch's view, the efforts undertaken by the OMT were hampered by the information provided and the challenges they faced in getting accurate information.[274] Drs McGuinness and Looker agreed that a key limitation in identifying contacts was that it depended on the quality of the information being provided.[275]

171. Contact tracing is overwhelmingly done through a voluntary and cooperative engagement with the infected or potentially infected people.[276] The question becomes whether that is a sufficient method by which to obtain critical information, the truthfulness of which, so says the evidence, may have significant consequences on the spread of the virus.

172. Section 188(1) of the *Public Health and Wellbeing Act 2008* (Vic) permits the CHO to direct a person to provide information specified in a direction, which the CHO believes is necessary to investigate whether there is a risk to public health or to manage or control a risk to public health. If a person fails or refuses to comply with that direction (without reasonable excuse) that person could be subject to a maximum penalty of around $10,000.[277] It is an offence to give information that is false or misleading in a material particular to the CHO under this Act. The penalty for doing so is also around $10,000.[278]

173. Despite this statutory power, it was not used as a way to overcome the risks of truthful information not being forthcoming. Rather, the evidence was that focus was on building trust, rapport and an ongoing engagement with the people from whom information was being sought. [279] The evidence from the experts was that this method of engagement, rather than a punitive and threatening one, was more conducive to obtaining reliable information efficiently.

174. Prof. Sutton's evidence was that he had not used his powers to compel information. He presumed that was because the OMT had not recommended he do so.[280]

175. I accept that it is necessary to build trust and familiarity with relevant people to enhance good and accurate information being collected. It is for this reason I recommended embedding a contact tracing team in the facility-based model in the Interim Report and adopted this recommendation in this Final Report (see Recommendation 38).

THE CASE CONTACT AND OUTBREAK MANAGEMENT TEAM

176. Dr Alpren explained that, as at early 2020, the Health Protection Branch of DHHS housed the Communicable Disease section.[281] He stated that the Communicable Disease section was responsible for the collection and management of incoming notifications and any relevant public health actions. In response to the novel coronavirus being listed as a notifiable disease in January 2020, the Public Health arm of the COVID-19 response was set up. It was within this newly set up Public Health arm where the collection of information and contact tracing was performed by the CCOMT. Dr Alpren explained that this team was not part of the Intelligence Team.[282]

177. He went on to explain, in his statement, that the duties of the Intelligence Team contained the management, development and maintenance of the infectious disease passive surveillance database used by the department, the Public Health Event Surveillance System (PHESS) in as far as its use pertained to COVID-19, data entry, classification and checking, and provision of data to assist case, contact and outbreak management and compliance with quarantine and isolation and development of centralised, integrated reporting of COVID-19. According to Dr Alpren, both the CCOMT and Intelligence Team 'evolved' from teams within the Communicable Disease section of the Health Protection Branch in response to the COVID-19 pandemic.

178. Dr Alpren made his statement on 4 August 2020. In that statement, in response to questions asked of him about workloads and resourcing, he said: 'Intelligence and Pathology are a [sic] new teams and did not exist prior to January 2020. The Incident Management Team was established in mid-January at which point I joined as Intelligence Officer in addition to my regular work as Principal Epidemiologist in Blood-Borne Viruses and Sexually Transmissible Infections. During February three people with regular positions in CDES (Communicable Disease Epidemiology and Surveillance) also worked on novel coronavirus. This has increased and we now have over 200 people in the Intelligence team, that I manage. It has been a significant scale up. Workloads have substantially increased. In order to fulfill [sic] the requirements of the response, Intelligence and CCOM are staffed 24hrs a day, 7 days a week'.[283]

179. Dr Alpren identified a list of six factors that affected the accuracy and completeness of information available to DHHS about the rate of COVID-19 cases. He noted among that list 'the capacity of the Department to enter cases and contacts to PHESS in a timely manner' and 'the capacity of the Department to review PHESS records for accuracy and ensure records reflect the content of the interview'.[284]

180. The above figures speak for themselves with respect to the 'significant scale up' of resources needed to respond to the contact tracing response to COVID-19. Inside DHHS, the response to the second wave was still unfolding throughout the course of the Inquiry. I understand that issues as to the adequacy of the data collections systems supporting those efforts have become the subject of a Parliamentary Inquiry. While not within the Terms of Reference or time constraints of this Inquiry, I do not consider it a 'long bow' to draw an inference that data management issues had an impact on the ability of the CCOMT to respond to the 'second wave' outbreaks from Hotel Quarantine.

ASYMPTOMATIC TRANSMISSION

181. I do not underestimate the difficulty for epidemiologists and contact tracing posed by COVID-19 not only being a highly infectious disease but that it can be transmitted from person-to-person despite the infectious person not experiencing any symptoms. It was estimated by Dr Alpren that about 17.9 per cent of cases will be asymptomatic.[285] This makes the disease difficult to control from an epidemiological perspective.[286] This, put together with the evidence that a person may be infectious for up to two days prior to experiencing symptoms, also adds its own complexity.

STAMFORD

182. During the investigation of the Stamford outbreak, a significant area of concern identified was that hotel and security personnel were not adequately educated in hand hygiene and the correct use of PPE. This included reports of irregular and inconsistent use by security guards of the alcohol-based hand sanitiser available on-site.[287] In addition, DHHS staff were concerned with guards incorrectly using PPE and wearing gloves for long periods of time, including while touching their phones and going to the bathroom.[288]

183. Another identified issue involved the lack of clearly designated areas or zones for handling clean and soiled items. For example, hotel staff removed rubbish and dirty, bagged linen from the rooms of positive cases and transported these items in a service elevator that was also used to deliver food.[289]

184. Failure to comply with social distancing requirements was another key concern. According to evidence given by Ms Peake, on 14 June 2020, a DHHS team leader at Stamford reported concerns about security guards hugging and approximately 70 people attending a handover meeting in a small room.[290] That meeting was held in a six-by-six metre room where the required physical distancing was plainly not possible. These activities all increased the risk of person-to-person transmission of COVID-19.[291]

185. Other concerns as to potential cross-contamination at Stamford were also identified. Particular points of concerns identified by Dr McGuinness included:[292]

> • the common use of a security guard room (including by other staff)
>
> • the use of non-disposable food utensils
>
> • the use of a shared coffee machine in the security guard room
>
> • security staff having access to the room used by nurses and other Department staff
>
> • shared use of elevators
>
> • shared use of some bathrooms.

186. Dr McGuinness observed that each of these matters may have increased the risk of COVID-19 transmission at Stamford, or at least would not have adequately protected against that risk.[293]

187. Dr McGuinness also agreed, in her evidence, that the poor IPC practices seen at Stamford mirrored what had been observed in relation to the Rydges outbreak.[294] Dr McGuinness stated it was 'disappointing' that such practices continued to present in the Program at that time.[295]

188. That said, it appeared that some of lessons were learned from the management of the Rydges outbreak. Dr McGuinness stated that swifter, more decisive action was taken at the Stamford as a result of what was learned from the Rydges outbreak.[296]

189. A full clean occurred almost immediately upon learning of the first COVID-positive staff member on 16 June 2020,[297] having been undertaken at 1.00 pm on 17 June 2020.[298] Importantly, on 16 June 2020, a decision was made that all staff who had worked from 1 June 2020 were required to be tested and all staff who had worked since 7 June 2020 were immediately stood down, with new staff deployed to the hotel following the deep clean.[299] By 18 June 2020, all staff members and contractors who had spent 30 minutes or more at Stamford from 8 June–17 June 2020 were considered close contacts and required to isolate for 14 days.[300]

190. As with the Rydges outbreak, difficulties in contact tracing were apparent. By way of example, the first case from the Stamford outbreak was identified by DHHS on 16 June 2020, after having reported symptom onset on 15 June 2020. It was later discovered that a case notified to the Department on 14 June 2020 after reporting symptom onset on 10 June 2020 was, in fact, also a Stamford worker.[301] When this person was first interviewed, they falsely stated that they did not work outside of the home.[302] This misinformation, undoubtedly, impeded the prompt identification and proper investigation of the Stamford outbreak.

9.4 Conclusions as to the impact of inadequate infection prevention and control measures on the outbreak

191. The specific factors that led to the transmission of COVID-19 from people in quarantine to workers in the Program, and beyond, to other members of the community, mirror some of the inherent problems with the Program as identified and explored in detail in this Report. Without repeating the detail of each of those systemic factors, it is important to focus attention on the ways in which those shortcomings created the conditions for the outbreaks that eventuated.

192. As has been noted, the Hotel Quarantine Program was predominately approached as a logistical or compliance exercise, rather than a health program.[303] Although the Program had important logistical and compliance aspects, those were to be called in aid of, and were necessarily ancillary to, its primary objective as a public health program: to prevent the further spread of COVID-19.

193. It appears that one of the consequences of the failure to conceive of the Program as, first and foremost, a health response was that inadequate attention was given to the primacy of IPC measures on the ground at quarantine hotels. This resulted in inadequate cleaning practices, unsafe PPE practices, risks of cross-contamination between different 'zones' and insufficient training in infection prevention and control, especially for those who were most at risk of exposure.[304]

194. Related to this, and as discussed in Chapter 8, there was insufficient public health, specifically IPC, expertise embedded in the Program. It was absent in the high-level management of the Program and in the personnel with the day-to-day implementation of the Program at hotel sites.

195. Infection prevention and control was inadequate across the Hotel Quarantine Program, and was particularly inadequate at Rydges following its designation as a hot hotel. The outbreaks that occurred, and the findings that emerged from their OMT investigation, are demonstrative of those inadequacies.

196. Those inadequacies, specifically as they materialised at Rydges, increased or, at least, substantially failed to mitigate the known risks presented at the hot hotel.

197. At all material times in the Hotel Quarantine Program, while scientific knowledge has continued to grow and develop throughout 2020, there was scientific guidance as to COVID-19 modes of transmission, including the possibility of environmental transmission.[305] Had public health experts in infection prevention and control played a greater role in the design and operation of the program, it is likely that IPC practices would have been more rigorous and more effective.

198. The proliferation of policies, without operational line of sight into the implementation of those policies, was insufficient to guard against what was known to be a pernicious virus.

199. The presence of a full-time designated IPC monitor at each quarantine hotel would have undoubtedly improved compliance with necessary practices and procedures.

200. The deficiencies in practices and procedures were plainly evident to the Outbreak Squads when they investigated the outbreaks at Rydges and Stamford.[306] Had IPC experts been present at each hotel throughout the program, those deficiencies would likely have been observed and addressed, and the risk of outbreaks reduced.[307]

201. I conclude that many of the deficiencies identified in IPC practices, which increased the risk of outbreaks, would have been detected and remedied, perhaps preventing the consequences that have flowed, had this relatively modest, but critically important, resource been appreciated.

202. A further systemic issue that emerged from the evidence concerned the nature of the workforce called upon to staff the Hotel Quarantine Program. Some of the characteristics of this workforce[308] exacerbated the risk created by the deficiencies in the IPC practices I have referred to in Chapter 6 and further interacted, in turn, to increase the risk that infected workers would transmit the virus into the community.

203. At the frontlines of the Program, agency nursing staff and private security contractors were used. It has been recognised that the private security workforce that was engaged, through a web of subcontracting arrangements, represented an inherently vulnerable cohort. Their vulnerabilities certainly bear emphasis in terms of their impact on the outbreak:

    A. Dr Crouch observed that, with hindsight, as a cohort, security guards, (through no fault of the individual workers) did not have an adequate understanding of necessary precautions, had poor health literacy, and were more likely to work multiple jobs or to have personal and employment circumstances that limited their ability to take leave when sick[309]

    B. there was also evidence before the Inquiry of 'potential cultural and language issues with respect to understanding the policies and procedures of physical distancing and the broader infection prevention and control measures that were in place'.[310]

204. These factors all drove difficulties with contact tracing, with personnel working across multiple sites within the Program and presenting a higher risk of further spread of the virus into the broader community.

205. The role of these systemic factors in the outbreaks is evident in the high proportion of transmission to private security guards (as opposed to other frontline workers)[311] and in the Outbreak Squad's concerns about security guards' misuse of PPE and non-compliance with IPC practices.[312] The use of the 'wrong cohort', including the highly casualised nature of much of the private security workforce,[313] exposed those people and, in turn, the broader Victorian community to a significant and increased risk. (See Chapter 6 for a more detailed discussion on the use of private security guards.)

9.5 Causation at law

206. The outbreaks at Rydges and Stamford — and their causal connection to the ensuing devastation on the Victorian community — was the subject of some controversy.

207. Counsel Assisting the Inquiry invited me to find that the failure by the Hotel Quarantine Program to contain the COVID-19 virus was responsible for the deaths of 786 people and the infection of some 18,418 others.[314] Counsel Assisting submitted such a finding was open to be made 'in light of the epidemiological, genomic sequencing, positive case data and mortality rates'[315] before the Inquiry.

208. DHHS, however, submitted that such a finding was not open on the evidence.[316]

209. It submitted that the Inquiry had only limited evidence before it and so there was no basis on which to make any reliable finding as to the mechanism of transmission from hotel guests at Rydges and Stamford to staff, nor as to what occurred after there was transmission and the chain of events that led to the spread in the community.[317]

210. DHHS contended that the evidence before the Inquiry did not include categories of evidence that would be relevant to the question of causation:

    A. whether the transmission event came about from environmental contamination or from the family to case 1, an intermediary person or to one or any of cases 2–5

    B. the consequences of deciding, on 30 May 2020, to cohort staff that had worked at Rydges, as opposed to making that decision earlier

    C. whether the eight hotel workers, and the other staff members that were so asked to isolate did, or did not, and whether they thus caused onward transmission

    D. how COVID-19 spread from the eight personnel that worked at Rydges and tested positive to the wider Victorian community, including to their household contacts

    E. the consequences of the delay in cleaning the hotel, from the evening of 26 May to the evening of 28 May

    F. the consequences of the timing of the outbreak and the general easing of restrictions in the Victorian community at that time

    G. whether the index family quarantined appropriately on release or caused onward transmission in the community.[318]

211. DHHS also noted difficulties faced by its OMT, such as with respect to contact tracing for some of the security guards and some continuing to work while symptomatic.

212. It would be unsafe, so submitted DHHS, to make a finding that 'the movement of the virus through the barriers of quarantining is responsible for some 99 per cent of the recent COVID-19 infections in Victoria', nor indeed any reliable finding as to the relationship of the events examined in the Program and the ultimate consequences in the community.[319] DHHS submitted that there were various matters that contributed to the community spread, and cautioned against making a finding as to why these transmission events spread in the way that they did.[320]

213. No doubt DHHS had in mind such factors, among others, as the high percentage of loss of life in the second wave being related to aged care facilities and, therefore, what other factors in that environment contributed to that loss and should be considered as part of the 'chain of causation'.

214. As to who, or what, was responsible for the Rydges outbreak and its impact on the community, Rydges submitted that the Inquiry did not explore many other points in time that the family of four (to whom the Rydges outbreak was traced) may have passed on the genomic strain to others.[321] It submitted that there was no way of determining whether one of the security guards, the hotel employee or the nurse first contracted COVID-19 from the family of returned travellers or passed COVID-19 on to any other person in the broader community.[322] Rydges, further, submitted that there were many points at which the family of four would have come into contact with others, both before and after their time at Rydges.[323]

215. Unified contended that there was no causal link between the conduct of any security worker engaged by Unified and the outbreak.[324] In particular, it submitted there was no causal link between Unified's reliance on subcontractors or not having received prior approval to use those subcontractors, or its training and supervision measures and the virus outbreak.[325]

216. Rather, it submitted that the 'second wave' of COVID-19 in Victoria was caused by systemic failures at the highest levels of government, in particular the failure of DHHS to adequately consider and assess the risks involved in the Program and the need to take responsibility for the Program as the agency in charge.[326] Unified stated another contributing factor was that Rydges was a hot hotel without necessary infection controls.[327]

217. Unified invited me to make a positive finding that Unified did not cause the outbreak at Rydges.[328]

218. MSS, on the other hand, submitted that, in considering the circumstances of the outbreak, the evidence did not afford a positive finding from a scientific perspective as to the cause of the outbreak.[329] MSS submitted that there was 'no direct evidence which conclusively illustrates the precise circumstances in which COVID-19 made its way from infected travellers to private security staff and beyond'.[330]

219. At their foundation, these submissions invited me to make findings as to what were the precise events in a chain of causation that led to the second wave of COVID-19 in Victoria.

220. The question of causation, in the way in which the law grapples with this issue, is a legally and factually complex one as all who have ventured into it will agree. The question of causation as a matter of law is one, if it is to be pursued, that must be properly pleaded before a court, seized of the jurisdiction, where the rules of evidence and procedure apply and arguments and submissions on the law can be made and ruled upon.

221. But what I can, and do, find is that the 'second wave' of COVID-19 that so catastrophically affected Victoria was linked to transmission events out of both Rydges and Stamford via returned travellers to personnel on-site, who then transmitted COVID-19 into the community. I do so having accepted the uncontroverted genomic and epidemiological evidence of Dr Howden and Dr Alpren and their conclusions from that evidence.

222. In terms of factors which contributed to those transmission events and the proliferation into the community, I rely on all of the contributing factors I have identified both in this Chapter, and throughout this Report.

9.6 Conclusions

The designation of a 'hot hotel'

223. The idea of cohorting positive COVID-19 cases together in a single location or a 'hot hotel' was a sound public health measure. If effectively and appropriately 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. In principle, a COVID-positive hotel should have had in place the same IPC measures as were implemented at all hotel quarantine sites. That is because the presumption for all quarantine facilities is that all people should be treated as carrying the virus. However, that does not set the bar for a COVID-positive hotel according to the lowest common standard. Rather, it requires that all quarantine sites employ the high standards expected of a COVID-positive environment.

224. 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 were to have particular regard to the make-up of the workforce and habits of those undertaking duties there.

225. I am unable to make a firm conclusion as to who made the decision to use Rydges as a 'hot hotel' (as between DHHS and DJPR), and why that decision was made, because there are no documents before the Inquiry that clearly answer those questions, and a dispute among the witnesses on this issue. There should be documents that record not only this significant decision, but the rationale for doing so and why this particular facility was considered appropriate, what investigations were made, what criteria was considered, including risks and benefits and risk mitigation strategies for this facility and the personnel on-site, and who was consulted. Falling short of documents setting this out, at least the witnesses involved in the decision-making should agree on what was decided and on what basis. This is another instance of where it could not be made clear to the Inquiry who was responsible for critical decisions in the Program.

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

Consultation regarding infection prevention and control at Rydges

227. Mr Hogan raised his view about the need to establish a model of care for guests in hot hotels. His view was a sound one. Mr Hogan's proposal for a model of care was not heeded, it seemed, which led to DHHS having missed an opportunity to develop, at an earlier opportunity, a quarantine environment at hot hotels that better protected against virus transmission.

Additional safeguards required in a 'hot hotel' environment

228. IPC measures, including advice and ongoing training, were not well-managed in practice. The training that was provided to security guards was provided far too late, being only after the outbreaks had occurred at both Rydges and Stamford in June 2020.

229. Nurses, GPs and security guards working at Rydges were not given adequate and timely infection prevention advice and guidance. IPC expertise was not sufficiently embedded in the design of Rydges as a 'hot hotel.'

230. Furthermore, 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.

Epidemiological and genomic evidence

231. 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.

232. Around ninety per cent of cases of COVID in Victoria since late May 2020 were attributable to that outbreak at Rydges.

233. Just under 10 per cent of positive cases in Victoria were attributable to the outbreak at the Stamford in mid-June.

234. The limits of the scientific evidence did not allow me to find, with certainty, what specific event caused the transmission from infected traveller to worker. But I do consider the likely mode of transmission at Rydges was through environmental transmission, particularly in light of the evidence from the outbreak team of poor cleaning products, poor PPE use by security staff and the lack of education around cleaning practices.

235. The evidence does not permit me to find, conclusively, whether the Stamford outbreak was due to person-to-person contact on the one hand or environmental transmission on the other.

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

237. 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.

Contributing factors to each outbreak

238. IPC 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, which may have also contributed to the outbreaks.

239. 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, I am of the view that 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 IPC measures) ought not to have been persuasive arguments against such cautious measures. The former approach was taken merely days later, without apparent adverse consequence.

240. With respect to contact tracing, timely and accurate information is vital to efforts to contain outbreaks. In particular, detailed information about the movements of cases and close contacts is vital to the work of the contact tracers.[331]

241. 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 all on-site entities and personnel with information that will enable those individuals and entities to understand and accept their obligations to provide accurate and timely information in the event of a possible or actual infectious outbreak. Developing those relationships enhances trust and understanding and, thereby, enhances safety for workers and the community alike.

242. 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 Stamford were not unique to hotels as environments and these factors all contributed to an increased risk that eventuated, with tragic consequences.

243. These risks were foreseeable and may have actually been foreseen had there been an appropriate level of health focus in the program from the top down to the sites themselves.

9.7 Recommendations

Recommendations 24, 27–30, 33 and 38 of the Interim Report, and adopted in this Final Report apply directly to this chapter:

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

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.

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.

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.

Endnotes

1 Exhibit HQI0144_P First witness statement of Commissioner Andrew Crisp, 27 [62].
2 Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 5 [15].
3 Exhibit HQI0049_RP Witness statement of Mr Unni Menon, 7 [22]–[23]; 17.
4 Exhibit HQI0099_RP Witness statement of Ms Simone Alexander, 2 [11]–[14].
5 Exhibit HQO0100_RP Appendix to the witness statement of Ms Simone Alexander, ALFH.0001.0001.0025-0029.
6 Exhibit HQI0008a_RP Witness statement of Dr Charles Alpren, 19 [81].
7 Ibid 19-20 [81]–[85].
8 Ibid 20 [83].
9 Ibid [86].
10 Exhibit HQI00104_RP Outbreak Management Plan Rydges Swanston, DHS.0001.0036.0147.
11 Exhibit HQI0008_RP Witness statement of Dr Charles Alpren, 20 [86].
12 Exhibit HQI0008 Witness statement of Dr Charles Alpren, 20 [87]; Exhibit HQI0104_RP Outbreak Management Plan Rydges Swanston, DHS.0001.0036.0149.
13 Transcript of day 14 hearing 8 September 2020, 1095; Exhibit HQI0104_RP Outbreak Management Plan Rydges Swanston, DHS.0001.0036.0147.
14 Exhibit HQI0104_RP Outbreak Management Plan Rydges Swanston, DHS.0001.0036.0147-0149; 0161; 0166.
15 Ibid DHS.0001.0036.0147; Exhibit HQI0008a_RP Witness statement of Dr Charles Alpren, 20 [87].
16 Exhibit HQI0008a_RP Witness statement of Dr Charles Alpren, 21 [95].
17 Ibid [97]; Exhibit HQI0106_RP Witness statement of Dr Sarah McGuinness 28 [98].
18 Ibid [96].
19 Ibid 22 [98].
20 Exhibit HQI0155_RP Annexures to witness statement of Prof. Brett Sutton, DHS.0001.0032.0204 (Outbreak Management Plan Stamford Plaza Hotel).
21 Exhibit HQI0008a_RP Witness statement of Dr Charles Alpren 22 [98].
22 While Rydges was the primary 'hot hotel' the Novotel South Wharf was used temporarily following closure of the Rydges Hotel, see Exhibit HQI0082_RP Second witness statement of Ms Rachaele May, 7 [32].
23 Exhibit HQI0113_P Witness statement of Dr Finn Romanes, 12 [57].
24 Transcript of day 12 hearing 3 September 2020, 869; Exhibit HQI0153_P Witness statement of Prof. Brett Sutton, 27 [148]; Exhibit HQI0113_P Witness statement of Dr Finn Romanes, 12 [59].
25 Transcript of day 12 hearing 3 September 2020, 869.
26 Exhibit HQI0116_RP Annexures to witness statement of Dr Finn Romanes, DHS.5000.0054.6660.
27 Exhibit HQI116_RP Annexures to witness statement of Dr Finn Romanes, DHS.5000.0054.9039.
28 Exhibit HQI0160_RP Witness statement of Dr Annaliese van Diemen, 29 [135].
29 Exhibit HQI0164 Affidavit of Mr Jason Helps, 9 [34].
30 Exhibit HQI0153_P Witness statement of Prof. Brett Sutton, 27–28 [146]; Transcript of day 18 hearing 16 September 2020, 1498.
31 HQI0160_RP Witness statement of Dr Annaliese van Diemen, 29 [136].
32 HQI0160_RP Witness statement of Dr Annaliese van Diemen, 29 [136].
33 Exhibit HQI0114_RP Annexures to witness statement of Dr Finn Romanes, DHS.5000.0131.0505.
34 Transcript of day 14 hearing 8 September 2020, 1066–1067.
35 Ibid 1066.
36 Exhibit HQI0153_RP Witness statement of Prof. Brett Sutton, 28 [151].
37 Transcript of day 3 hearing 17 August 2020, 43.
38 Exhibit HQI0153_RP Witness statement of Prof. Brett Sutton, 27 [150].
39 Ibid [149].
40 Exhibit HQI0114_RP Annexures to witness statement of Dr Finn Romanes, DHS.5000.0131.0505.
41 Transcript of day 23 hearing 23 September 2020, 2026.
42 Exhibit HQI0045_RP Witness statement of Mr Rosswyn Menezes 4 [11].
43 Ibid.
44 Exhibit HQI0185(2)_RP Further attachments to witness statement of Mr Simon Phemister, DJP102.007.9311–9313.
45 HQI0162 Witness statement of Ms Andrea Spiteri, 16 [66].
46 Ibid [67].
47 Exhibit HQI0163(1)_RP Annexures to witness statement of Ms Andrea Spiteri, DHS.5000.0001.1240.
48 Ibid.
49 Exhibit HQI0033(1)_RP Annexures to witness statement of Ms Claire Febey, DJP.102.009.3461.
50 Exhibit HQI0185(2)_RP Further Annexures to Witness Statement of Mr Simon Phemister, DJP.102.007.5658.

51 Exhibit HQI0133(1)_RP Annexures to witness statement of Ms Claire Febey, DJP.102.006.9546.
52 Exhibit HQI0258_RP Annexure to Affidavit of Mr Braedan Hogan, DHS.5000.0053.6633.
53 Transcript of day 16 hearing, 11 September 2020, 1282.
54 Transcript of day 24 hearing 24 September 2020, 2076.
55 Exhibit HQI0199_RP DHHS emails re returning passengers from Greg Mortimer cruise, DHS.0001.0013.2566; Exhibit HQI0161_RP Annexures to witness statement of Dr Annaliese van Diemen, DHS.0001.0013.2566.
56 Exhibit HQI0199_RP DHHS emails re returning passengers from Greg Mortimer cruise, DHS.0001.0013.2566; Exhibit HQI0161_RP Attachments to Witness Statement of Dr Annaliese van Diemen, DHS.0001.0013.2566; Transcript of day 23 hearing 23 September 2020, 1985.
57 Transcript of day 23 hearing 23 September 2020, 1987.
58 Transcript of day 16 hearing 11 September 2020, 1282.
59 Exhibit HQI0160_P Witness statement of Dr Annaliese van Diemen, 28 [134].
60 Transcript of day 13 hearing 4 September 2020, 959.
61 Ibid; Exhibit HQI0199_RP DHHS emails re returning passengers from Greg Mortimer cruise, DHS.0001.0013.2566.
62 Exhibit HQI0133_RP Minutes of Operation Soteria Meeting 10 April 2020, DJP.102.007.3065.
63 Transcript of day 23 hearing 23 September 2020, 2023; 2027.
64 Transcript of day 23 hearing 23 September 2020, 2026. See also evidence of Ms Bamert, transcript of day 16 hearing 17 September 2020, 1320-1321.
65 Exhibit HQI0165_RP Annexures to affidavit of Mr Jason Helps, DHS.0001.0131.0073.
66 Exhibit HQI0199_RP DHHS emails re returning passengers from Greg Mortimer cruise, DHS.0001.0013.2566; Exhibit HQI0033(1)_RP Annexures to witness statement of Ms Claire Febey, DJP.102.006.9546; Exhibit HQI0204, Annexures to witness statement of 'DHHS Infection Control Consultant', DHS.5000.0087.4479; Exhibit HQI0258_RP Annexures to Affidavit of Mr Braedan Hogan, DHS.5000.0053.6633; Exhibit HQI0133_RP Minutes of Operation Soteria Meeting 10 April 2020, DJP.102.007.3065.
67 Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 20 [41(f)].
68 Exhibit HQI0165_RP Annexures to affidavit of Mr Jason Helps, DHS.0001.0131.0073.
69 Ibid.
70 Exhibit HQI0162_P witness statement of Ms Andrea Spiteri, 16 [68].
71 Acknowledging that DHHS did engage Infection Prevention Australia to review the environment at the Rydges Hotel, which is discussed further below at [58]–[65].
72 Exhibit HQI0160_P Witness statement of Dr Annaliese van Diemen, 20 [94]–[95].
73 Ibid 21 [97].
74 Transcript of day 18 hearing 16 September 2020, 1531.
75 Exhibit HQI0033(1)_RP Annexures to witness statement of Ms Claire Febey, DJP.102.007.2385.
76 Exhibit HQI0098_RP Annexures to witness statement of Dr Clare Looker, DHS.5000.0054.4766-–4769.
77 Ibid.
78 Ibid.
79 Exhibit HQI0097_RP Witness statement of Dr Clare Looker, 3 [20].
80 Exhibit HQI0114_RP Annexures to witness statement of Dr Finn Romanes, DHS.5000.0131.0504.
81 Exhibit HQI0257_RP Affidavit of Mr Braedan Hogan, 8 [46].
82 Exhibit HQI0114_RP Annexures to witness statement of Dr Finn Romanes, DHS.5000.0131.0504.
83 Transcript of day 16 hearing 11 September 2020, 1324.
84 Exhibit HQI0258_RP Annexures to affidavit of Mr Braedan Hogan, 5000.0053.6633.
85 Ibid 5000.0053.6632.
86 Exhibit HQI0257 Affidavit of Mr Braedan Hogan, 4 [43]–5 [47]. .
87 Exhibit HQI0033_RP Annexures to witness statement of Ms Claire Febey, DJP.102.006.9546.
88 Exhibit HQI0033_RP Annexures to witness statement of Ms Claire Febey, DJP.102.006.9545.
89 Available at Exhibit HQI0033_RP Annexures to witness statement of Ms Claire Febey, DJP.102.006.9548.
90 Exhibit HQI0033_RP Annexures to witness statement of Ms Claire Febey, DJP.102.006.9545.
91 Transcript of day 23 hearing 23 September 2020, 2004.
92 Ibid.
93 Exhibit HQI0204_RP Annexures to witness statement of 'DHHS Infection Control Consultant', DHS.5000.0087.4479.
94 Exhibit HQI0203_RP Witness statement of 'DHHS Infection Control Consultant', 19 [89].
95 Exhibit HQI0204_RP Annexures to witness statement of 'DHHS Infection Control Consultant', DHS.5000.0128.7672–7673.
96 Ibid.
97 Ibid.

98 Exhibit HQI0256_RP Annexures to Affidavit of Mr Jason Helps, DHS.5000.0072.9119.
99 Exhibit HQI0136_RP Annexures to witness statement of Ms Merrin Bamert, DHS.0001.0021.0020–0021.
100 Ibid DHS.0001.0021.0021.
101 Ibid.
102 Exhibit HQI0135_RP Witness statement of Ms Merrin Bamert, 13 [40(a)].
103 Ibid [40(b)].
104 Exhibit HQI0088_RP Witness statement of Dr Stuart Garrow, 9 [29]–10 [30].
105 Exhibit HQI0160_P Witness statement of Dr Annaliese van Diemen, 22 [103]; Transcript of day 18 hearing 16 September 2020, 1552.
106 Exhibit HQI0113_P Witness statement of Dr Finn Romanes, 13 [63].
107 Exhibit HQI0203_RP Witness statement of 'DHHS Infection Control Consultant', 6 [26]–[28].
108 Exhibit HQI0186_RP First witness statement of Ms Kym Peake, 44 [229].
109 Exhibit HQI0135_RP Witness statement of Ms Merrin Bamert 10 [28].
110 Up to the time when the outbreaks occurred.
111 Exhibit HQI0204, Annexures to witness statement of 'DHHS Infection Control Consultant', DHS.5000.0087.4479.
112 Ibid DHS.5000.0087.8605.
113 Exhibit HQI0045_RP, Witness statement of Mr Rosswyn Menezes, 14 [44]–[45].
114 Ibid.
115 Transcript day 19 hearing 17 September 2020, 1599.
116 Ibid.
117 Exhibit HQI0136_RP Annexures to witness statement of Ms Merrin Bamert, DHS.0001.0021.0021.
118 Ibid.
119 Exhibit HQI0186_RP First witness statement of Ms Kym Peake, 44 [230].
120 Ibid 45 [234.3].
121 Ibid 44 [231].
122 Exhibit HQI0104_RP Outbreak Management Plan Rydges Swanston, DHS.0001.0036.0156.
123 Exhibit HQI0008a_RP Witness statement of Dr Charles Alpren, 22 [97].
124 Exhibit HQI0204_RP Witness statement of Dr Sarah McGuinness, 21 [73].
125 Ibid [73]–[74].
126 Ibid [73].
127 Exhibit HQI0008a_RP Witness statement of Dr Charles Alpren, 20 [86].
128 Ibid 22 [97].
129 Exhibit HQI0204_RP Annexures to witness statement of 'DHHS Infection Control Consultant', DHS.5000.0095.6927.
130 Exhibit HQI0186_RP First witness statement of Ms Kym Peake, 45 [234.3].
131 Ibid 44 [229].
132 Transcript of day 23 hearing 23 September 2020, 2007–2008.
133 HQI0204_RP Annexures to witness statement of 'DHHS Infection Control Consultant', DHS.5000.0108.1504.
134 Exhibit HQI0203_RP Witness statement of 'DHHS Infection Control Consultant', 9–10, [40].
135 Ibid 16 [72]; Exhibit HQI0204_RP Annexures to witness statement of 'DHHS Infection Control Consultant', DHS.5000.0099.6387; DHS.5000.0095.6935.
136 Exhibit HQI0204_RP Annexures to witness statement of 'DHHS Infection Control Consultant', DHS.5000.0099.6387.
137 Exhibit HQI0001a_P Witness statement of Prof. Lindsay Grayson, 15 [65].
138 Exhibit HQI0153_RP Witness statement of Prof. Brett Sutton, 28 [152].
139 Transcript of day 18 hearing 16 September 2020, 1499.
140 Exhibit HQI0153_P Witness statement of Prof. Brett Sutton 28 [151]–[152]; Transcript of day 18 hearing 16 September 2020, 1498-1499; Transcript of day 16 hearing 11 September 2020, 1282.; Exhibit HQI0104_RP Outbreak Management Plan Rydges Swanston, DHS.0001.0036.0156–0157.
141 Exhibit HQI0001_P Witness statement of Prof. Lindsay Grayson, 17 [68(c)].
142 Transcript of day 14 hearing 8 September 2020, 1069; See also Exhibit HQI0001a_P Witness statement of Prof. Lindsay Grayson 19 [76].
143 Transcript of day 14 hearing 8 September 2020, 1069. Transcript of day 14 hearing, 8 September 2020, examination of Dr Crouch, 1069.17–22; on the point that all returned travellers should be treated as potentially positive see Exhibit HQI0001a_P Witness statement of Prof. Lindsay Grayson, [76].
144 Transcript of day 14 hearing 8 September 2020, 1069.
145 Ibid 1069–1070.
146 Transcript of day 14 hearing, 8 September 2020, examination of Dr Crouch, Ibid 1069.17–22
147 Ibid 1065; Exhibit HQI0103_RP Witness statement of Dr Simon Crouch, 9 [42(a)].

148 Transcript of day 14 hearing 8 September 2020, 1066.
149 Transcript of day 18 hearing, 16 September 2020, 1499.
150 Ibid.
151 Ibid.
152 Ibid.
153 Transcript day 16 hearing 11 September 2020, 1281.
154 Ibid.
155 Exhibit HQI0104_RP Outbreak Management Plan Rydges Swanston, DHS.0001.0036.0154.
156 Exhibit HQI0001a_P Witness statement of Prof. Lindsay Grayson, 14–15 [61].
157 Ibid 19 [76].
158 Ibid [75].
159 Ibid.
160 Ibid.
161 Transcript day 16 hearing 11 September 2020.
162 Exhibit HQI0125_RP Witness statement of Ms Melissa Skilbeck, 24–25 [135].
163 Ibid 1288; Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 23 [49(d)].
164 Transcript day 16 hearing 11 September 2020, 1321.
165 Ibid 1321.
166 Ibid 1324.
167 Ibid 1321.
168 Exhibit HQI0114_RP Annexures to witness statement of Dr Finn Romanes, DHS.5000.0131.0504.
169 Exhibit HQI0186 First witness statement of Ms Kym Peake, 46 [240].
170 Exhibit HQI0082_RP Second witness statement of Ms Rachaele May, 7 [32]; Transcript of day 13 hearing 4 September 2020, 974.
171 Exhibit HQI0099_RP Witness statement of Ms Simone Alexander, 2 [11].
172 Exhibit HQI0008a_RP Witness statement of Dr Charles Alpren, 21 [90].
173 That is, they did not share any sufficient genomic similarity to link them with any other known cases in Victoria.
174 Transcript of day 4 hearing 18 August 2020, 103; Exhibit HQI0008a_RP Witness statement of Dr Charles Alpren, 21 [90].
175 Transcript of day 4 hearing 18 August 2020, 104; Exhibit HQI0008a_RP Witness statement of Dr Charles Alpren, 21 [91].
176 Exhibit HQI0008a_RP Witness statement of Dr Charles Alpren, 20–21 [87]–[94].
177 Ibid [99].
178 Ibid.
179 Ibid [100].
180 Ibid [101]; Transcript of day 4 hearing 18 August 2020, 104.
181 Ibid, 23 [105]–[106]; 25 [113]–[114]; Transcript of day 4 hearing 18 August 2020, 104.
182 Exhibit HQI0008a_RP Witness statement of Dr Charles Alpren, 23 [105].
183 Ibid 24 [108].
184 Ibid 23 [109].
185 By the time the genomic and epidemiological evidence was presented to the Inquiry in mid-August, by the close of evidence in September, or subsequently.
186 Exhibit HQI0008a_RP Witness statement of Dr Charles Alpren, 26 [119].
187 Ibid 28 [127].
188 Ibid 23 [106].
189 Transcript of day 4 hearing 18 August 2020, 106.
190 Ibid.
191 Ibid.
192 Ibid 107.
193 Exhibit HQI0008a_RP Witness statement of Dr Charles Alpren, 25 [114].
194 Ibid 27 [122]; 28 [130].
195 Transcript of day 26 hearing 28 September 2020, 2234; DHHS 'Media release–Coronavirus update for Victoria — Monday 15 June' (Media Release, 15 June 2020) <dhhs.vic.gov.au/updates/coronavirus-covid-19/media-release-coronavirus-update-victoria-monday-15-june>.

196 DHHS, 'Coronavirus update for Victoria — 24 November 2020' (Media Release, 24 November 2020) <https://www.dhhs.vic.gov.au/coronavirus-update-Victoria-24-November-2020>.
197 DHHS 'Coronavirus update for Victoria — 23 May 2020 (Media Release, 23 May 2020) <https://www.dhhs.vic.gov.au/coronavirus-update-victoria-23-may-2020>.
198 DHHS 'Coronavirus update for Victoria — 24 June 2020' (Media Release, 24 June 2020), <https://www.dhhs.vic.gov.au/coronavirus-update-victoria-24-june-2020>.
199 Exhibit HQI0008a_RP Witness statement of Dr Charles Alpren, 20 [82]-[87].
200 DHHS 'Victorian coronavirus (COVID-19) data' (web page, 15 December 2020) <https://www.dhhs.vic.gov.au/victorian-coronavirus-covid-19-data>; DHHS 'Coronavirus update for Victoria — 30 November 2020' (Media Release, 30 November 2020) <https://www.dhhs.vic.gov.au/coronavirus-update-victoria-30-november-2020>; DHHS 'Case locations and outbreaks' (web page, 15 December 2020) < https://www.dhhs.vic.gov.au/case-locations-and-outbreaks>; The Age 'Ten graphs that show the rise and fall of Victoria's COVID-19 second wave' (Article, 27 October 2020) < https://www.theage.com.au/national/victoria/ten-graphs-that-show-the-rise-and-fall-of-victoria-s-covid-19-second-wave-20201027-p5694b.html>.
201 Exhibit HQI0008a_RP Witness statement of Dr Charles Alpren, 25 [117]; 27 [123]; 28 [126].
202 Ibid 25 [115].
203 Ibid 26 [117–118].
204 Exhibit HQI0106_RP, Witness statement of Ms McGuinness, dated 21 August 2020, DHS.9999.0004.0001 at 17 [64].
205 Exhibit HQI0008a_RP Witness statement of Dr Charles Alpren, 26 [118]; Transcript of day 4 hearing 108–10918 August 2020, 108–109.
206 Transcript of day 4 hearing 18 August 2020, 110.
207 Exhibit HQI0008a_RP Witness statement of Dr Charles Alpren, 26 [118].
208 Ibid.
209 Ibid.
210 Ibid 27 [123].
211 Ibid 27 [123]; 28 [126].
212 Transcript of day 14 hearing 8 September 2020, 1075.
213 Exhibit HQI0097_RP Witness statement of Dr Clare Looker, 17 [83].
214 Transcript of day 14 hearing 8 September 2020, 1075.
215 Transcript of day 14 hearing 8 September 2020, 1075–1076.
216 Exhibit HQI0106_RP Witness statement of Dr Sarah McGuinness, 17 [64].
217 Transcript of day 14 hearing 8 September 2020, 1076–1077.
218 Exhibit HQI0104_RP Outbreak Management Plan Rydges Swanston, DHS.0001.0036.0156.0157.
219 Transcript of day 14 hearing 8 September 2020, 1114.
220 Ibid.
221 Ibid.
222 Exhibit HQI0106_RP Witness statement of Dr Sarah McGuinness, 24–25 [89].
223 Exhibit HQI0008a_RP Witness statement of Dr Charles Alpren [118].
224 Exhibit HQI0105_RP Annexures to the witness statement of Dr Simon Crouch, DHS.0001.0003.0054.
225 Exhibit HQI0103_RP Witness statement of Dr Simon Crouch, [31]–[32].
226 Exhibit HQI0105_RP Annexures to the witness statement of Dr Simon Crouch, DHS.0001.0003.0070.
227 See eg: Exhibit HQI0104_RP Outbreak Management Plan Rydges Swanston, DHS.0001.0036.0156.0157; Exhibit HQI0155_RP Annexures to witness statement of Prof. Brett Sutton, DHS.0001.0032.0205 (Outbreak Management Plan Stamford Plaza Hotel).
228 Transcript of day 14 hearing 8 September 2020, 1109.
229 Exhibit HQI0112_RP Annexures to the witness statement of Ms Kate Gavens, DELW.0001.0001.0653; Exhibit HQI0111_RP Witness statement of Ms Kate Gavens, 10 [42]–[43].
230 Exhibit HQI0104_RP Outbreak Management Plan Rydges Swanston, DHS.0001.0036.0156-0157.
231 Dated 13 July 2020.
232 Exhibit HQI0104_RP Outbreak Management Plan Rydges Swanston, DHS.0001.0036.0156-0157.
233 Exhibit HQI0001_P Witness statement of Prof. Lindsay Grayson, 9 [42].
234 Ibid 27 [122].
235 Exhibit HQI0106_RP Witness statement of Dr Sarah McGuinness, 13 [48].
236 Exhibit HQI0103_RP Witness statement of Dr Simon Crouch, 12 [54(a)].
237 Ibid 12 [54(c)]; Exhibit HQI0106_RP Witness statement of Dr Sarah McGuinness, 13 [48].
238 HQI0103_RP Witness statement of Dr Simon Crouch, 12 [54(c)].
239 Submission 08 Rydges Hotel Ltd, 19 [62].

240 Therapeutic Goods Administration, Disinfectants for use against COVID-19 in the ARTG for legal supply in Australia Department of Health (Cth), 12 November 2020 <https://www.tga.gov.au/disinfectants-use-against-covid-19-artg-legal-supply-australia>.
241 Exhibit HQI0106_RP Witness statement of Dr Sarah McGuinness, 14 [50].
242 Exhibit HQI0103_RP Witness statement of Dr Simon Crouch, 12 [54(b)].
243 Exhibit HQI0106_RP Witness statement of Dr Sarah McGuinness, 14 [51].
244 Transcript of day 14 hearing 8 September 2020, 1072-1073.
245 Exhibit HQI0106_RP Witness statement of Dr Sarah McGuinness, 13 [49].
246 Exhibit HQI0141 Rydges Outbreak Management Plan, DHS.0001.0036.0159; Transcript of day 14 hearing 8 September 2020, 1114–1115; Exhibit HQI0106_RP Witness statement of Dr Sarah McGuinness, 13 [49].
247 Transcript of day 14 hearing 8 September 2020, 1083; 1115.
248 Transcript of day 16 hearing 11 September 2020, 1257.
249 Ibid; Transcript of day 14 hearing 8 September 2020, 1115; Exhibit HQI0106_RP Witness statement of Dr Sarah McGuinness, 13 [49].
250 Transcript of day 16 hearing 11 September 2020, 1256.
251 Transcript of day 16 hearing 11 September 2020, 1257.
252 Transcript of day 16 hearing, 11 September 2020, 1255; Exhibit HQI0106_RP Witness statement of Dr Sarah McGuiness, 13 [49].
253 Transcript of day 14 hearing 8 September 2020, 1115.
254 Exhibit HQI0045_RP Witness statement of Mr Rosswyn Menezes, 12 [38(c)]; Exhibit HQI0046_RP Annexures to witness statement of Mr Rosswyn Menezes, RYD.0001.0001.0104.
255 Exhibit HQI0097_RP Witness statement of Dr Clare Looker, 7 [33]–[34]; Transcript of day 14 hearing 8 September 2020, 1084.
256 Exhibit HQI0104_RP Outbreak Management Plan Rydges Swanston, DHS.0001.0036.0164.
257 Ibid.
258 Transcript of day 14 hearing 8 September 2020, 1122.
259 Transcript of day 14 hearing 8 September 2020, 1090.
260 WHO, 'Modes of transmission of virus causing COVID-19: implication for IPC precaution recommendations' (Scientific 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>.
261 Submissions 03 Department of Health and Human Services 32 [172].
262 Exhibit HQI0103 Witness statement of Dr Simon Crouch, 8 [39]; Transcript of day 14 hearing 8 September 2020, 1066–1067.
263 Exhibit HQI0114_RP Annexures to witness statement of Dr Finn Romanes, DHS.5000.0123.3279.
264 Transcript of day 4 hearing 18 August 2020, 96.
265 Exhibit HQI0008_RP Witness statement of Dr. Charles Alpren, 9–10 [40]–[41].
266 Transcript of day 4 hearing 18 August 2020, 96.
267 Ibid.
268 Ibid.
269 Exhibit HQI0106_RP Witness statement of Dr Sarah McGuinness, 14 [52].
270 Transcript of hearing day 14, 8 September 2020, 1103.
271 Ibid.
272 Transcript of day 14 hearing 8 September 2020, 1090.
273 Exhibit HQI0106_RP Witness statement of Dr Sarah McGuinness, 28 [99].
274 Transcript of day 14 hearing 8 September 2020, 1090.
275 Transcript of day 14 hearing 8 September 2020, 11021103.; Exhibit HQI0097_RP Witness statement of Dr Clare Looker, 18 [86].
276 Transcript of day 18 hearing 16 September 2020, 1462.
277 PHW Act, s 188(2): at 1 July 2020, the value of a penalty unit is $165.22 (see Government Gazette No G16, 23 April 2020).
278 PHW Act, s 210(1): it is no offence if the person indicates in respect of which the information is false or misleading and if practicable, providing the correct information, or the person otherwise believed on reasonable grounds that the information was true and was not misleading.
279 Transcript of day 18 hearing 16 September 2020, 1462.
280 Ibid.
281 Exhibit HQI0008_RP Witness Statement of Dr Charles Alpren, 5 [25].
282 Ibid 5 [26] – [27].
283 Ibid 8-9 [36] – [37].
284 Ibid 18 [77].

285 Ibid 14 [57].
286 Ibid 13 [54] – [56].
287 Exhibit HQI0106_RP Witness statement of Dr Sarah McGuinness, 21 [74].
288 Exhibit HQI0186_RP First witness statement of Ms Kym Peake, 246–247 [243].
289 Exhibit HQI0106_RP Witness statement of Dr Sarah McGuinness, 21[76].
290 Exhibit HQI0186_RP First witness statement of Ms Kym Peake, 246–247 [243].
291 Exhibit HQI0106_RP Witness statement of Dr Sarah McGuinness, 21–22 [77].
292 Ibid 22 [78].
293 Ibid [79].
294 Transcript of day 14 hearing 8 September 2020, 1109.
295 Ibid.
296 Ibid 1120.
297 Exhibit HQI0097_RP Witness statement of Dr Clare Looker, 11 [55]; Exhibit HQI0155_RP Annexures to witness statement of Prof. Brett Sutton, DHS.0001.0036.0212.
298 Exhibit HQI0097_RP Witness statement of Dr Clare Looker 14 [63]; Exhibit HQI0155_RP Annexures to witness statement of Prof. Brett Sutton, DHS.0001.0036.0212.
299 Exhibit HQI0155_RP Annexures to Witness Statement of Prof. Brett Sutton, DHS.5000.0036.0212; DHS.5000.0036.3558–3559; Transcript of day 14 hearing 8 September 2020, 1118–1119.
300 Exhibit HQI0155_RP Annexures to Witness Statement of Prof. Brett Sutton, DHS.5000.0036.0212; Exhibit HQI0097_RP Witness statement of Dr Clare Looker, 14 [69].
301 Exhibit HQI0106_RP, witness statement of Dr Sarah McGuinness, 28, [98].
302 Ibid.
303 See eg Exhibit HQI0160_RP Witness statement of Dr Annaliese van Diemen, 32 [147].
304 Exhibit HQI0140 Outbreak Management Plan Rydges Hotel, DHS.0001.0036.0156–0157 Exhibit HQI0155_RP Annexures to Witness Statement of Prof. Brett Sutton, DHS.0001.0036.0205.
305 Exhibit HQI0106_RP Witness statement of Dr Sarah McGuinness, 17 [64].
306 Exhibit HQI0106_RP Witness statement of Dr Sarah McGuinness, 21–23 [73]–[79].
307 See e.g. Ms Peake's evidence in which she agrees it would be prudent to have a dedicated infection prevention and control person on-site as a feature of any model going forward: Transcript of day 23 hearing 23 September 2020, 2007–2008.
308 Review of Victoria's Private Security Industry–Victoria's Private Security Industry: Issues Paper for consultation Police Policy and Strategy (15 June 2020) <https://engage.vic.gov.au/private-security-review-2020>
309 Exhibit HQI0103_RP Witness statement of Dr Simon Crouch, 9 [42(d)].
310 Transcript of day 18 hearing 16 September 2020, 1494–1495.
311 Exhibit HQI0140_RP Outbreak Management Plan Rydges Hotel, DHS.0001.0036.0148; Exhibit HQI0155_RP Annexures to Witness Statement of Prof. Brett Sutton, DHS.0001.0036.0205 (Changed to the Outbreak Management Plan Stamford Plaza contained in Sutton material as this has been cited above consistently).
312 Exhibit HQI0097_RP Witness Statement of Dr Clare Looker 21 [95]; HQI0103_RP Witness statement of Dr Simon Crouch, 9 [42(d)]; 13 [57].
313 Transcript of day 18 hearing 16 September 2020, 1496.
314 Transcript of heading day 26, 28 September 2020, 2234.
315 Ibid.
316 03 Submissions, Department of Health and Human Services, 52 [282].
317 Ibid 18 [96]
318 Ibid 52 [282].
319 Ibid.
320 Ibid.
321 Submissions on Behalf of Rydges Hotel Ltd dated 5 October 2020, 4 [14].
322 Ibid, 4 [15].
323 Ibid, 18 [60]
324 Ibid, [1.11].
325 Ibid, 8–9 [3.4].
326 Board of Inquiry into the COVID-19 Hotel Quarantine Program–Submissions on behalf of Unified Security Group (Australia) Pty Ltd, 2 [1.5]
327 Ibid, [3.3]
328 Unified submissions, 28-29 [5.2].
329 Submissions of MSS Security Pty Ltd dated 5 October 2020, 47 [170].
330 Ibid, 47 [169].
331 Ibid 27 [96].

CHAPTER 10

Testing for COVID-19 at quarantine hotels

10.1 The initial testing regime for the Hotel Quarantine Program

1. 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 and to, accordingly, determine the exit management of detainees.
2. The initial testing regime for the Hotel Quarantine Program was only offered to those people placed in quarantine who reported symptoms of COVID-19. The evidence was that this was consistent with the public health advice at the time.[1] The Chief Health Officer (CHO), Professor Brett Sutton, stated that:

> In the beginning of the Hotel Quarantine Program across Australia, there was certainly a view that anyone who became symptomatic needed to be tested because they were developing the signs and symptoms of the coronavirus and they needed to be either excluded from having that illness or to be confirmed as positive and, therefore, managed in isolation.[2]

3. This initial testing regime raised three separate issues:
    A. First, what was happening to those people who had completed their 14 days of mandatory detention but had tested positive and remained so?
    B. Second, was the release of people reporting no symptoms after 14 days an appropriate strategy?
    C. Third, was there a risk that people were reporting no symptoms to ensure their release from mandatory detention?

Release of people from quarantine who had tested positive

4. Pam Williams, Department of Health and Human Services (DHHS) COVID-19 Accommodation Commander, outlined that between 28 March and 28 June 2020 and consistent with the public health advice and directions in place at that time, all returned travellers were permitted to exit quarantine once the 14-day quarantine period expired.[3]
5. In the event a returned traveller tested positive during their stay in hotel quarantine:
    A. the guest was permitted to depart if the guest could safely self-isolate, as required by the Isolation (Diagnosis) Direction[4] (as amended from time to time), consistent with the requirements that applied to members of the community who tested positive

B. travel to an interstate residence was not permitted until after the relevant isolation direction had been complied with and clearance provided

C. if the guest was subject to the Isolation (Diagnosis) Direction (as amended from time to time) and did not have a safe place to self-isolate, DHHS would support that guest with emergency relief hotel accommodation, subject to the relevant public health direction.[5]

6. In his evidence, the Deputy Public Health Commander, at DHHS Dr Finn Romanes, stated the following with respect to this policy:

> A further situation requiring judgement was what to do if someone whose detention period was ending was a confirmed case of COVID-19. Our assessment was that it was appropriate for someone to leave mandatory detention if they were a confirmed case of COVID-19 so long as we transitioned the person to a safe place to self-isolate for the remainder of their infectious period, as was required under the Diagnosed Persons and Close Contact Directions in force at the time, in keeping with other diagnosed persons already self-isolating in the community. This was because the key public health imperative was knowing whether or not someone was infected with COVID-19 and being clear with the person what actions were needed to prevent transmission. That way, we could agree and implement clear isolation arrangements, with a recognition between the person and the department that the person was potentially infectious and must carefully isolate.[6]

7. When questioned about the tension between allowing COVID-positive detainees to be released into the community after 14 days and the overriding objective of infection control, the Deputy Chief Health Officer at DHHS, Dr Annaliese van Diemen, stated:

> I see that a tension could be perceived. I believe that people's behaviour shifts significantly when they know that they have an infectious disease that is causing a worldwide pandemic, compared to when they have not been diagnosed with that condition, and that people … most people don't believe they will get COVID until they get it, if that makes sense. I also know that the compliance and daily check activities around cases was significantly greater than for contacts and returned travellers before the Hotel Quarantine Program, simply by virtue of numbers. There was physically no way of calling every returned traveller who was coming into the country in early March; there was tens of thousands of them.
>
> So that was a discussion that was had and there was a risk assessment that was undertaken in determining whether those people would be allowed to go home to quarantine. And one of the reasons for that was that we didn't want people to refuse to have a test because they knew that they would be kept in quarantine. So, in part, there was a degree of incentive there that, you know, if you have a test at day 10 or 11 and you're positive and you've got a safe place to go home to isolate and you're… we can see that you're cooperative and you're receiving daily phone calls and you're being required to state that you are staying home in isolation, that that was an incentive to ensure that people did report when they had symptoms and ensure that a test was undertaken. I can see that there could be a tension perceived there.[7]

8. I accept the assessments and opinions of these two public health experts with respect to their rationale for approving the release of those who tested positive and were assessed as suitable to be released on directions to self-isolate. I discussed this rationale in the Interim Report, which formed part of the basis for the recommendations for the home-based model, particularly at section 2.8: Risk of spread from non-compliance during self-quarantine.[8]

Release of people reporting no symptoms who may have been asymptomatic

9. As noted above, the initial testing regime in the Hotel Quarantine Program involved only those returned travellers reporting symptoms and consenting to a test before being released from the Program. This appeared to have been, somewhat, at odds with the more precautionary approach recommended by the Australian Health Protection Principal Committee (AHPPC) in its 29 January 2020 statement on the issue of asymptomatic and pre-symptomatic transmission of COVID-19:

> AHPPC is aware of:
>
> • very recent cases of novel coronavirus who are asymptomatic or minimally symptomatic, and
>
> • reports of one case of probable transmission from a pre-symptomatic case to other people, two days prior to the onset of symptoms.
>
> These data are very limited and preliminary and AHPPC still believes that most infections are transmitted by people with symptomatic disease. However, AHPPC believes that we should take a highly precautionary approach and is making the following new recommendations:
>
> 1. People who have been in contact with any confirmed novel coronavirus cases must be isolated in their home for 14 days following exposure;
> 2. Returned travellers who have been in Hubei Province of China must be isolated in their home for 14 days after leaving Hubei Province, other than for seeking individual medical care.
>
> Given the lower number of cases in China reported outside of Hubei Province, we do not currently recommend self-isolation for travellers from other parts of China or other countries. We are closely monitoring the development of cases outside of Hubei Province and will update this advice if necessary.
>
> AHPPC recognises that the evidence for pre-symptomatic transmission is currently limited, and this policy is highly precautionary. At this time, the aim of this policy is containment of novel coronavirus and the prevention of person to person transmission within Australia.
>
> Further details of the extent of pre-symptomatic transmission is being monitored and may result in changes to policy.[9]

10. Without doubt, asymptomatic cases had added considerable complexity to the task of addressing infection control, particularly if one was only testing on the basis of an individual presenting symptoms, which was the case at the start of the Hotel Quarantine Program.

11. In its submissions, DHHS referred to Dr van Diemen's evidence that, in the first few weeks of the Program, no jurisdictions in Australia were doing asymptomatic testing.[10] I accept that evidence and its implications as to why people in quarantine not reporting symptoms were being released, without testing, at the completion of their 14-day quarantine period.

12. However, Prof. Sutton acknowledged that the initial testing regime resulted in a situation where it was possible that people could have been released from quarantine while carrying the virus and while still infectious.[11]

13. He agreed that, in addition to a known case where a driver contracted COVID-19 from a returned traveller picked up from the Stamford Plaza Hotel, there were, potentially, other returned travellers who had been released whose COVID-19 status was undetermined.[12]

14. In his evidence, Prof. Sutton noted that the possible asymptomatic presentation of the virus or the spectrum of symptoms ranging from mild to more severe was something that became more known over time:

> What became known over time is that some people can have extremely mild symptoms, some people might develop asymptomatic illness, some with no symptoms whatsoever but potentially be infectious.[13]

Was there a risk that people were reporting no symptoms to ensure their release from mandatory detention?

15. Prof. Sutton's evidence identified that there may have been people in quarantine who minimised or downplayed their symptoms so that they would not have to be detained (or self-isolate) for longer than the 14-day quarantine period.[14] In other words, people who claimed to be symptom-free and who had not been tested, either because they were ineligible for testing or because they declined testing, were released into the community with no further requirement to quarantine.[15]

16. It was in this context that the approach to testing changed.

17. From early May 2020, a testing blitz was undertaken in Victoria. At this point, all returned travellers, even if asymptomatic, were offered voluntary COVID-19 testing on Day 3 and Day 11 of their detention. The evidence was that Victoria was the first jurisdiction to offer testing to people who were not symptomatic.[16]

18. The policy recommending testing on Day 3 and Day 11 for people in the Hotel Quarantine Program was codified in the *Operation Soteria Enhanced Testing Programme for COVID-19 in Mandatory Quarantine* on 21 May 2020, which specified that:

> Routine testing for COVID-19 is recommended for all individuals in mandatory quarantine on Day 3 and Day 11 of the quarantine period … COVID-19 testing is voluntary. Quarantined individuals cannot be forcibly tested.[17]

19. A fact sheet about the availability of Day 3 and Day 11 testing was provided to returned travellers[18] in the following terms:

Figure 10.1: Summary of routine testing process on days three and 11 from the *Operation Soteria Enhanced Testing Programme for COVID-19 in Mandatory Quarantine*

Routine testing on Day 3 and Day 11

The purpose of Day 3 testing is to detect cases of COVID-19 early in the quarantine period, so that appropriate isolation arrangements can be made both for the case and their close contacts, but also to reduce the possibility of an extended quarantine (and possibly detention) period.

The purpose of Day 11 testing is to detect cases of COVID-19 before they are due to exit mandatory quarantine, so that appropriate isolation arrangements can be put in place, and to reduce the risk of transmission in the community.

Tailored information on the Day 3 and Day 11 testing process must be provided to individuals at the beginning of the quarantine period and again before testing is carried out. Consent should be sought and documented as per the above procedure.

Day 3 and Day 11 testing will **NOT** be requested of the following groups:

- persons who are confirmed cases of COVID-19 (unless specifically indicated (e.g. if there is a specific clinical or public health indication, as determined by the treating medical practitioner and the department's CCOM)).
- persons who already have a COVID-19 test result pending.
- approved transit passengers who are generally in transit for less than 72 hours.

It should be noted that close contacts of confirmed cases who are residing at the COVID-19 designated hotel **should** be offered Day 3 and Day 11 testing, as per standard practice.

Where it is identified in advance that individuals are observing Ramadan and are unable to have a swab taken on the morning of Day 11, the test may be conducted on the evening of Day 10.

Confirmed cases should not be tested again unless specifically indicated (e.g. if there is a specific clinical or public health indication, as determined by the treating medical practitioner and the department).

Source: Exhibit HQI0131(2)_RP Annexures to witness statement of Ms Pam Williams.

20. 1 July 2020, a further public health direction[19] was issued, which required returned travellers who refused a COVID-19 test to undergo a further 10 days of hotel quarantine.[20] This was not a measure to compel testing *per se* but, rather, a measure to incentivise submission to voluntary testing by making refusal more disadvantageous. It was introduced to ensure that, in circumstances where a person refused a test, they could be detained for the full incubation period and full infectiousness period of the virus.[21]

21. In his evidence, Prof. Sutton stated that these more stringent requirements for testing were introduced to make the Hotel Quarantine Program as robust as possible.[22] Notwithstanding the acknowledged need to make the testing regime more robust, the coercive powers to require testing under the *Public Health and Wellbeing Act 2008* (Vic) (PHW Act) were not drawn upon.[23]

22. In her evidence, Dr van Diemen stated that the use of these powers was considered to ensure people were not released from quarantine while COVID-positive.[24] However, on balance, it was decided that it was less intrusive to require an additional 10 days' quarantine for people who refused to get tested.[25]

23. As explained by Prof. Sutton:

> It didn't come to mandatory testing, but there was a change in the directions, in the public health directions, which specified that those who were refusing testing at the day 11 or thereabouts mark would be held for an additional 10 days if they didn't get tested. And those additional 10 days are really a conservative measure of the infectious period if someone were to become unwell on the very last day of quarantine. Most people who develop illness have recovered and are no longer infectious before seven days are up and, certainly, the great majority will not be infectious at the 10-day mark. So that mechanism was used instead.[26]

24. The evidence was that, during the early stages of the Hotel Quarantine Program, people who were asymptomatic, not reporting symptoms or declined testing when offered were being released into the community while potentially infectious.[27]

25. DHHS submitted the following in respect of these matters:

> The Board should find that the testing policies deployed and applied in Hotel Quarantine were appropriate and adequate for the following reasons:
>
> A. throughout the program, testing was always offered to symptomatic guests as soon as they exhibit COVID-19 symptoms;
>
> B. there is no evidence of any break down in testing policies and procedures leading to unidentified community transmission. The limited circumstances of transmission because of untested positive guests leaving quarantine were isolated and, subsequently addressed by the 10-day extension to quarantine for people refusing testing;
>
> C. the Victorian position on testing was the most robust in Australia;
>
> D. the family of returned travellers at Rydges was tested and known to be positive at the time of the transmission event;
>
> E. there is no evidence to support a finding that the testing policies and procedures were not adequate or appropriate.[28]

26. The submission that testing policies deployed and applied in the Hotel Quarantine Program were not inadequate or inappropriate must come with some qualification. The extent to which testing policies prior to 1 July 2020 increased the risk of transmission was clear from the case of a guest at the Stamford Plaza Hotel guest who was released, without knowing he was COVID-positive, and infected the person who drove him away from the hotel.[29] The fact that this did not result in unidentified community transmission was fortunate, but served as a clear indication of the dangers arising from the policy at that time.[30]

27. I accept that the policy must be viewed having regard to the state of knowledge held in respect of COVID-19 at that time. Over time, as knowledge advanced and the risks posed by releasing people without testing for COVID-19 was acknowledged, the policy was revised and people refusing to be tested were subject to an additional 10 days' quarantine. I accept that this was appropriate.

10.2 Should mandatory testing powers have been used?

28. In his evidence, Professor Lindsay Grayson, Professor of Infectious Diseases at Austin Health, stated that:

> ... it would be sensible to test all people at the end of their quarantine period to see whether they are infected with the virus, irrespective of symptoms. If the criteria that people are not showing symptoms after 14 days is used as the sole determinant for whether people are released from quarantine, a proportion of those who are infected with the virus and potentially infectious, but who remain asymptomatic, could be released into the community.[31]

29. It goes without saying, the ability to test all people at the end of quarantine depends on people consenting to tests being undertaken and the availability of mandatory testing powers in the absence of consent.

30. Under s. 113 of the PHW Act, the CHO may make an examination and testing order if the CHO believes that:[32]

> A. a person has an infectious disease or has been exposed to an infectious disease in circumstances where a person is likely to contract the disease; and
>
> B. if infected with that infectious disease, the person is likely to transmit that disease; and
>
> C. if infected with that infectious disease, a serious risk to public health is constituted by —
>
> I. the infectious disease; or
>
> II. the combination of the infectious disease and the likely behaviour of that person; and
>
> D. the making of an order under this section is necessary to ascertain whether the person has the infectious disease; and
>
> E. a reasonable attempt has been made to provide that person with information relating to the effect of the infectious disease on the person's health and the risk posed to public health or it is not practicable to provide this information before making the order.

31. The penalty for non-compliance with a mandatory examination and testing order was nearly $10,000.[33]

32. While a person to whom such an order applies may be physically detained for up to 72 hours for the purposes of undergoing a test,[34] a requirement that a person undergo an examination or test could not be applied by the use of force.[35]

33. Prof. Sutton acknowledged the existence of these powers in his evidence, but said that he did not consider using them in the context of the Program, stating:

> [The powers] have, again routinely … not routinely, but they have historically … been used from time to time for individual persons for those issues. They relate to infectious diseases and some other settings such as with respect to food safety, where directing individuals or directing premises is warranted on an individual basis. Testing orders, for example, might be applied if a healthcare worker has been exposed to a needlestick injury and you want to know the status with respect to infectious diseases, hepatitis B or C or HIV, of the person whose blood was in the syringe who was involved in that needlestick injury. And if that information is not forthcoming and if you think it's appropriate and proportionate to make sure that person is tested to find out, then those orders can be applied in that instance. So that's an example.[36]

34. When asked about the issue of using coercive powers for testing, Dr van Diemen said the following:

> I did consider it. I considered it when we were discussing implementing testing in the hotel program. I also considered it on a number of occasions early on, very early on, in the pandemic when there were returned travellers who were suspected cases of COVID and refused to be tested. And in those instances, they weren't required because the individuals decided that they would accept a test. At the time of the … when we were determining the next steps to ensure that all returned travellers were tested, it was decided that a less intrusive route would be to extend the quarantine requirements for a further 10 days for people who had refused testing, in order to ensure that should they continue to refuse a test, that they had completed both a full incubation period and a full infectiousness period, should they happen to have become infectious at the end of their 14-day incubation period.[37]

35. DHHS submitted the following in this regard:[38]

> Other coercive powers of the CHO include the power under s. 113 for the making of an examination and testing order of a person in certain quite narrow circumstances. Prof. Sutton was asked about whether he considered using any of these powers and explained that he did not consider using them because they historically have been used infrequently and in the context of individuals. He was not specifically asked to address whether the legal conditions would have been satisfied for any specific persons, such as the class of persons subject to hotel quarantine. It is relevant here to note certain of these relevant circumstances:
>
> A. a person has an infectious disease or has been exposed to an infectious disease in circumstances where a person is likely to contract the disease (s. 113(1)(a)). There is no evidence to suggest that it would have been possible to ascertain in any rapid time frame whether returning travellers would fall into this category, given that few would know if they had got COVID-19 or been exposed to it;
>
> B. if infected with that infectious disease, the person is likely to transmit it (s. 113(1)(b)), a matter which, given the evidence as to the infectious nature of COVID-19 could, contrary to the first requirement, be readily assumed; and
>
> C. if infected with that infectious disease, a serious risk to public health is constituted by –
>
> I. the infectious disease; or
>
> II. the combination of the infectious disease and the likely behaviour of that person: s. 113(1)(c) –
>
> It [sic] unlikely to be possible to make determinations about the likely behaviour of large numbers of returning travellers, so whether this requirement, properly construed, is satisfied would depend on whether the fact that a person has COVID-19 of itself constitutes a serious risk to public health.

36. I accept that the exercise of power under s. 113 of the PHW Act was subject to limitations, including:

A. The CHO would need to exercise this power, and make an examination and testing order, in respect of each person refusing to undergo a COVID-19 test. It could not be exercised in respect of a class of people.

B. In order to exercise this power, the CHO must have the requisite 'belief'. This belief must include the belief that the person has at least been exposed to an infectious disease in circumstances where the person is likely to contract the disease. The belief must be evidence-based[39] and proportionate.[40] It is doubtful this belief could be based merely on the elevated risks generally associated with overseas travel or that this power could be exercised solely by reference to a person's placement in hotel quarantine. Further considerations, such as the person's country of origin, symptomology and contact with other persons carrying COVID-19 would likely need to be taken into account.

C. The exercise of this power is subject to s. 112 of the PHW Act, which provides that, where alternative measures are equally available that are equally effective in minimising the risk that a person poses to public health, the measure that is the least restrictive of the rights of the person should be chosen. A similar condition is placed upon the exercise of this power by s. 7(e) of the *Charter of Human Rights and Responsibilities Act 2006* (Vic) (Charter), which relevantly provides that a human right may be subject, under law, only to such reasonable limits as can be demonstrably justified, taking into account relevant factors including any less restrictive means reasonably available to achieve the purpose that the limitation seeks to achieve. When compared with other available measures, such as the extension of their quarantine period, it is not certain that a naseo-pharangeal swab would be the least restrictive means of minimising the risk of spreading COVID-19 from a person refusing a COVID-19 test at the end of their quarantine period. The first course would involve an intrusion upon their liberty while the latter would necessarily involve a physical intrusion upon a person. These are not easily quantifiable matters that can conveniently be measured against one another.

37. Another power that could conceivably have been exercised to enforce mandatory testing was s. 200(1)(d) of the PHW Act, which applies where a state of emergency has been declared and provides that an Authorised Officer may give any direction they consider is reasonably necessary to protect public health. While the exercise of this power is not subject to s. 112 of the PHW Act, it is subject to the 'least restrictive' principle contained in the Charter.

38. Like s. 113, it is also subject to the requirements contained in ss. 5 and 9 of the PHW Act, which require that decision-making be evidence-based and proportionate. It seems likely that similar considerations would, therefore, have needed to be taken into account when exercising this power. That is, in order to 'consider' whether a mandatory COVID-19 test was reasonably necessary to protect public health, among other things, the Authorised Officer would likely have needed to consider where the person has travelled from, their symptomology and close contacts.

Obtaining further clarity on these matters

39. These matters created ambiguity for the CHO and his delegates about the extent of mandatory testing powers available to them. This ambiguity needs to be remedied. The Responsible Minister should take steps to achieve clarity by obtaining legal advice from the Solicitor-General on the range of circumstances in which ss. 113 and 200(1)(d) of the PHW Act may be exercised to require that those refusing testing at the conclusion of their quarantine period undertake mandatory testing.

40. 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.

41. 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 CHO and Authorised Officers in their exercise of the powers under ss. 113 and 200(1)(d) of the PHW Act and consider matters, including:

    A. whether the power under s. 200(1)(d) of the PHW Act may be exercised for the purposes of mandatory testing

    B. if so, the criteria that must be met in order to exercise that power

    C. whether the powers available under s. 113 and/or s. 200(1)(d) of the PHW Act would be available to enforce mandatory testing in the scenarios provided in the request for advice

    D. the meaning of 'exposed' as it is contained in s. 113(1)(a) of the PHW Act and the considerations that should be taken into account when determining whether that condition is satisfied

E. whether naseo-pharangeal testing is likely to be considered the least restrictive option for addressing the risks posed by returned travellers who refuse testing when compared with the option of imposing an additional 10 days' detention

F. whether the powers contained in s. 113 and/or s. 200(1)(d) of the PHW Act should be exercised to enforce mandatory testing

G. if so, how the mandatory testing regime should operate in conjunction with the option of imposing an additional 10 days' detention

I. are both options equally available?

II. if not, in what circumstances should each option be preferred?

H. having regard to these matters, whether any of the following would be warranted in order to provide more certainty and serve the public interest sought to be achieved by mandatory testing:

I. an overriding declaration made by parliament pursuant to s. 31 of the Charter stating that the Charter does not apply to the exercise of powers in s. 113 and/or s. 200(1)(d) of the PHW Act for the purposes of mandatory testing

II. a declaration by the Minister for Police and Emergency Services pursuant to s. 24(2)(b) of the *Emergency Management Act 1986* (Vic), suspending the application of the Charter and/or relevant sections of the PHW Act (for example, ss 9 and 112) to the exercise of powers in s. 113 and/or s. 200(1)(d) of the PHW Act for the purposes of mandatory testing and/or

III. temporary legislative change.

42. 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.

43. 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 CHO and delegates, on the exercise of mandatory testing powers and/or the option of imposing an additional 10 days' quarantine.

Testing of those working in the Hotel Quarantine Program

44. The evidence in this Inquiry established that one of the most substantial risks associated with the Hotel Quarantine Program was the risk of infection spreading from returned travellers to staff and personnel working in the Program.

45. This much was clear from the circumstances of Victoria's second wave that, as discussed in Chapter 9, involved on-site personnel becoming infected then spreading the virus to household and other close contacts who, in turn, spread the virus into the broader community.

46. Public reports of on-site personnel in hotel quarantine in other states becoming infected via those held in quarantine confirms this is a significant ongoing risk.

47. In order to address this risk, it is vital that staff working in any future quarantine program undergo mandatory and regular COVID-19 testing. Failing this, the State's efforts to prevent and minimise the spread of the virus into the community will be significantly compromised.

48. The Inquiry understands, from recent media reporting, that in the revised Victorian hotel quarantine program, all on-site personnel, including frontline workers and cleaners, will be required to undergo daily saliva testing and weekly nasal swab testing.[41] The Inquiry also understands that regular, voluntary testing will be available for the families and household members of those working in the revised program.[42]

49. In my view, these are important and appropriate measures for addressing the substantial risks associated with infection spreading from international arrivals to personnel working on-site at quarantine facilities and into the wider community.

10.3 Conclusions

50. A significant, if not dominant, purpose of the 14-day quarantine period was to ascertain the COVID-19 status of those detained in the Program, and to allow for their post-release arrangements to be managed in an informed manner. To this end, the testing regime was of fundamental importance.

51. Initially, only those who showed symptoms were offered a test, and testing in the Hotel Quarantine Program remained entirely voluntary. The mandatory testing powers contained in the PHW Act were considered but not used.

52. 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.

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

54. Both approaches represent sound approaches and 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.

55. 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.

10.4 Recommendations

78. To provide clarity to the CHO 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:

    - 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 PHW Act may be exercised to require that those refusing testing at the conclusion of their quarantine period undertake mandatory testing
    - 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
    - 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 CHO and Authorised Officers in their exercise of the powers under ss. 113 and 200(1)(d) and consider matters including those listed above in paragraphs 41.a–41.h

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

Endnotes

1 Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 33 [76].
2 Transcript of day 18 hearing 16 September 2020, 1463.
3 Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 32 [74].
4 See Isolation (Diagnosis) Direction, <https://www.dhhs.vic.gov.au/sites/default/files/documents/202003/Isolation%20%28Diagnosis%29%20Direction%20-%20signed.pdf>.
5 Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 32 [74].
6 Exhibit HQI0113_P Witness statement of Dr Finn Romanes, 16 [77]. Note: The Diagnosed Persons and Close Contact Directions are a more recent iteration of the Isolation (Diagnosis) Direction, issued 25 March 2020, and referred to in Ms Williams' evidence above.
7 Transcript of day 18 hearing 16 September 2020, 1551.
8 Board of Inquiry into the COVID-19 Hotel Quarantine Program (Interim Report, 6 November 2020) <https://www.quarantineinquiry.vic.gov.au/reports>.
9 Australian Health Protection Principal Committee (AHPPC), 'Australian Health Protection Principal Committee (AHPPC) Statement on novel coronavirus', Australian Government Department of Health (Statement, 29 January 2020) <https://www.health.gov.au/news/australian-health-protection-principal-committee-ahppc-statement-on-novel-coronavirus-on-29-january-2020-0>.
10 Submission 03 Department of Health and Human Services, 45 [242].
11 Transcript of day 18 hearing 16 September 2020, 1465.
12 Ibid 1464–1465.
13 Ibid 1463.
14 Ibid.
15 Transcript of day 26 hearing 28 September 2020, 2248.
16 Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 33 [77]; Transcript of day 18 hearing 16 September 2020, 1463.
17 Exhibit HQI0131(2)_RP Annexures to witness statement of Ms Pam Williams, DHS.0001.0001.2353.
18 Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 33 [78]; See also Exhibit HQI0131(1)_RP Annexures to witness statement of Ms Pam Williams, DHS.5000.0003.1670.
19 Detention and Direction Order (No. 6) <https://www.dhhs.vic.gov.au/sites/default/files/documents/202007/Direction%20-%20Detention%20Notice%20%28No%206%29.pdf>.
20 Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 33 [79].
21 Transcript of day 18 hearing 16 September 2020, 1548–1549.
22 Ibid 1464.
23 Ibid.
24 Ibid 1548.
25 Ibid 1548–1549.
26 Ibid 1464.
27 Ibid 1464–1465; Submission 03 Department of Health and Human Services, 46 [246].
28 Submission 03 Department of Health and Human Services, 45 [241].
29 Transcript of day 18 hearing 16 September 2020, 1464–1465.
30 Cf Submission 03 Department of Health and Human Services, 45 [241], where the contrary is argued.
31 Exhibit HQI0001_P Witness statement of Prof. Lindsay Grayson, 12 [56].
32 PHW Act s. 113.
33 Ibid s. 116.
34 Ibid s. 113(3)(c).
35 Ibid s. 123(2).
36 Transcript of day 18 hearing 16 September 2020, 1461–1462.
37 Ibid 1548.
38 Submission 03 Department of Health and Human Services, 4 [19].
39 PHW Act s. 5.
40 Ibid s. 9.
41 Ashleigh McMillan, 'Help Wanted: Would you work in Victoria's quarantine hotels for $85k?', The Age (online, 29 November 2020) <https://www.theage.com.au/national/victoria/help-wanted-would-you-work-in-victoria-s-quarantine-hotels-for-85k-20201129-p56ivx.html>. Quote regarding testing was from Victoria's Chief Testing Commander, Jeroen Weimar.
42 Premier of Victoria, 'A Stronger Quarantine Program to Protect What We've Built' (Media Release, 30 November 2020) 1 <https://www.premier.vic.gov.au/stronger-quarantine-program-protect-what-weve-built>.

CHAPTER 11

Correcting the course: the 'pivot' to a health hotel model

1. On 30 June 2020, work was already underway to transfer responsibility for some aspects of the Hotel Quarantine Program away from the Department of Health and Human Services (DHHS) and to make changes to the workforce involved in the Program.

2. On 27 June 2020, a submission prepared for the Crisis Council of Cabinet (CCC) described the Hotel Quarantine Program in the following terms:

> DHHS currently has overall accountability for delivery of the hotel quarantine scheme. However, current operations utilise a combination of DHHS staff, Department of Jobs, Precincts and Regions [DJPR] staff, private security contractors, contract nurses and hotel support staff. This model has been built through a series of contractual arrangements across multiple departments, and security subcontracting arrangements.[1]

3. The submission identified that there had been 'incidents of non-compliance with infection prevention and control and physical distancing requirements, particularly from security contractors'.[2] The submission further identified the highest risk activities in hotel quarantine as including inconsistent application and use of PPE, entry and exits of large numbers of quarantined people, goods handling and the provision of fresh air and exercise breaks.[3]

4. On 27 June, 8 July and 27 July 2020, the CCC approved a series of actions and measures intended to address those high-risk activities and the incidents of non-compliance that had been described.[4]

5. On 27 July 2020, full responsibility for quarantine hotels resided with the Department of Justice and Community Safety (DJCS).[5] Although the Program, as it related to international travellers, was in abeyance because of the pause on international arrivals, designated hotels were still accommodating a number of COVID-positive persons who, for a range of reasons, were not able to safely self-isolate at home.[6] Such people remained subject to directions and detention orders issued under the *Public Health and Wellbeing Act 2008* (Vic) (PHW Act), but responsibility for administering certain emergency powers under that Act, insofar as they related to the Hotel Quarantine Program, had been transferred away from the Minister for Health to the Attorney-General.[7] Information provided to the Inquiry indicated that the plan was for DJCS to be the department responsible for quarantine arrangements if, and when, international arrivals to Victoria were to resume.

6. The transfers and changes that occurred in late June and July 2020 appear to have reflected assessments made by people at a range of levels within government that the model for hotel quarantine, as it stood in late June 2020, was not suitable and required remodelling.[8]

7. As explored in this Chapter, the three most significant elements of that remodelling or 'pivot' from DHHS-led quarantine to a program administered by DJCS were:

    A. the involvement of Alfred Health as the provider of clinical and infection prevention and control services

    B. the recruitment of a specialised workforce to work in the hotels, later complemented by a 24/7 Victoria Police presence

    C. the consolidation of responsibility for all aspects of the Program, including contracts, into one department.

8. The evidence before the Inquiry richly demonstrated the necessity of these elements for a successful quarantine program. It was entirely appropriate that the Government took steps to insert these elements into the program. As set out in the Interim Report, those elements should be central to any future program.

11.1 The involvement of Alfred Health

9. The participation of Alfred Health in the Hotel Quarantine Program commenced in late May 2020, after the Rydges outbreak (see Chapter 9). Pam Williams, DHHS COVID-19 Accommodation Commander, gave evidence that Alfred Health was asked to provide clinical staff and infection control governance and training.[9]

10. Simone Alexander, Chief Operating Officer of Alfred Health, gave evidence of the elements of the model established by Alfred Health and implemented at the Brady Hotel when it became the 'health hotel'.[10] The necessary elements of a facility-based model, including those described by Ms Alexander, are set out in the Interim Report.[11]

11. At the time of the CCC decision, on 27 June 2020, Alfred Health was in place at the Brady Hotel and DHHS was working towards introducing Alfred Health-led clinical and infection prevention and control services across all quarantine hotels.[12] Subsequent reports to CCC, in July 2020, indicated the model included separate health teams at each hotel being placed on separate rosters, with those in control moving towards having staff not work at more than one quarantine hotel.[13]

12. Ms Alexander gave evidence that, as of 8 September 2020, Alfred Health had clinical responsibility for all hotels that were part of the Hotel Quarantine Program.[14]

11.2 The need for an alternative workforce

13. As set out in chapters 6 and 7, and as summarised in the CCC submission of 27 June 2020, the Hotel Quarantine Program was led by DHHS but delivered by a combination of various government departments, agencies, personnel and private contractors.

14. As of late June 2020, the outbreaks were understood, within the Government, to have been due, in part, to the conduct of private security guards or to vulnerabilities caused by the security guard cohort, including limited understanding of infection prevention measures and some difficulties associated with contact tracing. These issues were discussed in more detail in chapters 6 and 9.

15. The evidence of former Minister for Health, the Hon. Jenny Mikakos, was that, from the time of the Stamford Plaza outbreak, she had formed the view that private security was not the appropriate workforce for the Program, and that she asked her department to investigate other options.[15] It was this view that led to the preparation of an options paper, a request (later rescinded) for Australian Defence Force (ADF) support as a temporary workforce[16] and the decision to use Corrections Victoria staff in the first stage of what became a transfer of the whole Program away from DHHS.

16. It should be noted here (as has been discussed earlier, in Chapter 5) that an email exchange, produced in response to a compulsory notice from the Inquiry, revealed that, in early April 2020, an email was sent from Phil Gaetjens, Secretary to the Department of Prime Minister and Cabinet, to his Victorian counterpart, Chris Eccles AO, the then Secretary to the Department of Premier and Cabinet.[17] Mr Eccles gave evidence that he had requested that the Commonwealth assist with the cost of private security at hotels.[18] Mr Gaetjens responded that New South Wales had been provided with support in the form of ADF personnel and that the same support might be available to Victoria if it were to reconsider its model of operating the Hotel Quarantine Program.[19]

17. Mr Eccles did not, so far as the documentary evidence reveals, respond other than by return email to say 'thanks'.[20] His oral evidence was that he could not recall taking any other action in response to this email.[21] He did not pass on this information to the Premier.[22] This was an opportunity lost to reset the model insofar as the use of private security was concerned. I cannot make a finding about the outcome had those responsible for Operation Soteria or the Minister for Health or the Premier been made aware of the specific potential for ADF support as security in hotels. What I do find is that, given the issue he sought to address by making contact with the Commonwealth (the significant cost to the public purse), it was a most unfortunate and inexplicable oversight on the part of Mr Eccles not to pass on this significant information to the Premier and Minister for Health.

18. In late June 2020, the Government revisited the availability of the ADF to provide support. After a discussion on 23 June 2020, Melissa Skilbeck, a deputy secretary at DHHS, was asked by the then Secretary of DHHS, Kym Peake, to prepare an options paper setting out alternatives to the use of private security.[23] One option was the increased use of ADF, although the preferred option was to use police and Protective Services Officers.[24]

19. Also on 23 June 2020, the Premier had a conversation with the Prime Minister during which the possibility of additional ADF resources was discussed.[25] The following day, Mr Eccles sought, and received, information from Ms Peake about the forms of ADF assistance that Victoria required. Ms Peake's email identified a number of different forms of support unrelated to the Hotel Quarantine Program but included a request for 50–100 people for 'ADF security support for passengers entering and exiting hotel quarantine'.[26] Mr Eccles then sent an email to Mr Gaetjens giving a 'heads up' that the request would be made.[27]

20. As the Emergency Management Commissioner for Victoria, it was Mr Crisp's role to make formal requests to the ADF.[28] He gave evidence that, after a meeting on 24 June 2020 with Ms Skilbeck, he was asked to make a request for 850 ADF officers, that being the number needed to replace private security in full (rather than the smaller number of 50–100 that had originally been identified in the options paper).[29] He made that, as one of a number of requests, having been asked by DHHS to do so.[30] The request was approved by the Commonwealth.[31]

21. On the morning of 25 June 2020, Commissioner Crisp exchanged text messages with Rebecca Falkingham, Secretary of DJCS, and the Hon. Lisa Neville MP, Minister for Police and Emergency Services, regarding the request that had been made the previous day.[32] Ms Falkingham and Ms Peake exchanged emails suggesting their view that Minister Neville would have a strong reaction to the use of the ADF.[33] Minister Neville, herself, said she had been surprised to learn of the ADF request via media reporting, rather than being informed.[34]

22. In the course of the day, Commissioner Crisp spoke to Ms Falkingham, who told him that other options to replace private security were being investigated.[35] At the request of Ms Falkingham, Commissioner Crisp rescinded the request for the 850 ADF personnel.

23. At 12.21pm on 25 June 2020, Mr Eccles received an email from Ms Peake that referred to 'multiple conversations yesterday … to scope options to replace hotel security, which is a priority, and the RFA [request for assistance] is being rescinded as further options are being developed'.[36]

24. A document summarising an alternative model was circulated by Ms Falkingham on 26 June 2020.[37] She noted that because of 'capacity issues with using VicPol we are using primarily Corrections [Victoria] staff'.[38] The model was described as a multi-agency response that would not change governance arrangements but that would 'phase out reliance on private security providers and ensure a more disciplined approach to infection control in hotel quarantine'.[39] In essence, it proposed leaving health services with DHHS, provided by DHHS workers and Alfred Health, and making supervision of those in detention the responsibility of DJCS, led by Corrections Victoria.

25. The following day — 27 June 2020 — CCC was presented with a submission inviting a decision to give effect to the alternative model.[40] Consistent with the document circulated by Ms Falkingham, the submission retained DHHS as the agency in overall control but advocated for DJCS as being well placed to 'quickly mobilise an effective, disciplined and well-trained workforce to deliver the supervision function'.[41] That workforce was to comprise Residential Support Officers (RSOs), who were to be drawn from the existing DJCS workforce and from contracted agencies, and to be built up over time to gradually replace the private security workforce.

26. As of 9 July 2020, the RSO role involved:

    A. supervising entry and exit points

    B. monitoring entry and exit of guests

    C. escorting and supervising guests for outdoor exercise as directed by the Authorised Officer

    D. escalating issues to the hotel's Team Leader.[42]

27. RSOs reported to the Team Leader at each hotel, who was responsible for working with the relevant Authorised Officer.[43]

28. The proposal to use the Corrections Victoria workforce was based on its staff having skills in supervision, communication, de-escalation and conflict management, and on them being bound by the Victorian Public Service Code of Conduct, and skilled at maintaining professional boundaries.[44]

29. Use of that workforce necessitated engagement with the Community and Public Sector Union (CPSU) regarding its likely concerns about workplace health and safety and the need for robust risk assessment and management processes.[45] As was noted in subsequent CCC submissions, there was a risk that DJCS staff would contract COVID-19 as private security guards had, and there were information and briefing materials developed by Alfred Health and the DHHS Infection Prevention Cell, and statewide operating procedures designed to minimise that risk.[46]

30. The planning for this new workforce included 'robust recruitment processes, clear communication of expectations and roles, operating model design, high quality supervision and swift consequences for any misconduct and unacceptable behaviour'. These measures were intended to 'manage the risk of RSOs failing to provide more effective supervision than private security contractors, leading to more outbreaks'.[47]

31. Those proposing the model were alive to the risk that use of Corrections Victoria staff might create the perception that those in quarantine were being treated too forcefully and might raise issues with the *Charter of Human Rights and Responsibilities Act 2006* (Vic).[48]

11.3 Transfers of accountability

32. From 2 July 2020, Corrections Victoria assumed progressive responsibility for the first tier of enforcement at quarantine hotels (re-named 'supervision services'), while responsibility for the overall program remained with DHHS.[49]

33. On 9 July 2020, CCC was asked to approve a general shift in accountability, from the Minister for Health to the Attorney-General, for delivery of the Hotel Quarantine Program.[50] The Chief Health Officer was to advise the Minister for Health on all matters related to the COVID-19 response and the Attorney-General in relation to the Hotel Quarantine Program. The Chief Health Officer, Deputy Chief Health Officers and Authorised Officers would be subject to the directions and control of both the DHHS Secretary and the DJCS Secretary so far as the Hotel Quarantine Program was concerned.[51]

34. As part of that shift, DJCS assumed responsibility for:

    A. detention oversight

    B. management of health services through a contract with Alfred Health

    C. management of hotel services (including any incidents at hotels)

    D. coordination of the enforcement function provided by Victoria Police.[52]

35. This meant the transfer of contracts previously held by DJPR, which had been in the process of being transferred to DHHS,[53] went to DJCS.[54]

36. The three private security firms originally contracted by DJPR (all of whose contracts had expired on 30 June 2020)[55] were transitioned out by 11 July 2020,[56] and all returned travellers were consolidated to a reduced number of sites.[57] As of 10 July 2020, there was a pause on international arrivals into Victoria, so numbers in hotel quarantine were reducing, but other COVID-related accommodation needs were supplementing those numbers.[58]

37. On 27 July 2020, further changes were reported to CCC and a decision was made to transfer overall administrative responsibility for Operation Soteria from DHHS to DJCS.[59] This meant that the whole of the Program would lie with DJCS, with relevant administrative changes to make the Attorney-General responsible for relevant sections of the PHW Act. The change was part of the transfer of responsibility for all COVID-19 emergency accommodation to DJCS.

38. The Commissioner for Corrections was appointed as the Deputy State Controller Health — Soteria to report to the State Controller — Health and the Emergency Management Commissioner, and to be a member of the State Control Team.[60]

39. A feature of the new model was a different level of police presence when compared to the quarantine hotels prior to this pivot or remodelling. A request was made on 16 July 2020 by DHHS to Victoria Police to provide a 24/7 on-site enforcement presence.[61] This followed the assessment that the security services subcontracted by Alfred Health had demonstrated some of the same vulnerabilities identified in the private security guards contracted by DJPR, including insufficient training, poor communication, inappropriate subcontracting and a lack of understanding of infection control practices.[62]

40. Victoria Police agreed to the request. Noting that Victoria Police had never been formally asked to provide a 24/7 presence at the quarantine hotels, Chief Commissioner of Police (CCP) Shane Patton said that the decision to provide such a presence at the 'hot' or 'health' hotels was influenced by the fact that those in the hotels presented with particular vulnerabilities and a range of risks that elevated the requirement for police presence.[63] That presence took the form of controlling access and egress, having a presence in the foyer and having a mobile presence patrolling the floors in support of the customer support officers.[64]

41. At the request of the Inquiry, CCP produced and described, in evidence, the documentation developed to support the police presence.[65] He said that there had been a full risk assessment, which had led to the creation of detailed procedures to ensure member safety. They included a Senior Sergeant taking the role of Safety Officer, briefings for all members, written instructions for different roles and the delineation of 'green' and 'red' zones with training for contamination events and specific locations for decontamination.[66]

11.4 Implications of the pivot

42. Commissioner Crisp's evidence was that the pivot to allocate control functions for the Hotel Quarantine Program to DJCS reflected the overall scale of the required COVID-19 response rather than any suggestion that DHHS was not the right agency to have been given initial control.

> We got to a point with all these operations that one State Controller could not sit above so many Deputy State Controllers with a whole range of different operations. Some of them were escalated to the Secretary that DHHS has taken on. So part of that control piece is that span of control and, in my opinion, the Secretaries could not sit over all those operations.[67]

43. The Premier agreed, in evidence, that the three significant shifts made to the Hotel Quarantine Program reflected some of what had gone wrong in the Program as it was initially established.[68] It did not have a sufficient clinical focus. It did not have an appropriate workforce. Although under the control of DHHS in emergency management terms, its reliance on private contracts held by DJPR meant there was no single point of accountability.

44. However, instead of consolidating responsibility for all aspects of the Program in DHHS, the department responsible for public health and communicable disease, the decision was made to transfer it all to DJCS.[69] An initial decision to replace private security guards with Corrections Victoria workers became,[70] within the month, the wholesale removal of the Program from DHHS to DCJS as part of the transfer of all COVID-19 accommodation programs.[71]

45. That the Program was removed from DHHS, the department with public health expertise, and given to DJCS, a department with no such expertise, including relevant accountabilities under the PHW Act, leads me to conclude that there was a view within government that DHHS was not capable of running the Program on its own, at least at that time. References in CCC submissions to DJCS being the department best placed to have sole accountability and operational control of the Hotel Quarantine Program[72] underpins the inference I draw that the CCC formed a view that DHHS was not best placed to hold those functions.

46. Former Minister Mikakos, in effect, seemed to share this view in her evidence, commenting that the multi-agency response to the Hotel Quarantine Program meant there were 'too many cooks spoiling the broth'; that DHHS lacked the contractual levers with either the hotels or security contractors, which was a significant weakness in how the Hotel Quarantine Program had been structured. She provided support for the transition of the Hotel Quarantine Program to a single agency (DJCS) that would be responsible for running all aspects of the Program.[73]

47. Mr Eccles, when asked whether the pivot suggested that the Program should not have been placed with DHHS under the emergency framework, resisted that suggestion. His answer particularly related to workforce issues.

> I don't think it's as simple as saying everything would have been … everything would have been better if originally Corrections [Victoria] had been responsible for the program. I mean, it emerged over time what the particular complexities were with the cohorts of people who were being detained and the supervisory arrangements, and I think the skill set of Corrections Victoria staff, it became apparent that private security was facing particular challenges, the sort of skill set that Corrections Victoria staff have in managing complex individuals with vulnerabilities, their ability to de-escalate particular situations, which is a feature of the hotel quarantine experience, so it's less about Corrections Victoria per se and more about the skill set of the workforce that is fit for a contemporary purpose. I wouldn't want to go back and use that as the basis for saying that there was an error in the original … the original arrangement.[74]

48. Inconsistent with this answer was the fact that Corrections Victoria recruited significant numbers of new staff for the Hotel Quarantine Program rather than using existing workers.[75] As of 9 July 2020, only 100 of the estimated 1,000 workers needed had come from inside Corrections Victoria, with recruitment from furloughed airline workers and other COVID-affected workforces also in train.[76] This suggested that it was not, in fact, a specific Corrections Victoria skill set that was required.

49. The decision to replace private security guards with RSOs[77] — a change in title while leaving the duties largely unchanged — reflected the extent to which the role played by private security guards had been well outside the scope of usual static guarding.

50. As set out in Chapter 6, the role creep that occurred in the duties assigned to security guards, plus the range of other issues identified in Chapter 6, meant that the roles they ultimately performed, in the absence of a clear supervisory structure and proper training, were not suited to such personnel. It was not reasonable to assume, with the tasks they had gradually thrust upon them, that those trained as static security guards would have the skill set and training necessary to work in this complex and dangerous environment. The submissions in June and July 2020 to CCC recognised the true nature of the role and the skill set required.[78]

51. A clear conclusion to draw from the pivot is that it was designed to provide for a greater degree of direct supervision and control exercised by the responsible department (DJCS) over those working in the Program. With RSOs being government employees, and Alfred Health providing services pursuant to a contract administered by DJCS,[79] none of the issues of subcontracting or contract management by different departments would arise. The Government, through DJCS, retained direct control over service delivery and was directly accountable for the safety of those in quarantine.[80] Whereas, in the initial model, security guards, nurses and cleaners were hired by and, in the first instance, accountable to external contractors, the model after the pivot created a line of control within government; for instance, there were team leaders for all RSOs, who were, themselves, government employees, rather than team leaders being security contractors or subcontractors.

52. The anticipated and actual involvement of unions in the planning of the new model — there were multiple references in the CCC submissions to the importance of consultation with the CPSU, the Transport Workers Union and the Police Association[81] — 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.[82] Rather than contracting out responsibility for training and PPE, the Government retained that responsibility. The hotel environment, after the pivot, became a safer workplace for those working in it, and this was, in part, attributable to the higher expectations — enforced where appropriate by union engagement — that government employees have of their employers.

53. The decision to place Victoria Police in a 24/7 role in the health hotels occurred in the context of the hotels housing COVID-positive people from a range of community locations, including public housing towers, which were locked down in early July 2020 as the pivot in the Hotel Quarantine Program was taking place.[83] In fact, any cohort of future returning travellers and international arrivals going into quarantine will be a diverse cohort and will, as the evidence of expert trauma psychologist, Dr Rob Gordon, suggests (see Chapter 12.2) include a substantial percentage of people with additional needs or vulnerabilities.[84] This suggests a role for Victoria Police in any future iteration of a Hotel Quarantine Program.

54. Whether enforcement in any future model is provided by police members or not, the model of operating instructions used for Victoria Police members provides a guide to the level of detail required in the operating procedures for a future enforcement workforce. That degree of detail and rigour ought to have been present in the instructions provided to private security guards. As set out in chapters 6 and 7, the Government took inadequate steps to ensure the safety of contractors working in the Hotel Quarantine Program, with heavy reliance on contractors to supervise themselves and obtain their own advice and develop their own safe systems of work. Whether a future quarantine model uses private contractors or not, there should be no departure from the principle that it is for the State to set, and to enforce, proper training and infection prevention and control measures for all those working in the system. This must be done to provide the safest system possible for workers at quarantine hotels, the people in quarantine and, thereby, the entire community.

55. The changes made to the Hotel Quarantine Program in June and July 2020 reflected deficiencies in the operating model that were apparent from much earlier than June 2020. The changes indicated that those deficiencies, once identified, were capable of being addressed.

56. DHHS had identified the need for a greater clinical focus but was slow to bring that focus to all of the hotels.[85] By late June, after the second outbreak, only one hotel — the Brady — was operating under the Alfred Health model.[86] 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.

57. In particular, the decision made by DHHS, in late June, to seek an alternative workforce to replace private security[87] 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 DHHS.

11.5 Conclusions

58. 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, leads me to conclude 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.

59. 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.

60. 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.

61. By late June, after the second outbreak, only one hotel — the Brady — was operating under the Alfred Health model. 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.

62. 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.

    A. Replacing private security guards with RSOs employed, trained and supervised by Corrections Victoria reflected and confirmed that privately contracted security guards were not the appropriate cohort to provide the roles that had expanded over time in the complex environment of the Hotel Quarantine Program.

    B. Whereas, in the initial model, security guards, nurses and cleaners were hired by and, in the first instance, accountable to external contractors, the model after the pivot created a line of control within one government department rather than a structure that conceived of each on-site contractor or agency supervising itself.

    C. The hotel environment after the pivot was a safer environment in which to work, due, in part, to greater attention to workplace safety following the engagement of a cohort with higher expectations of workplace rights and safety.

63. 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.

64. In the development of this 'health' model, there were multiple references in the CCC submissions to the importance of consultation with the CPSU, the Transport Workers Union and the Police Association. The involvement of unions and industrial advocates in the planning of the new model reflected the far greater degree of concern attached to workplace health and safety.

Endnotes

1 Exhibit HQI0177_RP Annexures to first witness statement of Mr Christopher Eccles, DPC.0012.0001.0464, DPC.0008.0001.3213.
2 Ibid DPC.0012.0001.0464.
3 Ibid.
4 Exhibit HQI0218_RP Witness statement of the Hon. Daniel Andrews MP, 1 [2], 2 [5]; Exhibit HQI0144_P First witness statement of Commissioner Andrew Crisp, 28 [63].
5 Exhibit HQI0178_RP Annexures to first witness statement of Mr Christopher Eccles, DPC.0012.0001.0835.
6 Ibid DPC.0012.0001.0837.
7 Exhibit HQI0186_RP First witness statement of Ms Kym Peake, 49 [254]; Exhibit HQI0211_P Witness statement of the Hon. Jenny Mikakos, former MP, 5 [27]; Administrative Arrangements Order (No. 236) 2020, <https://resources.reglii.com/VGG.2020.7.9.S347.pdf/>.
8 Exhibit HQI0211_P Witness statement of Hon. Jenny Mikakos, former MP, 5 [26]; Exhibit HQI0178_RP Annexures to first witness statement of Mr Christopher Eccles, DPC.0012.0001.0464.
9 Exhibit HQI0130_RP Witness Statement of Ms Pam Williams, 24 [51].
10 Exhibit HQI0099_RP Witness Statement of Ms Simone Alexander, 10–12 [41]–[50].
11 Board of Inquiry into the COVID-19 Hotel Quarantine Program (Interim Report, 6 November 2020) 13 <https://www.quarantineinquiry.vic.gov.au/reports>.
12 Exhibit HQI0099_RP Witness Statement of Ms Simone Alexander, 2 [11]–[12]; Exhibit HQI0178_RP Annexures to first witness statement of Mr Christopher Eccles, DPC.0001.0001.6545–6546.
13 Exhibit HQI0178_RP Annexures to first witness statement of Mr Christopher Eccles, DPC.0012.0001.0534.
14 Transcript of day 14 hearing 8 September 2020, 1042.
15 Exhibit HQI0211_P Witness statement of the Hon. Jenny Mikakos, former MP, 5 [25].
16 Ibid; Exhibit HQI0212_RP Annexures to the witness statement of the Hon. Jenny Mikakos, former MP, MIK.0144.0002.0001.
17 Exhibit HQI0180_RP Annexures to second witness statement of Mr Christopher Eccles, DPC.0014.0001.0004.
18 Exhibit HQI0179_RP Second witness statement of Mr Christopher Eccles, 4 [19]; Transcript of day 21 hearing 21 September 2020, 1772.
19 Exhibit HQI0180_RP Annexures to second witness statement of Mr Christopher Eccles, DPC.0014.0001.0004.
20 Ibid.
21 Transcript of day 21 hearing 21 September 2020, 1773.
22 Transcript of day 25 hearing 25 September 2020, 2150–2151.
23 Exhibit HQI0125_RP Witness statement of Ms Melissa Skilbeck, 10–11 [60]–[65].
24 Exhibit HQI0126(1)_RP Annexures to witness statement of Ms Melissa Skilbeck, DHS.0001.0001.2236.
25 Transcript of day 25 hearing 25 September 2020, 2152.
26 Exhibit HQI0180_RP Annexures to second witness statement of Mr Christopher Eccles, DPC.0018.0001.0002–0003.
27 Ibid DPC.0014.0001.0006. See also Transcript of day 21 hearing 21 September 2020, 1778.
28 Exhibit HQI0144_P First witness statement of Commissioner Andrew Crisp, 6 [12(j)].
29 Ibid 29 [69]; Transcript of day 17 hearing 15 September 2020, 1389.
30 Exhibit HQI0144_P First witness statement of Commissioner Andrew Crisp, 29 [69]–[70].
31 Exhibit HQI0142_RP Voluntary submission from the Commonwealth of Australia, HQI.0001.0002.0147–0148.
32 Exhibit HQI0148_RP Annexures to third witness statement of Commissioner Andrew Crisp, DOJ.515.001.0033–0034, DOJ.515.001.0018–0019.
33 Transcript of day 23 hearing 23 September 2020, 1958–1959.
34 Ibid 1960.
35 Exhibit HQI0144_P First witness statement of Commissioner Andrew Crisp, 29 [71].
36 Exhibit HQI0180_RP Annexures to second witness statement of Mr Christopher Eccles, DPC.0018.0001.0006.
37 Ibid DPC.0020.0001.0031–0032.
38 Ibid DPC.0020.0001.0031.
39 Ibid DPC.0020.0001.0032.
40 Exhibit HQI0178_RP Annexures to first witness statement of Mr Christopher Eccles, DPC.0012.0001.0463, DPC.0008.0001.3213.
41 Ibid DPC.0012.0001.0468–0469.
42 Ibid DPC.0012.0001.0536.
43 Ibid DPC.0001.0001.6541.

44 Ibid DPC.0012.0001.0468.
45 Ibid DPC.0012.0001.0472.
46 Ibid DPC.0012.0001.0545.
47 Ibid DPC.0012.0001.0546.
48 Ibid DPC.0012.0001.0546, DPC.0012.0001.0548.
49 Ibid DPC.0012.0001.0532.
50 Ibid DPC.0012.0001.0532; Exhibit HQI0177_RP First witness statement of Mr Christopher Eccles, 13 [51(g)].
51 Exhibit HQI0178_RP Annexures to first witness statement of Mr Christopher Eccles, DPC.0012.0001.0535.
52 Ibid DPC.0012.0001.0534.
53 Ibid DPC.0001.0001.5282.
54 Ibid DPC.0012.0001.0835; Exhibit HQI0195_RP Witness statement of the Hon. Martin Pakula MP, 5–6 [26]–[27].
55 Exhibit HQI0184_RP Witness statement of Mr Simon Phemister, 21 [101].
56 Exhibit HQI0069_RP Witness statement of Mr David Millward, 13–14 [79]; Exhibit HQI0061_RP Witness statement of Mr Gregory Watson, 25 [102]; Exhibit HQI0065_RP Witness statement of Mr Jamie Adams, 15 [109].
57 Exhibit HQI0178_RP Annexures to witness statement of Mr Christopher Eccles, DPC.0001.0001.6542.
58 'Information for overseas travellers' Coronavirus (COVID-19) Victoria (Web Page, 4 December 2020) <https://www.coronavirus.vic.gov.au/information-overseas-travellers#cap-on-international-arrivalsnbsp>.
59 Exhibit HQI0178_RP Annexures to witness statement of Mr Christopher Eccles, DPC.0012.0001.0835, DPC.0012.0001.0832; Exhibit HQI0177_RP First witness statement of Mr Christopher Eccles, 14 [51(h)].
60 Exhibit HQI0178_RP Annexures to first witness statement of Mr Christopher Eccles, DPC.0012.0001.0838.
61 Exhibit HQI0170_RP Annexures to witness statement of Chief Commissioner Shane Patton, APM VPOL.0005.0001.1276.
62 Exhibit HQI0178_RP Annexures to first witness statement of Mr Christopher Eccles, DPC.0012.0001.0842.
63 Transcript of day 19 hearing 17 September 2020, 1653–1654.
64 Ibid 1657.
65 Exhibit HQI0171_RP Victoria Police safety officer instructions.
66 Transcript of day 19 hearing 17 September 2020, 1657.
67 Transcript of day 17 hearing 15 September 2020, 1392.
68 Transcript of day 25 hearing 25 September 2020, 2165.
69 Exhibit HQI0195_RP Witness statement of the Hon. Martin Pakula MP, 5 [24].
70 Exhibit HQI0178_RP Annexures to first witness statement of Mr Christopher Eccles, DPC.0008.0001.3213, DPC.0012.0001.0463.
71 Ibid DPC.0012.0001.0835.
72 Ibid DPC.0001.0001.6538.
73 Exhibit HQI0211_P Witness statement of the Hon. Jenny Mikakos, former MP, 5 [26].
74 Transcript of day 21 hearing 21 September 2020, 1783.
75 Exhibit HQI0178_RP Annexures to First witness statement of Mr Christopher Eccles, DPC.0012.0001.0538–0539.
76 Ibid.
77 Exhibit HQI0215_RP Initial Responses of Parties, DOJ.516.001.0006–0007.
78 Exhibit HQI0178_RP Annexures to first witness statement of Mr Christopher Eccles, DPC.0008.0001.3213–3214, DPC.0001.0001.6536–6552, DPC.0012.0001.0832–0833.
79 Exhibit HQI0099_RP Witness statement of Ms Simone Alexander, 20 [72]–[73].
80 Exhibit HQI0177_RP First witness statement of Mr Christopher Eccles, 14 [51(h)].
81 Exhibit HQI0178_RP Annexures to first witness statement of Mr Christopher Eccles, DPC.0001.0001.6552, DPC.0012.0001.0854.
82 Transcript of day 26 hearing 28 September 2020, 2216.
83 Exhibit HQI0169_RP Witness statement of Chief Commissioner Shane Patton APM, 10 [4.6]; Transcript of day 19 hearing 17 September 2020, 1652–1654.
84 Exhibit HQI0176_P Witness statement of Dr Rob Gordon; Transcript of day 20 hearing 18 September 2020.
85 Transcript of day 14 hearing 8 September 2020, 1040–1041; Exhibit HQI0099_RP Witness statement of Ms Simone Alexander, 2 [12].
86 Ibid 2 [10]–[11].
87 Exhibit HQI0186_RP First witness statement of Ms Kym Peake, 49 [254], 52 [271]–[272].

CHAPTER 12

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

1. This chapter 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. It comprises two sections:

    A. **Section 12.1** — discusses the *Charter of Human Rights and Responsibilities Act 2006* (Vic) (Charter) and its application to the Hotel Quarantine Program during its establishment. It also considers whether there may be less restrictive measures to combat the threat of COVID-19 entering the community

    B. **Section 12.2** — highlights the psycho-social impacts of quarantine on returned travellers and how a future program can better support the health and wellbeing of returned travellers during their quarantine period.

12.1 The Victorian Charter of Human Rights and Responsibilities

12.1.1 The relationship between mandatory quarantine and the *Charter of Human Rights and Responsibilities Act 2006* (Vic)

2. The existence of the Charter has relevance to the Hotel Quarantine Program. It was not contentious that compelling people to undertake 14 days in a quarantine facility had obvious and significant impacts on their rights and liberties. As the Premier explicitly recognised in his 27 March 2020 media conference:

> It's a big step to take away someone's liberty — in effect to make them go to a certain place and stay there for two weeks — but this is life and death. There's too much at stake to do otherwise.[1]

3. The principle that mandatory quarantine was an acceptable public health response to a pandemic such as this was also not in dispute during the Inquiry.

4. Nor was it in dispute that the Charter was applicable to the actions of the Victorian Government, such as it related to the decision to issue the Direction and Detention Notice (Direction) mandating people into the Hotel Quarantine Program.

5. Whether there was compliance with the rights protected under the Charter was not a matter over which this Inquiry had any jurisdiction. However, given that those various government officials engaged in decision-making central to the Hotel Quarantine Program were bound to make their decisions in accordance with the Charter, it would have been unfair and artificial to ignore the considerations they were required to observe. It was for this reason that some attention was paid to the Charter.

6. The second purpose for consideration of the Charter was its contextual relevance to recommendations for the features of a future Quarantine Program as contained in the Interim Report, which I adopt in this Final Report.

12.1.2 The application of the Charter in this context

7. The Charter's main purpose is to protect and promote human rights, including by setting out rights that the Victorian Parliament specifically seeks to protect and promote,[2] and by imposing an obligation on all public authorities to act in a way that is compatible with these rights.[3]

8. It was important, therefore, to identify those rights protected by the Charter, insofar as they were particularly relevant to the Hotel Quarantine Program, before turning to how public authorities must act compatibly with them.

9. The rights protected are set out in Part 2 of the Charter. Importantly, for the Hotel Quarantine Program, those rights are not without limitation. Rights under the Charter may be limited in accordance with s. 7(2) of the Charter. That is, they may be subject, under law, only to such reasonable limits as can be demonstrably justified in a free and democratic society, based on human dignity, equality and freedom, taking into account all relevant factors.[4] Those factors include:

    A. the nature of the right

    B. the importance of the purpose of the limitation

    C. the nature and extent of the limitation

    D. the relationship between the limitation and its purpose

    E. any less restrictive means reasonably available to achieve the purpose of the limitation.[5]

12.1.3 Several relevant rights are protected by the Charter

10. In the context of a mandatory quarantine program, intended to stop the transmission of an infectious disease into the Victorian community by restricting the movement and ability of returned travellers to go about their ordinary lives, six Charter rights are particularly important. They are set out below.

A person has a right to life

11. Section 9 of the Charter provides that every person has the right to life and the right not to be arbitrarily deprived of life.[6] The Victorian Government has an obligation to give proper consideration to the right to life of all persons when making its decisions.[7] A mandatory quarantine program, designed to protect the lives of Victorians, necessitates consideration of that right.

A person has a right to liberty and security of person

12. Section 21 of the Charter provides that:

    A. every person has the right to liberty and security

    B. a person must not be subjected to arbitrary arrest or detention

    C. a person must not be deprived of his or her liberty except on grounds, and in accordance with procedures, established by law.

13. Quarantining involves a person's detention and, thus, a restriction of their liberty. A person's rights under s. 21 may be limited, but only where their detention is not arbitrary, is done in accordance with the law, and the limitation is reasonable and proportionate in all the circumstances, consistent with s. 7(2) of the Charter.

14. Section 200(6) of the *Public Health and Wellbeing Act* (Vic) (PHW Act) requires a review, every 24 hours, of the decision to detain a person to ascertain whether the continued detention is reasonably necessary. Failure to conduct such a review may render the detention unlawful for the purposes of s. 21 of the Charter.

15. The issue of *how* those reviews were conducted during the period of the Hotel Quarantine Program was the subject of some evidence before the Inquiry and the subject of some closing submissions as to whether there was or was not compliance with the Charter. DHHS, in its closing submissions, took exception to the issue being raised, but addressed it in any event.[8]

16. DHHS submitted that the reviews were based on the medical advice of the Chief Health Officer (CHO) and the Deputy Chief Health Officer (DCHO) that returned travellers should spend 14 days in quarantine on the basis of what was understood about the incubation period of the virus. Thus, the review was constituted by checking as to whether or not a returned traveller had completed his or her 14 days. DHHS provided various memoranda it had received containing legal advice on this issue that appear to support its submission and are summarised below.

17. A DHHS memorandum from Jacinda de Witts, Deputy Secretary, Legal and Executive Services Division and General Counsel to DHHS, to Dr Annaliese van Diemen, DCHO, dated 28 March 2020 (and signed by Dr Van Diemen on the same date), noted that the Legal Services Branch had assessed that the Isolation (International Arrivals) Detention Notices were compatible with the Charter.[9]

18. Part B of the same memorandum contained a section called 'Charter Assessment' and contemplated the human rights considerations in paragraphs 8–13 therein. For example, paragraph 9 told Dr van Diemen that her decision to sign the Isolation (International Arrivals) and Detention Notices would be compatible with the Charter.[10]

19. Paragraph 10 went on to identify eight rights impacted by the Detention Notices. These were:

    A. section 21 — right to liberty

    B. section 12 — freedom of movement

    C. section 14 — freedom of religion

    D. section 19 — cultural rights

    E. section 16 — freedom of peaceful assembly and association

    F. section 13 — rights to privacy, family and home

    G. section 17 — protection of families and children

    H. section 22 — right to humane treatment when deprived of liberty.[11]

20. Paragraph 12 stated that the Detention Notices were compatible with the human rights in the Charter.[12]

21. There was also Attachment D (12 pages) that detailed DHHS's assessment of human rights issues arising from the Detention Notices,[13] and Attachment C6 (14 pages), which was another memorandum of legal advice, summarising the human rights considerations related to individual Detention Notices.[14]

22. Also, in the bundle was an email from Rowena Orr QC of Counsel to Ms de Witts, dated 28 March 2020, saying that the Notice 'likely amounts to detention' and that the presence of police and military reinforced the idea that people required to stay in hotels were in some sort of 'custodial' setting.[15]

23. A further email from Sarala Fitzgerald of Counsel, dated 28 March 2020, to Ms de Witts referred to the 24-hourly review and what would be required for the purposes of s. 200(6) of the PHW Act. She suggested that, to satisfy this requirement, the authorised officer must ask themselves: 'is the continued detention of this person reasonably necessary to eliminate or reduce a serious risk to public health?' She stated that this was a simple question based on medical advice and need not be time consuming. She then suggested the review could be completed by simply appraising information on a database.[16]

24. For the reason contained in paragraph 4 above, that is, that I have no jurisdiction to rule on compliance or otherwise with respect to the Charter, I go no further on that point. I raise these matters to give an example of how DHHS gave consideration to this Charter right when making decisions as to detention.

A person deprived of liberty must be treated humanely

25. Under s. 22(1) of the Charter, all people deprived of liberty must be treated with humanity and with respect for the inherent dignity of the human person.

26. It could hardly be contentious that the Hotel Quarantine Program deprived people of their liberty. A person in quarantine should not be subject to any hardship or constraint in *addition* to that resulting from the deprivation of their liberty.[17]

27. Self-evidently, those conditions can include the nature of the accommodation itself, facilities for personal hygiene, opportunities for exercise, access to fresh air breaks and availability of medical and general health services. The conditions faced by individuals in quarantine should take into account any particular vulnerabilities of those in detention.

A person has a right to move freely

28. Section 12 of the Charter provides that every person lawfully within Victoria has the right to move freely within Victoria, and to enter and leave it, and has the freedom to choose where to live.

29. Clearly, a person's freedom of movement is restricted where they are required to quarantine within a particular hotel room. Whether or not the restriction is reasonable and proportionate so as to be justifiable under s. 7(2) of the Charter depends upon consideration of all of the circumstances.

A person has the right to freedom of conscience and religion

30. Section 14(1) of the Charter gives every person the right to freedom of thought, conscience, religion and belief, including the freedom to demonstrate his or her religion or belief in worship, observance, practice and teaching, either individually or as part of a community, in public or in private.[18]

31. Self-evidently, the ability of a person in hotel quarantine to participate in a religious life is restricted when they cannot attend face-to-face expressions of their religion. The right to observe or practice their beliefs within their rooms may also be restricted where they are not afforded the opportunity to observe customary dietary regulations.[19]

A person has rights to privacy, family and a home

32. Section 13(a) of the Charter provides that a person has the right to not have his or her privacy, family, home or correspondence unlawfully or arbitrarily interfered with. 'Privacy' is a broad term, which must relate to the autonomy and inherent dignity of the person.[20]

33. The private life of a person who is quarantined within a hotel is limited because it restricts the person's ability to go about their private lives; so, too, is their right to home limited where they are required to live in a hotel room and prevented from living in their home.[21]

34. Other Charter rights, as noted in the summary extract of advices to DHHS, are relevant to the Hotel Quarantine Program, such as:

    A. cultural rights under s. 19

    B. freedom of peaceful assembly and association under s. 16

    C. protection of families and children under s. 13

    D. protection from treatment or punishment in a cruel, inhuman or degrading way under s. 10(b).

12.1.4 Public officials are required to act and make decisions that are compatible with human rights

35. Each public official, including the DCHO, relevant departmental employees and Authorised Officers, is subject to the obligations imposed on public authorities by the Charter.[22]

36. Section 38(1) of the Charter states that it is unlawful for a public authority to act in a way that is incompatible with a human right or, in making a decision, to fail to give proper consideration to a relevant human right. This obligation is not limited to individual decisions relating to individual people; it extends to policy or program design where there is a potential impact on the Charter rights of a class of people.[23]

Are there less restrictive means to achieve the purpose of quarantine?

37. The need for public health measures, including quarantining, to limit the spread of the virus that affected the rights of all Victorians, was not in question before the Inquiry. Compulsory quarantining of people impacts Charter rights. What the Charter requires, among other considerations, is that the limit on rights is reasonable and proportionate. Of critical importance to the proportionality test is the existence of 'any less restrictive means reasonably available to achieve the purpose that the limitation seeks to achieve' at s. 7(2)(e) of the Charter.

38. I accept the evidence of the DCHO that, in contemplating whether the detention orders would be compatible with human rights under the Charter, she considered a number of factors relevant to the purpose of the quarantine program including, by way of summary:

    A. The exceptional circumstances in which the Direction was proposed to be made. That is, there was a continued widespread international outbreak of a viral pandemic for which there was no current vaccine or cure.[24]

    B. The Direction purported to minimise community exposure to COVID-19 and prevent or, at the very least, reduce the risk of the Victorian health system becoming overwhelmed with COVID-19 cases.[25]

    C. It was considered that, on the available medical evidence, it was the 'least restrictive means reasonably available to stem the spread of [COVID-19], particularly since less restrictive measures for international arrivals failing to self-isolate in their homes for 14 days — in clear defiance of previous directions — had caused the further spread of the virus'.[26]

39. Two observations may be made from the decision to give the Direction:

    A. The purpose of the limitation on people's rights (that is, to stop transmission of COVID-19 to the community) and the nature of the rights under the Charter were considered in general terms and without specific consideration to individual needs or circumstances, including health and wellbeing needs. It was understood that this was because the decision was made with respect to a cohort and the threat that was being posed to the rights of all the people of Victoria.

    B. It was understood, on the evidence, that it was not possible or practical, in the circumstances of the initial onslaught of hundreds of people arriving in planes and, potentially, threatening a major spread of the virus, to give proper and individual consideration to less restrictive measures for individual travellers at that time.

Concern about non-compliance with self-isolation directions

40. As I set out in the Interim Report, in particular at Sections 2.7 and 2.8, a key consideration in the decision to direct mandatory hotel quarantining was concern about the levels of non-compliance with the self-isolation orders under the Non-Essential Mass Gatherings and Self-Quarantine following Overseas Travel Directions[27] but, more significantly, those of the Airport Arrivals Direction of 18 March 2020.[28]

41. For clarity, references to 'self-isolation orders', 'home-detention' and 'home quarantine requirements' in this section are used to mean those orders and directions that were issued to returned travellers to isolate at home, as distinct from orders and directions that were applicable to other cohorts of the Victorian community; for example, those required to self-isolate at home due to testing positive for COVID-19 or for being a close contact of a positive case or awaiting the outcome of test results.

42. The Inquiry heard evidence about instances of non-compliance with such orders and directions,[29] but there was no empirical data provided as to the scale of non-compliance. Instead, evidence was provided regarding a lack of confidence in the compliance of returned travellers isolating at home,[30] being that they not only 'stay in their own home, but (that) others do not come within 1.5m of them, and actually further isolated'.[31] This lack of confidence was based on 'a significant amount of public commentary concerning the non-compliance of self-isolation [and] the observation by other jurisdictions and the discussion around AHPPC of significant non-compliance in their own jurisdictions'.[32] Dr van Diemen outlined that 'we had a reasonable amount of evidence, albeit over a short period of time, that people were not adhering to the home quarantine requirements as strictly as we needed them to do'.[33]

43. This evidence led to a view, understandably held by Dr van Diemen at the time she formed her opinion, that returned travellers were not complying with self-isolation orders.[34]

44. Dr van Diemen gave evidence that she had given thought to issuing individualised notices detaining people in their own homes under the threat of a $20,000 fine.[35] However, it appears that this option was not pursued because there was a close to (if not equal) fine associated with existing orders, which did not appear to have deterred a number of people from breaching the order[36] and Dr van Diemen had already formed the view, at that particular time, that she agreed with the requirement for hotel quarantine as opposed to home-based quarantine.[37] Dr van Diemen understood there were a number of people not complying with home-detention, based on intelligence gained through contact tracing.[38]

45. As noted in the Interim Report (at page 74) the former Chief Commissioner of Police, Graham Ashton, gave evidence about Victoria Police's reports of returned travellers' non-compliance with home-quarantine orders. He said:

> … there were regular occasions when people were found not to be home when they were checked upon and that we then had to go through [an] exercise of locating them, working out where in fact they were when they were supposed to be at home. I should add that in many occasions people were isolating but they weren't isolating at the place where the Australian Border Force thought they were going to be, and so we had to adjust records, et cetera, and try and clean the data a lot on where people actually were. But there were levels of non-compliance as well.[39]

46. Despite those identified levels of non-compliance, Mr Ashton could not recall being asked for his view about the sufficiency of home quarantine as a model for dealing with people who were being required to isolate.[40]

12.1.5 Future options: home quarantine model and the Charter

47. I accept the evidence of Dr van Diemen that, in making the mandatory detention orders, she 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.

48. While it is accepted there were extraordinary pressures and concerns impacting upon the decision to impose the mandatory Hotel Quarantine Program in the circumstances of 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.

49. I adopt the recommendations made in Section 2 of the Interim Report regarding the option of a home-based quarantine model.

50. Mandatory home 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.

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

12.1.6 Recommendations

52. Recommendations 58–69 in Section 2 of the Interim Report apply to this Section. For reference, the recommendations are listed below.

Recommendations 58–69 of the Interim Report

HOME-BASED 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 DIRECTIONS 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.

12.2 Psycho-social impacts of quarantine on returned travellers

70. To confine a person within a hotel room for a period of 14 days (even with some breaks) is to significantly interfere with a person's normal life. For those who have not been subject to such quarantine, it may be difficult to imagine the impact such an experience would have on their social and private lives, as well as their physical and mental wellbeing.

71. It should not be forgotten that, while the Hotel Quarantine Program aimed to protect the Victorian community from the risk of COVID-19 virus transmission, at its heart, it involved people whose freedoms were suspended while they had no choice but to remain detained at their assigned hotels.

72. Within the context of such a large and unplanned program, it was always going to be a challenging task to meet the needs of people who had specific requirements or vulnerabilities. The standards and processes for the health and wellbeing of those detained were, therefore, matters that required a commensurate level of care and attention.

73. This section highlights how such a program might — and did — impact the wellbeing of those within it, so that potential psycho-social impacts can be considered and incorporated into any future model of mandatory hotel or facility-based quarantine.

74. More than 20,000 people went through the Hotel Quarantine Program in Victoria.[41] No doubt, the experience of returned travellers in the Hotel Quarantine Program and its impact varied greatly.

75. The Inquiry, of course, did not hear about the experience of every one of those returned travellers or, indeed, even a significant proportion of them. The Inquiry did, however, hear evidence from some returned travellers during its public hearings; moreover, it received information from people who contacted the Intake and Assessment Team to take the opportunity to speak about their experience otherwise than as formal witnesses.

76. The Inquiry heard evidence from Safer Care Victoria, the peak State authority for quality and safety improvement in healthcare.[42] Safer Care Victoria produced two reports that identified significant shortcomings in the health and welfare aspects of the Hotel Quarantine Program, and that recommended better onboarding processes to understand the needs of those undertaking quarantine.[43]

77. The Inquiry heard evidence from those working in various roles across the Program, such as Nurse Jen, who observed that returned travellers 'who had no particular health needs and who were tech-savvy did okay in quarantine'.[44] However, she thought others, particularly those with health concerns — even minor ones — had a more challenging time.[45]

78. Quiet compliance does not necessarily mean the Program did not have an impact on individuals within it. The Inquiry heard evidence on this matter, and the ways in which quarantine might have impacted on returned travellers, from experienced trauma psychologist, Dr Rob Gordon, whose evidence was not challenged.

79. Dr Gordon stated that compliance can be a reflection of our culture and of the confidence or trust most people have in the authorities. According to Dr Gordon, research demonstrates that people will often subject themselves to high levels of stress, for long periods of time, for a variety of reasons personal to them. In other words, compliance does not necessarily reflect a lack of impact on an individual.[46]

80. It was clear from some of the evidence that some returned travellers found the hotel quarantine experience stressful, given the necessary denial of the usual freedoms that returning travellers would otherwise have in their day-to-day lives. The experience of hotel quarantine had a negative emotional and psychological impact in respect of some returned travellers.

Figure 12.2.1: Quotes from returned travellers about their experience in the Hotel Quarantine Program

Returned Traveller 3: Being detained at the hotel was a degrading and dehumanising experience for me. I contacted the Inquiry to share my experience in the hope I can spare other people such needless pain and grief.

Returned Traveller 4: It was honestly the worst 2 weeks of my life!!!

Returned Traveller 5: I wasn't mentally strong enough to deal with hotel quarantine.

Returned Traveller 9: I knew it would be difficult, but I felt that we were being 'incarcerated' and we had 'no rights'.

Returned Traveller 11: I felt like a prisoner, not someone in quarantine. My experience was that hotel quarantine felt like jail: you are locked in your room 24 hours a day, I had one 10-minute fresh air session in 14 days, and I had no choice on what to eat.

Returned Traveller 12: I am now being treated by my GP for the trauma I experienced whilst away and in quarantine and am still trying to deal with the way the general community treats a person who has been COVID positive.

Source: Information provided to the Inquiry via the Intake and Assessment team between 15 July to 3 December 2020. Names of sources have been de-identified for privacy purposes.

12.2.1 A proportion of people in quarantine will be vulnerable and require particular support

81. Dr Gordon gave evidence that it was his understanding that the cohort of returned travellers entering quarantine would reflect the spectrum of people in the Victorian community.[47] From Dr Gordon's experience and research, his evidence was that the population can be split approximately 80-20 in terms of the level of underlying needs and vulnerabilities, and ability to cope in stressful situations.[48] That is, about 20 per cent of the population has various forms of needs, instabilities or personal issues that require a higher level of support than the remaining 80 per cent.[49] These include, for example, mental health problems, disabilities, social disadvantage and other problems, such as a history of loss or illness.[50] The 20 per cent will have experience accessing government services, while the remaining 80 per cent will likely have had little or no contact with support services throughout the course of their lifetime.[51]

82. In the Hotel Quarantine Program context, the cohort changed over time and became more complex, requiring a more nuanced assessment of its health and wellbeing needs.[52] Pam Williams, from the Department of Health and Human Services (DHHS), noted that those returned travellers who initially arrived were mainly business travellers or people returning from an overseas holiday.[53] As time went on, and the Commonwealth repatriated Australian citizens who may have been living overseas, the cohort changed to include 'more families with young children, people with diverse languages and cultures, and [those with] complex medical and mental health issues'.[54]

83. Ms Williams said that if the Commonwealth was more directive in dealings with airlines, it would have assisted with better planning for arrivals, the numbers of travellers and their specific needs, and, especially, the needs of families with young children.[55]

84. Kym Peake, then Secretary of DHHS, gave similar evidence in this regard. She stated that there was little advance notice of the needs of returning travellers or even demographics; flight manifests often did not list children under two years of age and there was little information on unaccompanied minors.[56]

Figure 12.2.2: Narrative from Returned Traveller 5

I needed to get to Australia for family support after leaving my relationship overseas due to family violence.

I had given birth to my daughter two weeks earlier via c-section and was still in severe pain. I was in a wheelchair and carrying a mobility crutch, still recovering. I travelled with my newborn, toddler son as well as my mother.

I was very distressed when I arrived at the airport. I was crying and pleading with the Department of Health and Human Services (DHHS) staff to not make me go into quarantine. I had too many physical problems and mental scarring.

I was told to go to the hotel and just get through the first night, and that an exemption would be processed the next day for me and my family to complete quarantine at home.

On the first night, I called the coronavirus hotline as I had no nappies. The operator advised me to make a Woolworths order which would take 3–4 days to arrive. In the end the nurses got nappies for me, as I needed them urgently. I had come with nothing — I left my whole life in less than a week. The nurses also got me maternity pads and toys for my son.

By 4pm on day two, I had not heard anything. I soon realised no one had started the exemption process for me.

The next day, DHHS told me an exemption had been granted for me to quarantine in a 'Mother Baby Unit'. I contacted this unit and they told me they'd never heard of me and explained they were not able to accommodate a person requiring quarantine. Based on this, my exemption was revoked.

I struggled with this outcome. I felt suicidal. That night, the Crisis Assessment and Treatment (CAT) team had to be called to help me. They spoke to DHHS and finally, an exemption was granted for me and my family to quarantine at home.

Three nurses really helped me while I was in Quarantine, I believe they kept me alive during this time. The nurses did everything for me, the hotel staff, DHHS staff and coronavirus line didn't want to know about me. When I spoke to DHHS on the phone, I felt like a problem.

I wasn't mentally strong enough to deal with hotel quarantine. I was not in a position to be there and things needed to be done differently. After escaping family violence, I found being made to stay in one room very hard, wrong and dehumanising. I had no way to get rid of dirty nappies which piled up. I had no information provided in relation to laundry and there was no way to wash clothes.

In my opinion, the biggest gap in the quarantine program was the lack of assistance for my children. Families were being placed in unsuitable accommodation and it doesn't surprise me that children would get distressed, my son became distressed almost immediately.

He didn't understand quarantine and he'd been through so much already. I experienced a complete behavioural change with him, and he became very clingy. At least once we were at home, he could run around in the garden and have space.

I understand the need for quarantine, but the cost of this program was too high for some people. For me, the mental impacts were devastating. I had just escaped domestic violence and to be locked up again was very difficult.

Families being quarantined should be placed into serviced apartments with balconies, this would be more appropriate.

Source: Information provided to the Inquiry via the Intake and Assessment team between 15 July to 3 December 2020. Names of sources have been de-identified for privacy purposes.

85. Despite the increase in the Commonwealth's efforts at repatriation, Ms Williams observed there should have been better management of the numbers and the arrival port of incoming travellers on the part of the Australian Border Force and the Commonwealth Department of Foreign Affairs and Trade.[57] Ms Williams gave evidence that those agencies could have been more directive in their dealings with airlines; to that end, she noted that, at times, the Program received flights with up to 40 per cent of arrivals being from other states, many of whom found it difficult to get to their home states and who had to undergo a second period of quarantine.[58]

86. The increasingly diverse cohort of arrivals with varying medical needs added a further layer of complexity for the staff running the Program. A number of travellers who contacted the Inquiry said that their medical conditions were ignored or not taken seriously.

Figure 12.2.3: Narrative from Returned Traveller 6

My partner and I had returned from overseas. My partner has stage four terminal cancer, so we needed to urgently return home to Brisbane for his chemotherapy. When we arrived at the airport, I told a DHHS officer about my partner's circumstances and asked about getting an exemption from quarantine. They told me to speak to someone from the hotel. We had to wait a long time before we were allowed to get off the bus. My partner was in severe pain and the delay made it worse. We waited for the exemption but never received any response. I ended up contacting the Chief Medical Officer and Minister for Health in Queensland, and the Victorian Minister for Health. I was then told that the exemption was never lodged. Eventually an exemption application was lodged about six days later. I felt like the staff misinformed me.

Source: Information provided to the Inquiry via the Intake and Assessment team between 15 July to 3 December 2020. Names of sources have been de-identified for privacy purposes.

87. Returned Traveller 3 highlighted that dirty air in their hotel room exacerbated their chronic asthma:

> I had three asthma attacks, so had to take a lot of asthma medication. This made my heart race, and the nurses called a doctor. He suggested I needed to go to hospital for steroids. I told them that just having fresh air breaks would assist my breathing. The doctor asked four DHHS officials if I could be given fresh air breaks - they all refused.[59]

88. Meanwhile, Returned Traveller 4 experienced delays in receiving medical attention after falling sick while in quarantine:

> I woke up at 4am with excruciating stomach cramps and diarrhoea. I felt feverish and could not eat or drink. After two phone calls, a doctor came up to my room to see me around 10am, wearing goggles, gloves and a mask. He called an ambulance. Seven hours later an ambulance arrived. I was taken to the Royal Melbourne Hospital and stayed overnight. They did tests and put me on an IV drip. They discharged me the following morning and told me to eat a 'bland diet'. Back at the hotel, I told a nurse that I needed a bland diet. I felt worse the next day so spoke again to the nurse who consulted a doctor. She said my case wasn't an emergency, so wasn't much she could do.[60]

89. Nurse Jen told the Inquiry that she was gravely concerned for the physical wellbeing of one returned traveller who suffered from endometriosis and was in considerable pain. The woman treated her condition with Chinese herbs but was refused access to a kettle to boil water to prepare the medicine by DHHS.[61] Nurse Jen stated:

> I was really concerned. If I ever had a patient in my care like that in a hospital, it would definitely be a medical emergency just to get the pain under control straightaway. In this situation we unfortunately couldn't really do much.'[62]

90. Dr Gordon's evidence was that, in a normal social setting, experience shows when members of the community can meet together, the more functional members of the 80 per cent will play a supportive role towards those who are more vulnerable or struggling to cope. This usually reduces the stress experienced by those in the 20 per cent and also reduces the need for external assistance.[63] Of course, meeting together while in quarantine was not a possibility, so this type of informal support that exists in other emergency scenarios was not possible.

91. Dr Gordon stated, based on previous studies, that the only way to effectively intervene with populations carrying high levels of stress but who have not previously experienced it, is to initiate communication, drawing people into the discussion. Otherwise, those in the 80 per cent will usually not reach out until things get desperate.[64]

92. An example of this can been seen in the evidence of Sue and Ron Erasmus. Ms Erasmus was a registered nurse and Mr Erasmus the CEO of an Indian branch of an Australian business. They returned to Australia with their two children following the sudden death of Mr Erasmus's father in South Africa. Mr Erasmus found quarantine very difficult, as he was not only dealing with grief following the loss of his father, he was continuing to work in his role as CEO and was unable to exercise, which was his usual method to deal with stress. When the situation became too much, Mr Erasmus did reach out to a DHHS staff member about his difficulties and was provided with a number for bereavement counselling. It was a big step for Mr Erasmus to ask for this kind of support. Unfortunately, he stated that, when he did speak with the counsellor, it was clear that information about his personal difficulties had not been shared with her, and Mr Erasmus did not feel cared for or supported. It exacerbated the difficulties he was experiencing in quarantine.[65]

93. Returned Traveller 4 shared their quarantine experience regarding a daily 8.30am welfare call by a nurse and daily fresh air breaks.

> During one welfare check the nurse asked if I had any thoughts of self-harm. I said 'of course I do, I'm locked in a room every day. I am sick and every day has been a fight to get the medical treatment that I need. I am tired of fighting to get appropriate food for my bland diet … I just want to go home.' I got a call later saying my first 'fresh air break' was at 3.15pm. But no one called or came to collect me.[66]

94. Witness Liliana Ratcliff, who, during her own quarantine period expressed ongoing concerns to Hotel Quarantine Program staff about the mental health of returning travellers, said that she told the staff: 'If I was going to commit suicide, I would do it just after their daily call, because I would know that no one would check on me for another 24 hour'.[67]

12.2.2 Potential stressors for some people in quarantine

95. Dr Gordon identified some of the types of stressors that some people placed in quarantine were likely to experience. He described these as the 'key threats' likely to be perceived by returned travellers in the context of a hotel quarantine program: the threat of the virus itself, the threat of isolation and the threat of disruption to lifestyle.[68]

The threat of COVID-19 as a stressor

96. Dr Gordon's evidence was that the threat posed by COVID-19 itself was an abstract one for which most returned travellers would have no firsthand experience.[69] Dr Gordon said that the threat posed by the virus was likely to engender mixed responses.[70] It was possible, he said, that some returned travellers may not take the threat seriously.[71]

97. One example of the threat of the virus itself causing additional anxiety was the evidence of Ms Ratcliff, who experienced quarantine with her two children. Ms Ratcliff was a health professional and familiar with infection control in the hospital setting. She suffered from an auto-immune disease and was especially anxious about getting COVID-19.[72] Her anxiety about contracting the virus was increased because she observed lax infection prevention and control measures throughout her time in the Hotel Quarantine Program. It was Ms Ratcliff's level of understanding about infection prevention and control that increased her anxiety, because she believed the Program was not being run correctly and that those working within it were not adequately trained in infection control. She observed that 'the approach was so different to what she was used to from working in hospitals'.[73]

98. The stress that could be caused by the risk of being infected by COVID-19 were not limited to within the hotel quarantine environment. Indeed, the Inquiry heard evidence of unsafe PPE use and social-distancing practices in the process of transporting returned travellers to their quarantine hotels. Witnessing — and being required to participate in — practices that increased the risk of virus transmission, would doubtlessly have compounded returned travellers' anxiety about being exposed to the COVID-19 virus.

99. The process of transporting returned travellers to their hotels involved travellers being escorted from an area at the back of Melbourne Airport, where there were SkyBuses waiting for them.[74] Those buses were used to transport returned travellers to their hotels.

100. Kaan Ofli, returned traveller, described his experience on the bus used to transport him to his hotel. He recalled his bus as being 'quite full', with approximately 40–50 people on board.[75]

101. There was evidence given to the Inquiry that there was no social distancing observed between passengers.[76] Hugh de Kretser, a returned traveller and Executive Director of the Human Rights Law Centre who was detained with his wife and two children, observed that it was very difficult to maintain physical distancing on the bus from the airport to the hotel, creating unnecessary risks of transmission.[77] He did not remember being asked to wear a mask on the bus,[78] nor were there any instructions around maintaining distance on the bus; however, Kate Hyslop and Ricky Singh, returned travellers, recalled that they were required to wear their masks.[79]

102. Some witnesses reported that, when the bus arrived at a quarantine hotel, security guards carried returned travellers' luggage from the bus and into the hotel. Professor Lindsay Grayson, Professor of Infectious Diseases at Austin Health observed, in the context of security guards assisting in the movement of returned travellers disembarking from those buses, the risk of transmission would be restricted if those guards wore a gown, a mask, eye protection and, if they were going to handle objects that belong to the individuals, they wear gloves, because those objects may be contaminated.[80]

103. Returned Traveller 1 said, however, that they saw security guards handling luggage without wearing gloves or other PPE.[81]

104. Returned travellers were, from the moment they arrived in Victoria, subject to the Hotel Quarantine Program. In chapters 6 and 7 I set out, in detail, why and how the Government was responsible for infection prevention and control measures in the Program. The evidence of Prof. Grayson shows that infection prevention and control measures were necessary to be taken well before returned travellers entered their hotels.

105. Transporting large numbers of potentially infected returned travellers, on buses designed to carry passengers sitting or standing in close proximity to one another, necessarily creates a risk of infection transmission. That is particularly so given what we know about how the COVID-19 virus is transmitted, including by way of surface contamination.

106. It is imperative that proper infection prevention and control measures are adopted on those buses (and also after passengers have alighted) so as to minimise the risk of infection transmission.

107. The conclusions as to what are proper infection prevention and control measures set out in this Final Report — and also in the Interim Report — apply with equal force to transit arrangements. That includes, as a minimum, a need to enforce social distancing, implement cleaning and PPE practices, and reduce the potential for those involved in transporting returned travellers to be exposed to other members of the public.

108. Moreover, where proper infection prevention and control measures are implemented in the transit process — and are also seen to be implemented — it would go a significant way to reducing anxiety that returned passengers may feel about being exposed to the risk of COVID-19 infection.

Isolation as a stressor, and the need for human connection

109. The second threat identified by Dr Gordon was that posed by the isolation of hotel quarantine.[82] Any effective quarantine program necessitates a loss (albeit temporary) of the ordinary and spontaneous social interactions inherent in everyday life. Dr Gordon stated that, in the absence of these interactions and the feedback about one's self that is routinely provided, the hotel quarantine experience had the potential to undermine an individual's internal sense of identity.[83] He explained this would not apply to everyone. Those people who had a strong, stable sense of their own personal identity would be able to manage without constant social feedback. However, individuals who needed that constant feedback to maintain their identity would find its sudden removal disorientating and stressful.[84]

110. Returned Traveller 11 described their experience of isolation in quarantine:

> It is not as easy to sit in a room by yourself, as people think. Being locked up is definitely bad for mental health, but what makes it way worse is the way the system and the staff who run the system treat you — in my 15 interactions with different people, why did only a few people ever follow up? Why couldn't a friend drop something off, yet a taxi was able to?[85]

111. Another returned traveller highlighted that the mental health needs of those in quarantine needed to be better considered:

> The government should have been much more proactive in how they handle the mental health needs of quarantined travellers. It's definitely no picnic or luxury holiday, and for those with existing mental health issues, it can be too much to bear. A more proactive attitude is especially important for men, who are unlikely to reach out for help whilst in distress and much more likely to harm others or themselves. If it were up to me, I'd make it policy that all quarantined travellers receive daily mental health check-ups and daily access to fresh air as a matter of right.[86]

112. In contrast, Returned Traveller 10 shared that they found their quarantine experience more pleasant:

> I coped quite well with the 14 days and felt that the program was run well. I passed the time by discovering WhatsApp, and spending time on my tablet. I was allowed to receive a care package during my detention, which helped. I had friends call me, and I had a lovely view so I could watch the ships come and go and see the traffic on Kings Way.[87]

113. Of the experiences described by returned travellers who contacted the Inquiry, the description of a positive quarantine experience was limited to a small minority. Many returned travellers described feeling isolated, unsupported and punished. I accept that the motivation to contact the Inquiry to report negative experiences may have been a driver, at least in part, for this result. This does not detract from the importance of the information provided, though, in terms of its relevance to improvements to future quarantine programs.

114. One of the nurses working in the Program, Michael Tait, identified the loneliness experienced by some. Mr Tait observed that many people became depressed because they were lonely, in particular the elderly guests, as they were not comfortable using technology to stay connected. As he observed: 'you could tell they were struggling as they just needed some human connection'.[88]

Disruption of lifestyle as a stressor

115. Dr Gordon identified a third threat posed by hotel quarantine; namely, the disruption of lifestyle.[89] He explained that, while regular routines and habits are often taken for granted, disruption to this stable fabric in the context of hotel quarantine can result in an eruption of anxiety and unstable emotional responses.[90] He explained that this disruption of routine is common in disasters and has a destructive influence itself. Because people often do not recognise the importance of routines, or that they even have a routine, losing that stability can lead to a loss of resilience, self-management and understanding.[91]

116. Dr Gordon stated that it is important to bring this loss of routine to the attention of those in quarantine, as they often do not realise that is what they are experiencing. This would enable the returned traveller to identify what was important to them, and to build a routine for themselves for the 14 days of isolation.[92]

117. In addition to the specific potential threats of hotel quarantine, Dr Gordon described the most common effect of a high-stress situation was an increasingly self-centred focus; that is, one's focus becomes solely on the stressor. He described this as an 'adaptive reorganisation to maximise resources' with the result that attention to contextual factors and systems was compromised.[93] What compounds this problem, in the quarantine scenario, is the link between this self-focus and the strong desire for reunification with loved ones.[94]

118. As Dr Gordon described it '... this really is a consequence of the fact that our attachments with our most important people are the fundamental cornerstones of our personality and the most highly-valued aspects of our experience and the very basis for security, comfort and everything we need to counteract the stress'.[95] Accordingly, the separation from loved ones during the quarantine period would, itself, be an added stressor for returned travellers.[96]

119. The Inquiry heard from some returned travellers who shared that they desperately needed contact with their loved ones because they were experiencing grief.

Figure 12.2.4: Narrative from Returned Traveller 3

I am an Australian citizen. I came back to Australia because my father was gravely ill. I was desperate to get home to my family.

I took a COVID-19 test before I left to ensure I wasn't positive. I got a flight to Adelaide and applied for an exemption from quarantine. I wanted to travel on to Melbourne to be close to the hospital and my family. I would never have sought an exemption if I had been COVID positive. In transit I heard from DHHS that my exemption was refused, but it might be possible to quarantine in Melbourne. I had a second COVID-19 test when I arrived in Adelaide, which was also negative.

The officials in SA were understanding of my situation. They supported my request to complete quarantine in Melbourne, liaised with DHHS and told me to book a flight. I was later told DHHS considered that my father's condition was not serious enough to warrant me coming to Melbourne. I was told to cancel my flight.

Not long after this my brother called me to say Dad was not going to make it, and could I come to Melbourne sooner. I was then granted the right to transfer and finish my quarantine in Melbourne.

Sadly, this was too late for me. My father passed away the night before I was allowed to return to Melbourne. I had to watch my father take his last breath over messenger video, while I was alone and distressed in a quarantine hotel in Adelaide.

I feel it was unnecessarily cruel that DHHS did not let me return to Melbourne sooner, and give me the chance to see my Dad one last time.

I was grieving and then I faced further difficulties in my remaining days of quarantine.

Source: Information provided to the Inquiry via the Intake and Assessment team between 15 July to 3 December 2020. Names of sources have been de-identified for privacy purposes.

120. Having identified the potential threats that may be perceived by those in a hotel quarantine scenario, Dr Gordon was able to provide suggestions to assist in the design of a hotel quarantine program that seeks to counteract those potential stressors. In summary, his advice about the fundamental thing to get right is **communication**.[97]

12.2.3 Clear, consistent and accurate information needed

121. A key theme that emerged from the evidence of returned travellers who gave evidence or provided information to the Inquiry was a perceived failure by the authorities to provide clear, consistent and accurate information regarding the operation of the Program, and a lack of clear points of escalation to raise issues or concerns. Returning travellers who gave evidence or contacted the Inquiry variously described receiving information at intake that was inaccurate, requesting and being denied access to relevant policy documents, and information changing without clear explanation.

122. Some returned travellers identified this lack of clear, consistent and accurate messaging as having contributed to feelings of uncertainty, unpredictability and stress.

> We had both tested positive to the virus, but it was not explained to us exactly what this meant, and what would happen next. The whole quarantine situation was extremely stressful for us — separated from our family, and also especially hard due to my father passing away. No one listened to our concerns at the time.[98]

123. Others felt that the language used in documents and the attitude of some staff was cruel and punitive, as highlighted in Figure 12.2.5 below.

Figure 12.2.5: Quotes from returned travellers about use of language in the Hotel Quarantine Program

Returned Traveller 3: I had my birthday during this time and friends and family dropped off gifts and care packages for me. I was required to sign a 'consent for inspection' form. This was harshly worded and written with a tone of intimidation. I was told in a sarcastic and authoritarian tone by a DHHS official that if I didn't sign the form, I would not get my birthday presents. I felt like I was being punished.

Returned Traveller 12: Even the wording of the Detention Notice was harsh. There seemed to be no thought given to the possibility that some of us are already in a fragile state of mind when we land … I felt like I was being punished for going overseas for a trip of a lifetime.

Source: Information provided to the Inquiry via the Intake and Assessment team between 15 July to 3 December 2020. Names of sources have been de-identified for privacy purposes.

124. The evidence of Dr Gordon assists in analysing and explaining why some returned travellers found the experience of hotel quarantine stressful and difficult. Dr Gordon identified the types of threats that may be experienced by those in hotel quarantine and potential strategies to overcome those threats.

125. Dr Gordon identified the ability to recruit people's confidence and trust as essential to the management of the hotel quarantine scenario. Trust and confidence lead to acceptance and an understanding that what people are being asked to do is necessary, thus leading to cooperation.[99] Dr Gordon explained that the ability to maintain security, trust and confidence of returned travellers will counteract, to some extent, the anxiety, stress and perceived threat they may experience while in quarantine.

126. Some of the returned travellers who contacted the Inquiry described that it was very difficult to get responses from staff and they had to have many conversations, raising the same concerns, before their issues were resolved.

Figure 12.2.6: Quotes from returned travellers regarding issues with communication and processes

Returned Traveller 7: My experience over the two weeks of quarantine was that it seemed like no one knew what was going on. I don't think that the staff knew who was in our room - at least twice during my stay, I got calls from staff asking to speak to my two-year-old daughter. I said, 'I'm happy to give her the phone, but she's 2 years old.'

Returned Traveller 11: I repeatedly asked for drinks to be delivered to my room, but they never got delivered. Staff would promise to follow things up and get back to me, but they only got back to me about 20 per cent of the time.

Returned Traveller 12: There was no clear process, the left and right hand didn't know what they were doing, the incompetence was absurd.

Source: Information provided to the Inquiry via the Intake and Assessment team between 15 July to 3 December 2020. Names of sources have been de-identified for privacy purposes.

127. Indeed, Ms Ratcliff repeatedly raised concerns about infection control at the Stamford Plaza Hotel. As well as using the daily calls from nurses as a means of raising a range of concerns, she also made a complaint to DHHS by email. Ms Ratcliff received an automated reply from DHHS's 'Feedback Management System' on 18 May 2020 but, as at the time of giving evidence to this Inquiry, Ms Ratcliff still had not received a proper response from DHHS.[100]

> I felt that I was brushed off. I believe there should have been proper processes for escalating concerns and complaints.[101]

128. Luke Ashford, who was an Authorised Officer in the Program, stated that '[t]here was no formal procedure for complaints or issues to be raised'.[102]

129. Moreover, there was some evidence that DHHS held a view that the Government helpline ought not proffer advice to detainees that they reach out to parliamentary representatives to raise concerns about their treatment in hotel quarantine.

130. When she appeared before the Inquiry, Merrin Bamert, Director — Emergency Management, DHHS, confirmed that she recalled receiving email correspondence that indicated the helpline run by the Department of Jobs, Precincts and Regions (a 1800-number available to people in quarantine) was saying that people should advocate via their local Members of Parliament.[103] Ms Bamert replied, via email, saying that that was not appropriate at all.[104] Ms Bamert described what she recalled of the complaint that had given rise to the relevant email chain and to explain that it was not appropriate to tell people to ring their local Members because '[t]here should be internal mechanisms' that would allow for a more timely and appropriate response.[105]

131. Ms Bamert was correct that there should be internal mechanisms to enable a timely and proper response to issues and concerns raised by people being held in quarantine. However, internal mechanisms for responding to health and welfare needs and external avenues for escalating concerns are not mutually exclusive.

132. In fact, external oversight (whether by the Ombudsman or by a local Member of Parliament) should operate to strengthen internal processes. The option of complaining to a local Member provides an avenue for people in quarantine to escalate concerns in the event that internal processes are inadequate, either broadly or in a specific respect. Noting the inherent vulnerability of people in mandatory quarantine, it is not 'inappropriate' for people in quarantine to be informed of the full range of options available to them if they have concerns or issues for which they believe they are not getting an adequate response.

133. Dr Gordon stressed that the quarantine program needed to be communicated as being protective against the threat of COVID-19, so that the isolation and disruption is more readily accepted.[106] Returned travellers need to be active participants in discussions and have the opportunity to ask questions.[107] Authorities need to provide clear, repeated information about the situation,[108] as well as channels through which to communicate.[109] As part of this process, the relevant authorities should provide advice on issues returned travellers are likely to experience.[110] Having an understanding about what to expect can greatly lessen the stress of unfamiliarity.

134. Dr Gordon emphasised the importance, in particular, of repetition of information and ensuring the authorities, to the best of their ability, provide consistent information. As Dr Gordon put it:

> I think a very demoralising feature for people who are in any kind of disaster or trauma situation is losing confidence in the clarity and consistency of the authorities, because they are very, very dependent on them, and if they can't feel confident in them, then you see this massive escalation in their level of anxiety. So therefore we come to the notion of regularly repeating all the basic information in varying forms and in varying modalities, speech, written information, stuff on the internet, television, whatever, and just having this circulating through. It's better to bore them than for them to go into this state where they just don't know what's going on.
>
> … With the best intentions, any inconsistency, contradictions or serious failure of coordination has a very profound effect on the confidence and security and therefore the anxiety management of the people concerned. So, I'd say that that would be a really important point to be monitoring and watching. Again, it's about the social psychology of the information management.[111]

135. The evidence of some of the returned travellers who experienced difficulties in the Hotel Quarantine Program demonstrated how communication was vital to ensure trust and confidence in the system. For example, Ms and Mr Erasmus had already been subject to a harsh lockdown in South Africa prior to being able to arrange a mercy flight back into the country, which was a difficult prospect at that time. Due to their challenging personal circumstances, they communicated with the authorities, in advance, to make them aware of some of the issues they were experiencing.[112]

136. However, while they were in quarantine, it became clear that the information was not being shared.[113] This led to the family having to, repeatedly, explain their difficult circumstances, causing re-traumatisation. As they observed: 'Communication was appalling and inconsistent and added to the overall stress … at what was already a difficult time for our family … it really was made so much harder by how disorganised and disjointed the while [sic] process was'.[114]

137. Mr de Kretser, who was detained with his wife and two children, gave evidence about the inconsistency of information being provided to him and his family. Mr de Kretser was aware of the procedure under the PHW Act that required a daily review of each person detained. He asked three different people from DHHS whether his family's detention was being reviewed daily. As he observed: 'One officer seemed surprised by the question and told me we were being detained for 14 days. Another told me that the nurses do the review (presumably referring to the daily nurse welfare check) and another told me that the detention "wasn't really reviewed"'.[115]

Fresh air breaks

138. The importance of fresh air breaks for health and wellbeing is addressed in the Interim Report at page 49, as follows:

> Fresh air breaks are necessary and will need to be factored into not only the layout of the facility, but also a robust and appropriately developed process for safely facilitating such breaks. The process should include clear instructions to facility personnel as to how these breaks are to be safely conducted, together with good communication with people in quarantine as to what they can expect, and what they are required to do and not do during such breaks.[116]

139. In this context, the Interim Report also addressed the need for the facility to be one that can provide a physical environment that facilitates safe access to fresh air and exercise.

140. In relation to information about 'fresh air breaks', availability of fresh air breaks and the impact of not having access to fresh air and exercise breaks for 14 days, the evidence and information obtained by the Inquiry set out in this section speaks to those issues.

141. Mr de Kretser described the information he was provided with to be inconsistent and his family was not given a break from their room until their second last day in quarantine.[117] In fact, when he sought a copy of the policy governing fresh air breaks, Mr de Kretser faced a number of, what he described as, evasive responses from DHHS personnel until eventually he was told to make a Freedom of Information request.[118] Irrespective of the unsatisfactory state of the evidence as to what policies applied at what time, there was at least some form of a fresh air policy in existence when Mr de Kretser asked for it.

142. Ms Hyslop and Mr Singh, who were quarantined in mid-April 2020, received documents upon arrival into Australia, including a letter stating that they were not to leave their rooms.[119] They never left their room and were not told they were allowed fresh air breaks.[120]

143. Ms Ratcliff shared that she and her children had one fresh air break, and chose to not have more, as the fresh air break caused them stress. 'My kids and I only had one walk while in quarantine, despite being offered more fresh air breaks. After the first walk I did not want to go outside again, as I did not feel that safe practices were being observed and the children felt it made them stressed, being watched by four strange men.'[121]

Figure 12.2.7: Narrative from Returned Traveller 4

I got a call … saying my first 'fresh air break' was at 3.15pm . But no one called or came to collect me. At 3.30pm I called hotel staff. I was frustrated. They booked me another fresh air walk for 7.15pm that night, which went ahead. The walk, and the opportunity to talk with the security guards during the walk, made me feel a lot happier … I became friends with one security guard who treated me kindly. He and two other security guards I also became friends with arranged extra fresh air breaks for me and escorted me on those breaks. I had a factsheet that said that fresh air breaks are 'weekly'. But because of those three security guards, I usually got two to four fresh air breaks every day. I felt like no one else showed me kindness, except the security guards.

Source: Information provided to the Inquiry via the Intake and Assessment team between 15 July to 3 December 2020. Names of sources have been de-identified for privacy purposes.

Inconsistent information: multiple data sets

144. Mr Tait described inconsistency in DHHS policy with advice constantly changing, often quickly and without explanation. He learned, as a result, not to make any promises to the returned travellers.[122]

145. Mr de Kretser witnessed DHHS staff changing constantly and inconsistent information about policies being given to those staying in the hotel as a result.[123] This experience of staff changing everyday was also observed by Ms and Mr Erasmus, again leading to inconsistent and difficult communication while in quarantine.[124]

146. With better data collection and management systems in place, returned travellers' experiences could have been improved in this regard. Both Ms Bamert and Ms Williams identified that data collection and management were areas requiring improvement.[125] Ms Williams gave evidence that multiple data sets were not adequately harmonised, improvements were slow due to pressures on staff and skill shortages, and that there was the need to develop a tailored technological solution across the whole operation.[126] Ms Bamert similarly recognised the need for improved efficiency in the development and uptake of IT systems, data collection and reporting.[127]

Building trust and acceptance through clear communication

147. Dr Gordon emphasised in his evidence that the key to maintaining management of the quarantine program was fundamentally an exercise in social psychology; that is, recruiting the confidence and trust of those in the system.[128] Dr Gordon explained, as set out above, that returned travellers in hotel quarantine could be expected to perceive three key threats: the threat posed by illness in contracting COVID-19, the threat posed by isolation and the threat posed by disruption of lifestyle.[129] 'Where quarantine is felt as threatening and causes a state of high arousal, the best way to reduce the stress caused by the combination of these three threats is to hold on to the illness as the major threat, and to view the other problems as safety procedures designed to protect from the threat, rather than impositions which are felt as threats in themselves'.[130] Communicating this effectively will motivate adherence and build trust that the measures are necessary.[131] It is much easier to accept personal difficulty and sacrifice if one understands why it is necessary.

148. This ability to build trust and acceptance with returned travellers was compromised due to the difficulty in accessing helpful information; as much can be found from the evidence outlined above. Moreover, Mr de Kretser said that, when planning for his family to return to Australia in May 2020, he found the available information from the Government about hotel quarantine was very poor. He largely relied upon information from Facebook groups set up by returned travellers already in quarantine.[132]

149. Ms Hyslop and Mr Singh shared a similar experience. They conducted research into what to expect of the quarantine program prior to returning to Australia but did not understand how it operated.[133] They agreed that Facebook became a key source of information because they found it was hard to get information from staff.[134]

150. Dr Gordon stressed the importance of the supportive way in which returned travellers need to be communicated with. He explained that 'supportive' in this context means communicating in a way that demonstrates understanding. It is a qualitative feature of communication, not an outcome-based one;[135] in other words, even if a request cannot be met, the person will still feel supported and understand why something cannot be done in the circumstances.

151. Dr Gordon described what it means to create a 'supportive environment':

> Support is a quality of interpersonal contact. It is [a] qualitative not quantitative characteristic of communication. A person will feel supported if they know who to contact with their concerns and if they get timely and consistent responses. Support is created when the person needing support gets a clear understanding that the person they are talking to understands their experience, even if they cannot do anything to change the situation.[136]

152. Ms Ratcliff spoke of the kindness of the nurses toward her children,[137] which she noted was appreciated at the time and made her feel that the staff were trying to address some of her family's needs.

153. Returned Traveller 5 shared that they felt particularly supported by the nurses:

> Three nurses really helped me while I was in Quarantine, I believe they kept me alive during this time. The nurses did everything for me; the hotel staff, DHHS staff and coronavirus line didn't want to know about me. When I spoke to DHHS on the phone, I felt like a problem.[138]

154. Some returned travellers felt unsupported during their stay in hotel quarantine, leading to additional stress and anxiety. For example, a witness, identified as Returned Traveller 1 was in quarantine with his wife, who was 28 weeks pregnant, as well as two young children, aged two and three. Returned Traveller 1 told the Inquiry about shortcomings in communication, including being given inconsistent information and instructions, and being treated in a way that he felt was unsupportive:

> We were often told by people from the Department that 'you knew what you were getting into'. We were told words to the effect that 'you knew we were being locked in and wouldn't get certain things, like walks every day' and 'no one promised you walks'. Hotel quarantine staff were not always understanding and at times my wife was told words to the effect that 'you're not the first pregnant woman to come here'.[139]

155. Dr Gordon stated that '[o]pportunities for regular, caring, informal unsolicited communication supports a person's sense of identity, as well as providing emotional support and confidence'.[140] He suggested that one way of achieving this is through a daily check-in: 'this should be a genuine chat in which being a human being is the focus rather than just checking for symptoms or needs'.[141]

Creating a sense of community

156. Finally, Dr Gordon identified that creating a sense of community among those in hotel quarantine could assist in bringing down a sense of stress or arousal. As he observed:

> … one of the greatest assets to the containment and processing and therefore bringing arousal down of the situation is to help the whole group that's affected communicate together … that creates a sense of common identity, which counteracts the sense of isolation, which is one of the most damaging factors in the quarantine situation.[142]

157. Communication between those in quarantine should be facilitated in a constructive way,[143] such as through moderated discussion groups.[144] While some returned travellers formed their own groups via social media, Dr Gordon was of the view that it would be more effective to integrate these discussions into the government communication process.[145]

158. Dr Gordon explained the benefits of a sense of community solidarity and support being fostered among the people in quarantine:

> Creating a sense of community solidarity and support amongst quarantined people would give the 80% of the quarantine population who are more resilient opportunities to support and reassure the 20% who are more likely to be struggling with the situation. The constructive effects of promoting community formation and interactions for supporting and managing distress are well understood in the emergency management context. Emergency management workers use information, humour, satire, shared experiences, problem solving and morale boosting. Communication networks encouraging them to express their fears, which helps to think about them and manage them. Being part of a group reduces the sense of solitary exposure.[146]

12.2.4 Safer Care Victoria reports

159. Two Safer Care Victoria reports[147] identified shortcomings in the health and welfare aspects of the Hotel Quarantine Program.

160. Findings in the reports included that there were insufficient staff to conduct the required welfare checks, and that welfare checks were delayed or infrequent.[148]

161. The reports were undertaken at the request of the Secretary of DHHS following two critical incidents that occurred in early April 2020 and which uncovered significant risks to the health and wellbeing of detainees.[149]

162. The reports identified contributing factors relevant to the incidents and made a number of findings that revealed, first, a lack of safe processes in the Program and, second, that extraordinary demands were being placed on all Operation Soteria staff, who were significantly under-resourced for the task.[150]

163. These reports were requested to identify and address any ongoing risks to those who were being detained in hotel quarantine.[151]

164. This was what was found:

KEY FINDINGS AND RECOMMENDATIONS FROM THE SAFER CARE VICTORIA REPORT REGARDING INCIDENT ONE

165. Incident One occurred on 11 April 2020, when a returned traveller was found deceased in their room at the Pan Pacific Hotel, Docklands.[152] The traveller had been detained in quarantine since 3 April 2020.[153] There had not been any indications that the traveller was particularly vulnerable or under significant stress.

166. The Incident One report found that staff were often not able to access all detainee health and welfare information that they needed in order to provide adequate care to detainees, due to the lack of a comprehensive, central, accessible repository for such information,[154] and that detainee health and welfare information was collected in a fragmented manner.[155]

167. The report noted that, at the time, none of the required forms asked about mental health concerns or whether the detainee may wish to speak with someone about any issues of concern regarding their health and welfare.[156]

168. The report also found that there was a lack of specific formal policy about the threshold for escalating concerns about repeated unanswered COVID-19 assessment calls, and a lack of formal procedure for tracking these.[157] In addition, due to workload and delegation challenges, Authorised Officers were sometimes required to prioritise multiple competing demands, resulting in delays in attending to potential health and welfare concerns of returned travellers.[158]

169. The Incident One report made 13 recommendations, including:

    A. improved 'onboarding' processes

    B. daily health and welfare calls

    C. targeted risk assessments

    D. improved information in the form of a central repository

    E. clear processes for escalation of concerns

    F. rapid response surge capacity for staff, such as AOs, if they are overloaded with tasks or demands.[159]

KEY FINDINGS AND RECOMMENDATIONS FROM THE SAFER CARE VICTORIA REPORT REGARDING INCIDENT TWO

170. Incident Two involved the care of a traveller who developed COVID-19 symptoms and deteriorated rapidly, requiring an intensive care unit admission at The Alfred Hospital.[160]

171. The Incident Two report found that on-site clinicians were constrained in their ability to conduct face-to-face clinical assessments due, in part, to an insufficient supply of readily accessible and reliable PPE.[161]

172. The report also found that there was unavailable or unreliable access to clinical equipment for physical examination and clinical monitoring of returned travellers, such that clinical decision-making was being based on incomplete clinical information and assessment.[162] Further, the report found that some staff were unclear on the scope of their role, as well as the delineation of roles and responsibilities within and between teams, which affected care delivery and completion of tasks to address returned traveller health and welfare needs.[163]

173. There was also no clear agreement between the hotel quarantine system and Ambulance Victoria about managing the hospital transfer needs of returned travellers. The report found this contributed to improvised clinical decision-making by frontline staff.[164]

174. Other factors that contributed to the incident included the absence of an accessible, comprehensive, central repository for health and welfare information, and an inability to identify returned travellers with high and/or escalating health and welfare risks because of this. This resulted in the impairment of staff's ability to have good visibility, in a timely manner, of the full clinical picture of unwell returned travellers.[165]

175. Further, the in-room communication system (such as the hotel room telephone) was not able to be used by some returned travellers in order to make calls external to the hotel, and not all returned travellers had access to a functioning mobile phone.[166] The report noted that, while this may not have directly been a contributing factor to the incident, there was an opportunity to make improvements.[167]

176. The Incident Two report made 18 recommendations, including:

    A. implement measures to ensure an adequate and reliable on-site supply of PPE that is readily accessible to all staff working in the hotel quarantine system, and policies to ensure appropriate use of PPE by staff

    B. development of policies and processes to enable visual telehealth consultations

    C. a centralised information system

    D. clear role descriptions for all staff and formal communication and handover

    E. clear processes and communications regarding escalation of issues

    F. implement a formal agreement between all relevant parties in the hotel quarantine system and Ambulance Victoria regarding the ambulance service requirements of returned travellers

    G. on arrival, returned travellers should have suitable access to a functioning mobile telephone

for the duration of their mandatory detention.[168]

177. Additionally, in the Incident Two report, Safer Care Victoria identified that '[t]here was inconsistent language used to describe returned travellers in hotel quarantine (e.g. passengers, guests, detainees)' and observed that '[s]ome of the terms have connotations that could bring unconscious bias to the way they are cared for by the personnel working in the hotel quarantine environment'.[169]

178. As stated in the Interim Report, that inconsistency in language persisted throughout the Inquiry's hearings, where people in quarantine were variously referred to as 'returned travellers', 'detainees', 'guests' and 'patients'. It was admirable that the hospitality personnel of hotels consistently referred to the people in quarantine as 'guests'.[170]

179. The language used to describe the people in quarantine in a facility is important. It adds a quality to the culture of the facility that is likely to reflect behaviour. Language that is dehumanising or derogatory or invokes a sense of fault or blame in those being contained in a quarantine facility risks having a negative effect on the culture of the facility. The word 'detainee' was derived from the section of the PHW Act that provides the power to issue a Detention Direction mandating people into quarantine.[171]

180. However, inside a quarantine facility, it would be appropriate to adopt more neutral language such as 'resident' rather than 'detainee' when referring to those people compelled to stay there through no fault of their own.

181. It is not the focus of this section to consider the extent to which, and when, the Safer Care Victoria recommendations were implemented in the Hotel Quarantine Program. I am looking to what the findings and recommendations mean for a future model.

182. Suffice to say, the findings of the two Safer Care Victoria reports highlighted many areas of risk to the welfare of returned travellers in quarantine, and that safeguarding the health and wellbeing of those in quarantine proved to be far more complex than had, perhaps, first been anticipated.

183. The need to focus on health and welfare earlier and better than it was, was the subject of some evidence by Operation Soteria leaders.

12.2.5 Health and welfare were initially not the main focus of DHHS in the Program

184. Jason Helps, the State Controller — Health, gave evidence that the initial welfare arrangements that were put in place for the commencement of the Program had limited understanding of the risks or issues that may arise in the Program.[172] He said that they had no passenger health or demographic information and no experience in how people might react in a quarantine environment, other than to draw on a comparison to what people's needs were in other emergency and crisis situations.[173]

185. Ms Williams held the view that there was an assumption in the Hotel Quarantine Program that detention within the Program could be achieved without undue impact on the health and wellbeing on the detainee.[174] Ms Williams observed that the Program 'was criticised on human rights grounds' for its impact on the mental health and wellbeing of guests.[175] She said, and I agree, that DHHS should have made a more nuanced assessment of the balance between transmission risk and guest health, wellbeing and human rights.[176]

186. In any case, it was Mr Helps's evidence that, around 28 March 2020, the focus on welfare expanded from providing welfare calls to quarantined returned travellers to embedding welfare in the *Operation Soteria Operational Plan* as one of the 'highest priorities' for the Program.[177] This was an appropriate addition to the Operation Soteria plan.

12.2.6 Implications of quarantine on people's health and wellbeing

187. Returned travellers who contacted the Inquiry consistently raised concerns about the conditions of their detention, including access to fresh air, the cleanliness of the hotel rooms, difficulties with dietary requirements, concerns about being infected with the virus due to poor infection control procedures, and poor communication that resulted in confusion as to who was in charge.[178]

188. Indeed, Mr Ofli shared that he and his partner only received enough food for one person. 'It was not until later that we realised we weren't getting enough food because they didn't know I was in the room as well'.[179] He also noted that his specific dietary requirements could not be met. 'I had been eating the food we had been given previously, thinking it was Halal, because my partner had told them that I was Halal in the beginning. It was a shock for us when we realised the meat I had been eating was not Halal'.[180]

Figure 12.2.8: Quotes from returned travellers about dietary issues in quarantine

Returned Traveller 3: The food was unhealthy, and I found the majority of meals to be inedible. I spoke with a woman in charge of the quarantine meals and she encouraged me to order from the in-house menu instead. These meals were very expensive. I felt like this was exploiting a 'captive' market for the hotel to profit from. I was not very hungry anyway, as I was grieving my father.

Returned Traveller 11: When I arrived at the hotel, I hadn't had anything to eat for about 20 hours, and as the hotel wouldn't provide anything simple to eat that I could eat, I ended up not eating for 30 hours. I eventually gave up and ordered Uber Eats.

Source: Information provided to the Inquiry via the Intake and Assessment team between 15 July to 3 December 2020. Names of sources have been de-identified for privacy purposes.

Figure 12.2.9: Quotes from returned travellers about the cleanliness of hotel rooms

Returned Traveller 3: The air in the hotel room was dirty. This was a serious problem for me as I am a chronic asthmatic. I had to change rooms four times due to cigarette smoke and one room not being clean. When I reported that I could still smell that there was a smoker next door to me, I was told by staff that I was ridiculous. I don't blame people for smoking as it is a stressful experience to be quarantined, but for me, it was a health issue because of my asthma.

Returned Traveller 12: After taking 5 hours to get off plane and get to hotel the first thing I needed was to use was the amenities. To my horror when I opened the toilet lid in our room, there were faeces in the toilet and around the lid and seat was filthy. There were a lot of stains in the room also. It made me wonder if any checks had been done on the cleanliness of the rooms to see they were up to standard.

Source: Information provided to the Inquiry via the Intake and Assessment team between 15 July to 3 December 2020. Names of sources have been de-identified for privacy purposes.

189. Issues were likely exacerbated for returned travellers who required a higher level of care due to physical or mental health concerns, or who simply felt unable to cope with being detained. As one returned traveller told the Inquiry:

> Many of us returning to Australia are doing so out of necessity. We are returning to a dying relative or a death in the family. Others have lost their jobs, homes and residency rights and visas in a country they adopted as their home. Many of us are already in a fragile state of mind when we land and this harsh, corrections model is inappropriate for returning citizens who have not committed a crime other than return to their homeland in a time of crisis.[181]

12.2.7 Exemptions and temporary leave arrangements as a means to promote welfare

190. DHHS did make efforts to cater to the needs of returned travellers. In its submissions, the department gave examples of having done so,[182] such as:

    A. Dr Finn Romanes, Deputy Public Health Commander, being responsible for a *Physical Distancing Policy*, which included policies and procedures to address the health and wellbeing of people in quarantine, and included content regarding welfare checks.[183]

    B. Dr Romanes' evidence about an *Interim Healthcare and Welfare Mandatory Quarantine Plan*, which included an initial assessment of welfare, a welfare check requirement and protocols regarding smoking, fresh air breaks and exercise, nutrition and food safety, care packages and safety, and family violence risks.[184] However, Dr Romanes could not say, with certainty, whether all of the measures in that Plan were adopted by Operation Soteria.[185]

    C. Consideration of human rights, consistent with the Charter.[186]

191. Efforts were also made to provide for the health and wellbeing needs of returned travellers through the process of considering and granting exemptions from the requirement to quarantine in a hotel setting.

192. Dr van Diemen gave evidence that the detention directions applied to all returned travellers and that exceptional circumstances were required for people seeking not to be ordered into hotel quarantine.[187] Dr van Diemen and Chief Health Officer, Professor Brett Sutton, agreed with each other that exemptions should be granted in limited circumstances.[188] Exemptions from the requirement to quarantine were initially granted for the following reasons:

    A. attending a medical facility to receive medical care

    B. where it was reasonably necessary for physical or mental health

    C. on compassionate grounds

    D. in case of emergencies.[189]

193. By mid-May 2020, the categories for which exemptions could be granted by the Enforcement and Compliance Commander expanded to include:

    E. unaccompanied minors in transit to another state

    F. unaccompanied minors where a parent or guardian does not agree to come into the hotel

    G. foreign diplomats coming into the country

    H. people with a terminal illness

    I. people whose health and welfare cannot be accommodated in a hotel environment (mental health or requirements for in-facility health treatment)

    J. people who are transiting directly to another country (and who do not need to travel domestically first)

    K. air crew including medevac crew

    L. maritime workers who have come off a boat and would be leaving by boat, depending on their particular movements

    M. maritime workers who have come off a plane and would be leaving by boat within the quarantine period, depending on their particular movements.[190]

194. For those categories, exemptions could be granted (on certain conditions) for non-complex cases without the need for Dr van Diemen to approve those exemptions.

195. The *Physical Distancing Plan* in place allowed for applications for permission to leave in certain circumstances, including in 'instances where a person has a reasonably necessary requirement for physical or mental health or compassionate grounds to leave the room, as per the Detention Notice'.[191]

196. Authorised Officers were to make decisions as to exemptions and temporary leave applications. Dr van Diemen said that Authorised Officers were required to balance the needs of the person and public health risk. In this context, Dr van Diemen referred to the *Physical Distancing Plan*, which provided that:

> If the person needs immediate medical care, public health risks need to be managed appropriately, but the expectation is that the leave would automatically be granted. This would be more nuanced and complex when the request is made on compassionate grounds where there is a question about how public health risks might be managed. However, again, human rights need to be considered closely.[192]

197. DHHS said that more than 439 temporary leave permits were granted to allow people to take leave from quarantine for compassionate reasons.[193]

198. Ms Peake gave evidence that there were '440-odd exemptions that were provided to people so that they could complete their quarantine program in an alternative setting, and often that was on the basis of input of the assessment of either the mental health nurses or the CART team, that someone with complex needs, that this setting wasn't appropriate for them'.[194]

199. That this happened 'often' was not borne out by the evidence. Material from DHHS's answer to questions put to Ms Peake showed that a total of 426 individuals were granted an exemption. Of those exemptions, 269 were for travellers in transit; that was, travellers continuing to a further international or interstate destination, with only 56 granted on medical or compassionate grounds.[195] Therefore, around 13 per cent of exemptions granted were related to a person's welfare.

200. I consider that exemptions could and likely should have been granted in more situations with proper regard having been given to the welfare needs of returned travellers. That would be especially so in circumstances where it was inappropriate for a returned traveller to be confined in a hotel room because of their needs, whether they be mental health needs, physical needs or needs arising from their family situation, and in situations where the returned traveller could demonstrate that they could safely and reliably quarantine in their own home or some other suitable residential premises.

12.2.8 Conclusions

201. The health and welfare needs of people in the Hotel Quarantine Program had a very considerable impact on the manner in which the Program operated and developed.[196] 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.[197]

202. In some instances, the manner in which these needs were handled increased the risk of transmission,[198] detrimentally affected the health and wellbeing of people detained in quarantine and created considerable strain on those working in the Program.

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

204. In order to address health and wellbeing issues, the health, wellbeing and needs of those in quarantine must be a central feature of a future quarantine program.

205. In the Hotel Quarantine Program, expert advice should have been obtained in order to understand and account for the 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.

206. The fact that such advice was not obtained is likely to be attributable to several factors: 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 I have found to be a disproportionate focus by 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 in my view insufficient, attention given to the mental health and overall wellbeing of returned passengers.

207. There were areas where there were shortcomings or systemic gaps in meeting the health and human needs of those in quarantine. These can be summarised from this section as follows:

    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. that 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. that 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. that clear, consistent and accurate information was necessary but not available or it was difficult to find or it was in a language that was not accessible

F. that the system for acquiring and maintaining information on people in quarantine was inadequate

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

H. that the process of access to applications for leave and/or exemptions was not clear or consistent.

208. The difficulties this posed were then not sufficiently revisited over time. This was particularly the case in the areas 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.

209. I accept that efforts were made to keep all returning travellers safe and comfortable and to offer appropriate support to all of them. But meeting the health and wellbeing needs of a range of returned travellers is a complex and nuanced task that needs proper attention. Those responsible for the welfare of those in quarantine must be continuously mindful of performing their roles in a way that does not impose additional stressors beyond those already imposed by reason of a highly stressful and unusual situation.

12.2.9 Recommendations

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.

Recommendations 2–6, 37 and 40–57 of the Interim Report have been adopted for the purposes of this Report and apply directly to this chapter. I have set out these recommendations below.

Recommendations 2–6, 37 and 40–57 of the Interim Report

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 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.

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 I set out at paragraph 21 of Section 1 of my Interim Report).

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 and existing or preferred healthcare professionals and supports to participate in case conferencing directed to the health and wellbeing of those in quarantine facilities.

43. 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 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, concern or 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 and 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.

Endnotes

1 Exhibit HQI0210_P Transcript of Press Conference by the Hon. Daniel Andrews MP on 27 March 2020, 2.
2 *Charter of Human Rights and Responsibilities Act 2006* (Vic) (Charter) s. 1(2)(a).
3 Ibid s. 1(2)(c).
4 Ibid s. 7(2).
5 Ibid s. 7(2)(a)–(e).
6 Victorian Equal Opportunity & Human Rights Commission, 'Right to life' (Web Page) <https://www.humanrights.vic.gov.au/for-individuals/right-to-life/>; Case of Osman v The United Kingdom (1998) 29 EHRR 235, 30
7 *Charter of Human Rights and Responsibilities Act 2006* (Vic) s. 38.
8 Submission 03 Department of Health and Human Services, 66–67 [357].
9 Exhibit HQI0226_RP Bundle of notices and advices tendered by DHHS, DHS.0001.0004.1702.
10 Ibid DHS.0001.0004.1703.
11 Ibid.
12 Ibid.
13 Ibid DHS.0001.0011.0658.
14 Ibid DHS.0001.0004.1872.
15 Ibid DHS.0001.0103.0008.
16 Ibid DHS.0001.0104.0094.
17 Human Rights Committee, General Comment No.21: Article 10 (Humane Treatment of Persons Deprived of Their Liberty), 44th sess, UN Doc HRI/ GEN/1/Rev.9 (10 April 1992) 1 [3] <https://www.refworld.org/docid/453883fb11.html>.
18 Charter s. 14(1)(b).
19 Human Rights Committee, General Comment No. 22: Article 18 (Freedom of Thought, Conscience or Religion), 48th session, UN Doc CCPR/C/21/Rev.1/Add.4 (30 July 1993) 1 [4] <https://www.refworld.org/docid/453883fb22.html>.
20 *Kracke v Mental Health Review Board (General)* (2009) 29 VAR 1; [2009] VCAT 646 [619]–[620].
21 See eg *Director of Housing v Sudi* (2010) 33 VAR 139, [34].
22 See Charter s. 4 for the definition of a 'public authority' and s. 6(2)(c) with respect to the Charter applying to public authorities.
23 *Certain Children v Minister for Families and Children & Ors (No 2)* [2017] VSC 251 [190].
24 Exhibit HQI0226_RP Bundle of notices and advices tendered by DHHS, DHS.0001.0004.1873 [10].
25 Ibid [11].
26 Ibid [12].
27 See 'Direction from Chief Health Officer in accordance with emergency powers arising from declared state of emergency, Part 2 - Self-Quarantine Following Overseas Travel', Exhibit HQI0155_RP Annexures to witness statement of Prof. Brett Sutton, DHS.5000.0055.3881–3882.
28 See 'Direction from Deputy Chief Health Officer (Communicable Disease) in accordance with emergency powers arising from declared state of emergency — Airport Arrivals, (Airport Arrivals Direction) <http://www.gazette.vic.gov.au/gazette/Gazettes2020/GG2020S135.pdf#page=1>.
29 Exhibit HQI0218_P Witness statement of the Hon. Daniel Andrews MP, 5 [23].
30 Transcript of day 15 hearing 10 September 2020, 1230.
31 Ibid 1228.
32 Ibid 1230.
33 Transcript of day 18 hearing 16 September 2020, 1537.
34 Transcript of day 15 hearing 10 September, 1230–1231.
35 Transcript of day 18 hearing 16 September 2020, 1538.
36 Ibid; Transcript of day 15 hearing 10 September 1230–1231.
37 Transcript of day 18 hearing 16 September 2020, 1538; Transcript of day 15 hearing 10 September 2020, 1230–1231.
38 Transcript of day 18 hearing 16 September 2020, 1540.
39 Transcript of day 19 hearing 17 September 2020, 1681.
40 Ibid.
41 Exhibit HQI0135_RP Witness statement of Ms Merrin Bamert, 26 [92].
42 Exhibit HQI0116_RP Witness statement of Prof. Euan Wallace AM, 2 [7].
43 Exhibit HQI0117_RP Annexures to the first witness statement of Prof. Euan Wallace AM, DHS.0001.0002.0068–0076, DHS.0001.0002.0042–0053.

44 Exhibit HQI0009_RP Witness statement of 'Nurse Jen', 7 [56].
45 Ibid.
46 Transcript of day 20 hearing 18 September 2020, 1742.
47 Exhibit HQI0176_RP Witness statement of Dr Rob Gordon, 7 [28].
48 Ibid 7 [29].
49 Ibid.
50 Ibid.
51 Ibid 7 [29]–[30].
52 Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 5 [15].
53 Ibid.
54 Ibid.
55 Ibid.
56 Exhibit HQI0186_RP First witness statement of Ms Kym Peake, 37 [185].
57 Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 38 [100].
58 Ibid.
59 'Returned Traveller 3', Information provided to the Inquiry via the Intake and Assessment team between 15 July to 3 December 2020.
60 'Returned Traveller 4', Information provided to the Inquiry via the Intake and Assessment team between 15 July to 3 December 2020.
61 Exhibit HQI0009_RP Witness statement of 'Nurse Jen', 9 [76]–[77]; Transcript of day 5 hearing 20 August 2020, 144.
62 Transcript of day 5 hearing 20 August 2020, 144.
63 Exhibit HQI0176_P Witness statement of Dr Rob Gordon, 8 [31].
64 Transcript of day 20 hearing 18 September 2020, 1737.
65 Exhibit HQI0019_P Witness statement of Ms Sue and Mr Ron Erasmus, 4 [23]–[24].
66 'Returned traveller 4', Information provided to the Inquiry via the Intake and Assessment team between 15 July to 4 December 2020.
67 Exhibit HQI0020_P Witness statement of Ms Liliana Ratcliff, 8 [62].
68 Exhibit HQI0176_P Witness statement of Dr Rob Gordon, 8–9 [35].
69 Ibid 9 [36].
70 Ibid 9 [35.1]; Transcript of day 20 hearing 18 September 2020, 1731–1733.
71 Exhibit HQI0176_P Witness statement of Dr Rob Gordon, 9-10 [36]–[38].
72 Exhibit HQI0020_P Witness statement of Ms Liliana Ratcliff, 1 [3], 15 [56]–[57].
73 Ibid 11 [87].
74 Exhibit HQI0018_P Joint Witness Statement of Ms Kate Hyslop and Mr Ricky Singh, 1 [5]; Exhibit HQI0016_P Witness statement of Mr Hugh de Kretser, 4 [23]; Exhibit HQI0020_P Witness statement of Ms Liliana Ratcliff, 2 [14]–[15]; Exhibit HQI0027_P Witness statement of Mr Kaan Ofli, 1 [6].
75 Exhibit HQI0027_P Witness statement of Mr Kaan Ofli, 1 [6].
76 Exhibit HQI0018_P Joint Witness statement of Ms Kate Hyslop and Mr Ricky Singh, 1 [5].
77 Exhibit HQI0016_P Witness statement of Mr Hugh de Kretser, 4 [23].
78 Ibid.
79 Exhibit HQI0018_P Joint Witness statement of Ms Kate Hyslop and Mr Ricky Singh, 1 [5].
80 Transcript of day 3 hearing 17 August 2020, 65.
81 Transcript of day 5 hearing 20 August 2020, 162.
82 Exhibit HQI0176_P Witness statement of Dr Rob Gordon, 9 [35.2].
83 Transcript of day 20 hearing 18 September 2020, 1730.
84 Ibid; Exhibit HQI0176_P Witness statement of Dr Rob Gordon, 10 [40]–[41].
85 'Returned Traveller 11', Information provided to the Inquiry via the Intake and Assessment team between 15 July to 3 December 2020.
86 'Returned Traveller 13', Information provided to the Inquiry via the Intake and Assessment team between 15 July to 3 December 2020.
87 'Returned traveller 10', Information provided to the Inquiry via the Intake and Assessment team between 15 July to 3 December 2020.
88 Exhibit HQI0014_RP Witness statement of Mr Michael Tait, 9 [73].
89 Exhibit HQI0176_RP Witness statement of Dr Rob Gordon, 9 [35.3].
90 Transcript of day 20 hearing 18 September 2020, 1731.
91 Ibid.
92 Ibid.
93 Ibid 1725.

94 Exhibit HQI0176_P Witness statement of Dr Rob Gordon, 6 [20]–[21].
95 Transcript of day 20 hearing 18 September 2020, 1725.
96 Ibid; Exhibit HQI0176_P Witness statement of Dr Rob Gordon, 6 [21].
97 See Transcript of day 20 hearing 18 September 2020, 1741.
98 'Returned traveller 12', Information provided to the Inquiry via the Intake and Assessment team between 15 July to 3 December 2020.
99 Transcript of day 20 hearing 18 September 2020, 1726.
100 Exhibit HQI0020_P Witness statement of Ms Liliana Ratcliff, 1 [89].
101 Ibid 1 [88].
102 Exhibit HQI0023_P Witness statement of Mr Luke Ashford, 6 [38].
103 Transcript of day 16 hearing 11 September 2020, 1314.
104 Ibid.
105 Ibid 1315.
106 Exhibit HQI0176_P Witness statement of Dr Rob Gordon, 11 [45].
107 Ibid 15 [62].
108 Ibid 17 [66.1].
109 Ibid 17 [66.3].
110 Ibid 17 [66.5].
111 Transcript of day 20 hearing 18 September 2020, 1739.
112 Exhibit HQI0019_P Joint witness statement of Ms Sue and Mr Ron Erasmus, 1; Transcript of day 6 hearing 20 August 2020, 227–230.
113 Exhibit HQI0019_P Joint witness statement of Ms Sue and Mr Ron Erasmus, 3 [19]–[22].
114 Ibid 8 [46]–[47].
115 Exhibit HQI0016_P Witness statement of Mr Hugh de Kretser, 8 [53].
116 Board of Inquiry into the COVID-19 Hotel Quarantine Program (Interim Report, 6 November 2020), 49 [140].
117 Ibid.
118 Ibid 2 [10].
119 Exhibit HQI0018_P Joint witness statement of Ms Kate Hyslop and Mr Ricky Singh, 1–2 [6].
120 Ibid 2 [9].
121 Exhibit HQI0020_P Witness statement of Ms Liliana Ratcliffe, 7 [55].
122 Exhibit HQI0014_RP Witness statement of Mr Michael Tait, 7 [61].
123 Exhibit HQI0016_P Witness statement of Mr Hugh de Kretser, 2 [10].
124 Exhibit HQI0019_P Joint witness statement of Ms Sue and Mr Ron Erasmus, 4 [21]–[22].
125 Exhibit HQI0135_RP Witness statement of Ms Merrin Bamert, 23 [73]; Exhibit HQI0130_RP Witness Statement of Ms Pam Williams, 40 [107].
126 Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 40 [107].
127 Exhibit HQI0135_RP Witness statement of Ms Merrin Bamert, 23 [73].
128 Transcript of day 20 hearing 18 September 2020, 1726.
129 Exhibit HQI0176_P Witness statement of Dr Rob Gordon, 8–9 [35].
130 Ibid 11 [44].
131 Transcript of Day 20 hearing 18 September 2020, 1729.
132 Exhibit HQI0016_P Witness statement of Mr Hugh de Kretser, 2 [10], 3 [15]–4 [21].
133 Exhibit HQI0018_P Joint witness statement of Ms Kate Hyslop and Mr Ricky Singh, 1 [4].
134 Ibid 2 [13].
135 Transcript of day 20 hearing 18 September 2020, 1735.
136 Exhibit HQI0176_P Witness statement of Dr Rob Gordon, 14–15 [56].
137 Exhibit HQI0020_P Witness statement of Ms Liliana Ratcliff, 9 [67].
138 'Returned traveller 5', Information provided to the Inquiry via the Intake and Assessment team between 15 July to 3 December 2020.
139 Exhibit HQI0013_RP Witness statement of 'Returned traveller 1', 7 [61].
140 Exhibit HQI0176_P Witness statement of Dr Rob Gordon, 15 [60].
141 Ibid 15 [60.1].
142 Transcript of day 20 hearing 18 September 2020, 1728.
143 Exhibit HQI0176_P Witness statement of Dr Rob Gordon, 8 [33].
144 Ibid 15 [59].
145 Transcript of day 20 hearing 18 September 2020, 1736–1737.
146 Exhibit HQI0176_P Witness statement of Dr Rob Gordon, 15 [58].
147 Exhibit HQI0117_RP Annexures to the first witness statement of Prof. Euan Wallace AM, DHS.0001.0002.0068–0076, DHS.0001.0002.0042–0053.

148 Ibid DHS.0001.0002.0068, DHS.0001.0002.0045–0046.
149 Ibid DHS.0001.0002.0058.
150 Ibid DHS.0001.0002.0068-DHS.0001.0002.0073; DHS.0001.0002.0042–0048.
151 Ibid DHS.0001.0002.0058.
152 Ibid DHS.0001.0002.0062.
153 Ibid.
154 Ibid DHS.0001.0002.0069.
155 Ibid DHS.0001.0002.0069–0070.
156 Ibid DHS.0001.0002.0070.
157 Ibid DHS.0001.0002.0071–0072.
158 Ibid DHS.0001.0002.0072.
159 bid DHS.0001.0002.0075–0076.
160 Ibid DHS.0001.0002.0036.
161 Ibid DHS.0001.0002.0042.
162 Ibid DHS.0001.0002.0043.
163 Ibid DHS.0001.0002.0049.
164 Ibid DHS.0001.0002.0050.
165 Ibid DHS.0001.0002.0042–0050.
166 Ibid DHS.0001.0002.0051.
167 Ibid DHS.0001.0002.0053.
168 Ibid DHS.0001.0002.0052–0053.
169 Ibid DHS0001.0002.0051.
170 Board of Inquiry into the COVID-19 Hotel Quarantine Program (Interim Report, 6 November 2020), 53.
171 *Public Health and Wellbeing Act 2008* (Vic) s. 200.
172 Exhibit HQI0164_RP Witness statement of Mr Jason Helps, 28 [125].
173 Ibid 28 [126].
174 Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 36 [94].
175 Ibid.
176 Ibid 36–37 [93]–[94].
177 Exhibit HQI0164_RP Witness statement of Mr Jason Helps, 29 [130].
178 Board of Inquiry into the COVID-19 Hotel Quarantine Program (Interim Report, 6 November 2020), 54 [171].
179 Exhibit HQI0027_P Witness Statement of Mr Kaan Ofli, 2 [11].
180 Ibid 2 [13].
181 'Returned Traveller 3', Information provided to the Inquiry via the Intake and Assessment team between 15 July to 3 December 2020.
182 Submission 03 Department of Health and Human Services, 59–64 [329]–[344].
183 Exhibit HQI0113_P Witness statement of Dr Finn Romanes, 9 [46].
184 Ibid 10 [50].
185 Ibid 10 [51].
186 Submission 03 Department of Health and Human Services, 67 [359]–[361].
187 Exhibit HQI0160 Witness statement of Dr Annaliese van Diemen, 8–9 [40].
188 Ibid 9 [42].
189 Ibid 9 [44].
190 Ibid 12 [55].
191 Ibid 10 [47].
192 Ibid 10 [49].
193 Submission 03 Department of Health and Human Services, 69 [372].
194 Transcript of day 23 hearing 23 September 2020, 2039.
195 Exhibit HQI0228_RP Letter from MinterEllison dated 25 September 2020, Responsive to questions posed to Ms Kym Peake, 2.
196 Submission 03 Department of Health and Human Services, 59–64 [329]–[344].
197 Exhibit HQI0162_P Witness statement of Ms Andrea Spiteri, 15 [59]; Submission 03 Department of Health and Human Services, 60 [330].
198 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, 912–13.

CHAPTER 13

Victoria's Quarantine Program: future options

13.1 Introduction

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

13.2 A facility-based quarantine model for the future

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

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

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

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

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

On-site management and role clarity

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

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

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

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

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

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

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

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

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

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

A dedicated mix of personnel is necessary

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

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

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

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

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

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

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

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

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

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

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

PPE should be made available and properly used

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The program should include testing for returned travellers

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

There should be provision for exemptions from quarantine

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

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

Safe transport arrangements need to be implemented where necessary

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

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

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

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

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

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

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

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

Endnotes

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

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

CHAPTER 14

How we went about our work

1. Boards of Inquiry set up pursuant to s. 53 of the *Inquiries Act 2014* (Vic) (Inquiries Act) are relatively new statutory investigatory bodies. To date, they have not been widely used. This particular Board of Inquiry was set up and operated in an unchartered environment for Inquiries in general, including operating in circumstances where the consequences of the subject-matter of the Inquiry were still unfolding, resulting in the Inquiry having to change its physical location and adapt its methodology as it was running.
2. For these reasons and others, it seemed important to outline how the Inquiry went about its work from establishment through to this Final Report, and to provide copies of Practice Directions and letters and various notices (see Appendices D and F).

14.1 Establishment of the Inquiry

3. The Inquiry was established by an Order of the Governor in Council on 2 July 2020, which set out the Terms of Reference (available at page 136).
4. Pursuant to the Order in Council, the Inquiry was directed to examine, report on and make any recommendations in relation to its terms of reference, including:
    A. decisions and actions of Victorian government agencies, hotel operators and private service providers
    B. communication between Victorian government agencies, hotel operators and private service providers
    C. contractual arrangements
    D. information, guidance, training and equipment provided to relevant personnel
    E. policies, protocols and procedures
    F. any other matters necessary to satisfactorily resolve the above matters.

14.2 Engagement of staff to support the Inquiry's work

5. Following the appointment of the Chief Executive Officer, administrative and legal teams were set up to support the work of the Inquiry.
6. Mr Tony Neal QC was engaged as Senior Counsel Assisting the Inquiry. Soon after Mr Ben Ihle SC, Ms Rachel Ellyard, Mr Steven Brnovic and Ms Jessica Moir were also engaged as Counsel Assisting the Inquiry.
7. Additional staff were seconded to the Inquiry to provide expertise and assistance across its key categories of work. This included administrative, legal, communications and media staff, and staff to support the policy, research, writing and public engagement functions of the Inquiry.

8. Inquiry staff were engaged to assist the Board pursuant to s. 56 of the Inquiries Act.

9. Section 56(2) of the Inquiries Act empowers the Board to (among other things):

    A. enter into any agreements or arrangements for the use of services of any staff of a Department, statutory authority or other public body

    B. engage people with suitable qualifications and experience as consultants

    C. if authorised to do so by the establishing Order for the Board of Inquiry, engage one or more Australian legal practitioners to assist the Board of Inquiry as counsel

    D. enter into agreements or arrangements for the provision of any other services to the Board of Inquiry.

10. Section 56(4) of the Inquiries Act also provides that:

    > The employment or engagement of members of staff of a Board of Inquiry may be on any terms and conditions the chairperson considers appropriate and all members of staff are subject to the direction lof the chairperson.

11. In addition, s. 57 of the Inquiries Act provides:

    > If the public sector values referred to in section 7(1)(a)(i) and (c)(iii) of the *Public Administration 2004* (Vic) would, but for this section, apply to a member of staff of a Board of Inquiry, those public sector values do not apply to the member of staff in respect of their employment or engagement with the Board of Inquiry.

12. Sections 7(1)(a)(i) and (c)(iii) of the *Public Administration Act 2004* (Vic) deal with providing advice to the government and implementing government policies and programs.

13. A total of 34 people were employed to support the Chair of the Inquiry to undertake its work.

Table 14.1: Staff engaged by the Inquiry

Category of work	Number of staff engaged by the Inquiry
Chief Executive Officer	1
Senior Counsel Assisting	1
Counsel Assisting	4
Legal Associate to the Board	1
Office/Project Coordinator	1
Intake and Assessment	3
Community, Digital and Media	2
Policy, Research and Report Writing	4
Office of Solicitors Assisting the Inquiry	17

14.3 Shift to remote working

14. Initially, I and a small number of administrative and legal staff supporting the Inquiry were physically located in the Inquiry's office in Melbourne's CBD. Inquiry staff were provided with training and induction to ensure a COVID-safe work environment.

15. On Wednesday 8 July 2020 at 11.59pm, one week after the Inquiry was established, Stage 3 coronavirus restrictions were reinstated in metropolitan Melbourne and Mitchell Shire.[1] Consistent with these restrictions, Inquiry staff shifted to, largely, working from home. The Inquiry's office remained open to Inquiry staff who needed to use it, with COVID-19 safety protocols in place, until Stage 4 restrictions came into effect in Melbourne on 2 August 2020.[2] Further detail on the implications of Stage 4 restrictions on the Inquiry's work is provided below.

14.4 Community engagement and Intake and Assessment

16. Efforts in the early weeks of the Inquiry focused on putting in place processes to allow media, members of the public and lawyers to contact the Inquiry to provide information relevant to its Terms of Reference or seek advice or direction.

17. On 15 July 2020, the Inquiry's website went live with information about its establishment, purpose and contact details for media enquiries.[3] From 15 July to 3 December 2020, the Inquiry's website received approximately 139,000 unique visitors, with the website receiving an approximate total of 755,000 page views by those unique viewers.

18. A dedicated email address, 1800 number and post office box were also established by 15 July 2020 to facilitate contact from members of the public.[4]

19. Between 15 July and 3 December 2020, the Inquiry received a total of 186 phone calls and 847 letters and emails from a wide range of sources. Those sources included returned travellers, security staff, cleaners and nurses involved in the Hotel Quarantine Program, as well as members of the public who witnessed activity at quarantine hotels or ran businesses near quarantine hotels.

20. Information provided to the Inquiry via these various forms of communication assisted in informing aspects of the Inquiry's investigations. A number of witnesses who gave evidence to the Inquiry were also identified via these channels.

14.5 Practice Directions

21. The Inquiry issued five Practice Directions on 15 July, 6 August and 31 August 2020 to set out the practice and procedure of its hearings. A copy of each Practice Direction is located at Appendix D. A summary of each Practice Direction is outlined below.

15 JULY 2020

- Practice Direction 1: set out the way in which the Inquiry would deal with claims of 'reasonable excuse' in response to a Notice to Attend (a notice compelling a person who received it to attend the Inquiry to give evidence) or a Notice to Produce (a notice compelling the production of specified documents or things), and how the Inquiry would receive materials in response to a Notice to Produce or an informal request for information.
- Practice Direction 2: provided general guidance about applications for leave to appear at the evidentiary public hearings of the Inquiry.
- Practice Direction 3: set out the way in which the evidentiary public hearings of the Inquiry would be conducted.

6 AUGUST 2020

- Practice Direction 4: related to the conduct of the evidentiary public hearings that would be held as part of the work of the Inquiry in a virtual environment.

31 AUGUST 2020

- Practice Direction 5: related to the handling of documentary evidence produced to the Inquiry.

14.6 Notices to Produce

22. On 10 and 11 July 2020, the Inquiry commenced sending letters to a range of government departments, security firms and hotels that were identified by the Inquiry as potentially being relevant to the Hotel Quarantine Program. These letters requested an initial response from parties to help the Inquiry understand which parties and matters were directly linked to the work of the Inquiry. The letters also notified parties that they would receive a Notice to Produce and provided information on the Inquiry's hearings, including timelines and likely requests for witness statements.

23. From 14 July 2020, Notices to Produce were sent to government departments, security firms and hotels seeking documents relevant to the Hotel Quarantine Program and the Inquiry's Terms of Reference. Given the tight timeframes to which the Inquiry was working, parties were asked to provide, by 24 July 2020, documents that were publicly available or not subject to a claim excusing their production, with remaining documents to be provided by 31 July 2020. While a substantial number of documents were received by 31 July 2020, there were significant delays in many critical documents being provided to the Inquiry. Further detail on these delays is provided at paragraphs 34 to 43.

24. It was through receipt of these documents, as well as information received via community engagement, that the Inquiry was able to identify possible witnesses who could provide the Inquiry with critical insight and evidence.

25. The Inquiry issued a total of 170 Notices to Produce, comprising 62 notices to produce documents and 108 notices to produce witness statements or affidavits.

26. In excess of 70,000 documents were received by the Inquiry, comprising more than 350,000 pages.[5] The Inquiry's legal team was expanded to undertake the significant amount of work required to review these documents ahead of, and during, the Inquiry hearings.

14.7 Inquiry hearings

27. All Inquiry hearings were live streamed with a closed caption service on the Inquiry website. Hearing transcripts and exhibits were published on the Inquiry website.[6] Visitors could also view previous hearings on the website as all were recorded and uploaded onto the website.[7]

28. The Inquiry had viewers from all over the world including Hong Kong, Canada, Malaysia and the Netherlands. Approximately 300,000 unique viewers tuned in to the hearings, via the live link on the Inquiry's website, over the course of all 27 hearing days. That link to the livestream was hosted by an external provider and the number of unique viewers is therefore treated separately to the number of unique visitors to the Inquiry's website, as identified at paragraph 17. The unique viewer count also does not include those who tuned into the hearing via links provided on other websites or on broadcast networks.

29. On 20 July 2020, Senior Counsel Assisting the Inquiry, Mr Tony Neal QC, delivered an opening statement from a hearing room that had been hired for the Inquiry at the Fair Work Commission (FWC), in a COVID-safe environment. On this day, it was announced that public evidentiary hearings would commence on 6 August 2020.[8]

30. On 2 August 2020, a State of Disaster was declared for Victoria and Stage 4 restrictions were introduced in Melbourne.[9] This led to an unscheduled public sitting (extraordinary sitting) on 5 August 2020 to announce the Inquiry would reset its working arrangements. To continue as intended, the Inquiry had to set up the capacity to conduct the entire working and hearing process electronically and virtually with me, the entire staff and Counsel Assisting all working from home. To achieve this, the evidentiary hearings were adjourned to commence on 17 August 2020. As a result of this disruption and the massive amount of material being received by the Inquiry, an extension to the Inquiry's reporting deadline was sought and granted.[10] Further detail on the extraordinary sitting is provided at paragraphs 38 and 39.

31. Public evidentiary hearings commenced on 17 August 2020 and concluded on 25 September 2020. Counsel Assisting delivered oral closing submissions on 28 September 2020. An additional extraordinary hearing was held on 20 October 2020 to tender additional documents (discussed further at paragraph 41). In total, 27 hearing days were held.

32. Ninety-six witnesses gave evidence via witness statements and/or affidavits, with 63 of these witnesses appearing at hearings to give evidence. Witnesses comprised medical experts, returned travellers, security staff, hotel staff, public servants, Ministers and the Premier. A full list of witnesses who provided evidence and witnesses who appeared is available at Appendix G.

33. Thirty parties were granted leave to appear before the Inquiry and 263 exhibits were tendered during the course of the hearings. A list of parties with leave to appear is available at Appendix E and a list of exhibits tendered at hearings is available at Appendix H.

14.8 Extensions to the Inquiry's reporting deadline

34. The Inquiry's Terms of Reference originally required delivery of the final report by 25 September 2020. It became clear, during the early stages of the Inquiry, that further time would be needed to complete the work.

35. On 3 August 2020, following the declaration of the State of Disaster and the introduction of Stage 4 restrictions, I wrote to the Premier seeking a six-week extension to the reporting date of the Inquiry due to:

    A. logistical difficulties arising from the introduction of Stage 3 restrictions in metropolitan Melbourne, including delays in the Inquiry being provided with many critical documents in an inaccessible form

    B. the volume of documents received from government departments and private entities (106,000 pages had been received as at 2 August 2020)

    C. the impact of the declaration of a State of Disaster for Victoria and Stage 4 restrictions for metropolitan Melbourne on 2 August 2020.

36. These factors added to significant concerns Counsel Assisting already held about the feasibility of completing the Inquiry within the allocated timeframe.

37. On 5 August 2020, the Premier wrote to me approving an extension to the Inquiry's reporting date to 6 November 2020. On the same day, the Order of the Governor in Council was to extend the Inquiry's reporting date to no later than 6 November 2020.

38. As stated above, on the afternoon of 5 August 2020, the Inquiry held an extraordinary sitting where I addressed the impact of the State of Disaster and Stage 4 restrictions for metropolitan Melbourne on workplaces across Victoria, including the Inquiry's workplace.

39. At that sitting, I announced that the Inquiry would continue its work despite these obstacles but do so remotely. The Inquiry vacated the hearing room at the FWC and its offices in the CBD. As noted above, the first public evidentiary hearing was rescheduled to 17 August 2020 so the relevant technology could be installed in my home and the homes of Counsel Assisting, and so that associated testing and training could be delivered.

40. The public evidentiary hearings concluded on 25 September 2020, whereupon the final stage of the Inquiry's work — report writing — commenced.

41. However, following the receipt of additional material in early October, another extraordinary sitting of the Inquiry was held on 20 October 2020. I announced that the Inquiry was continuing to conduct investigations, following new documents coming to light, and that this may impact on the delivery of this report. The delays to the Final Report are discussed further at paragraphs 48 to 73.

42. I then wrote to the Premier, on 28 October 2020, to advise that the Inquiry would not be able to deliver a final report by 6 November 2020. I proposed that an interim report, instead, be delivered on that date, with the final report to follow on 21 December 2020.

43. On 29 October 2020, the Premier responded and advised he agreed that the final reporting date should be extended.

14.9 Interim Report

44. The Interim Report was delivered, as per the revised timeline, on 6 November 2020.[11]

45. My view was that, as restrictions started to ease and Victoria began to consider re-opening to international arrivals, it was important that the Inquiry contribute to the ongoing work of developing and implementing a robust quarantine system for our State. It was in this context that the Interim Report was prepared, including recommendations for a future quarantine program in Victoria.

46. The recommendations I made in that Interim Report are set out in this Final Report at pages 38–46 of Volume I.

14.10 Final Report

47. The Inquiry's Final Report synthesises evidence provided through documents from government departments, hotels, security firms, medical staff and medical experts, mental health experts and returned travellers. Inquiry staff produced hearing summaries during the course of the Inquiry to assist with the considerable task of preparing this Final Report.

14.10.1 Delays to the Final Report

48. On 25 September 2020, Counsel Assisting the Board announced the close of evidence.[12] In the eight weeks that followed, new evidence was produced to the Board, generally relating to four issues:

    Issue 1: decision to engage private security

    Issue 2: Prof. Sutton and private security

    Issue 3: role of the Department of Health and Human Services (DHHS) Public Health Team in Operation Soteria

    Issue 4: document production.[13]

49. I sought documents relating to Issue 1 in response to issues raised by Parties with Leave to Appear in closing submissions.

50. Documents relating to Issues 2–3 were sought in response to matters separately reported to the Inquiry subsequent to the close of evidence. These matters, and the belated production of documents in response to Issues 2–3, gave rise to a further issue about the approach taken by DHHS and its lawyers, MinterEllison, to document production (Issue 4). I sought information on this issue from DHHS and MinterEllison in the form of correspondence and affidavit evidence. Counsel Assisting and DHHS subsequently made Further Written Submissions on the following matters relating to this issue:

    A. whether the material produced by DHHS subsequent to the close of evidence should have been produced earlier

    B. whether Prof. Sutton 'instructed' MinterEllison not to produce one of the latterly produced documents when it was raised with him after the close of evidence

    C. compliance by DHHS and MinterEllison with the Model Litigant Guidelines.

51. These, and other related matters, are discussed in this section. Issues 1 and 2 are addressed in Chapter 5 and Issue 3 is addressed in Chapter 8.

Should the material produced by DHHS subsequent to the close of evidence have been produced earlier?

52. A total of 494 documents were produced by DHHS after the close of evidence. At least 138 of these documents were new documents being produced for the first time.

53. In its Further Written Submissions, DHHS rejected 'in the strongest possible terms' those aspects of Counsel Assisting's Further Written Submissions that suggested a failure on the part of DHHS and its legal team to produce relevant documents.[14] DHHS submitted that:

    A. DHHS's production obligations were limited by the Board, including by reference to the concept of 'critical documents' informed by s. 26 of the *Civil Procedure Act 2010* (CPA), the standard for which is not the same as 'relevance' and is significantly narrower than general discovery[15]

    B. the concept of 'critical documents' involved the Department making a 'good faith assessment' as requested by the Inquiry[16]

    C. certain practical circumstances should be acknowledged, including:

        I. the volume of documents being dealt with, which included 500,000 documents on 'the database' and 4,542 documents being produced

        II. the short timeframes for producing documents and the long hours required of DHHS's legal team working remotely during stage 4 restrictions

        III. the volume of witness statements and evidence concurrently required, which included 26 witness statements and 14 witnesses giving *viva voce* evidence

        IV. DHHS's ongoing pandemic response activity.[17]

54. Having regard to these matters, I accept that latitude must be afforded when considering the approach taken by DHHS and its lawyers to document production.

55. I am, nevertheless, satisfied that there is at least one instance where a document should have been produced earlier by DHHS, being Exhibit 230. Exhibit 230 is a chain of emails sent on 27 March 2020, which includes a request from the Commonwealth Department of Home Affairs to Prof. Sutton for information on the Victorian hotel quarantine arrangements then in place, a response from DHHS Agency Commander, Mr Braedan Hogan stating that private security would be contracted, and a reply from Prof. Sutton thanking Mr Hogan for providing that response.[18]

56. This email chain was the subject of specific enquiries as it appeared to conflict with evidence previously given by Prof. Sutton stating that he was unaware that private security had been engaged in the Hotel Quarantine Program until after the outbreaks at the Rydges Hotel had occurred in late May 2020. As discussed in Chapter 5, I accept the evidence subsequently given by Prof. Sutton on this matter. That is, while emails such as those contained in Exhibit 230 presented an opportunity for Prof. Sutton to become aware that private security had been engaged before late May 2020, I accept his sworn evidence that he did not 'register' such information at that time.

57. Exhibit 230 was also the subject of specific enquiries regarding why this email chain was not produced until 15 October 2020.

58. In its Further Written Submissions, DHHS submitted that this document was not produced earlier upon it being identified by DHHS and its lawyers, because:

    A. it is doubtful that the document was captured by the Notice to Produce issued to DHHS on 14 July 2020 (NTP-001) as it did not 'evidence a decision or action (in particular to use private security)', it did not constitute a 'communication between Victorian Government agencies, hotel operators and Private Security Providers' and no other category contained in NTP-001 has 'any realistic application'[19]

    B. it was not 'critical', in the sense conveyed by s. 26 of the CPA, because the document had no bearing on the issue of who determined to use private security, and merely recorded arrangements then in place, in respect of which a large amount of consistent evidence had already been led[20]

    C. Prof. Sutton had a 'strong view' that the document did not change his evidence — because, as explained in his 4 November 2020 affidavit, he did not register that Exhibit 230 referred to private security being used. Because Exhibit 230 did not mean that Prof. Sutton wished to alter anything in his statement or oral evidence, the DHHS's legal team also concluded that there was no legal obligation for the document to be produced to the Board in order to make any correction to his earlier evidence.[21]

59. I do not accept these submissions as a complete response, for reasons including the following:

    A. the terms of NTP-001, which reflected the Board's Terms of Reference, are wide and are to be interpreted broadly at law

    B. Exhibit 230 clearly evidences the decisions and actions of Victorian government agencies involved in the Hotel Quarantine Program in respect of COVID-19 Quarantine Containment, and is therefore captured by NTP-001

    C. even if Exhibit 230 was not a 'critical document' before Prof. Sutton gave evidence on 16 September 2020 (a matter about which I have reservations), it became a 'critical document' when Prof. Sutton gave evidence that was apparently inconsistent with the contents of this document on that date

    D. even if DHHS and its lawyers did not turn their minds to that issue on that date, the evidence is that Exhibit 230 and other documents were sent by a DHHS employee to a DHHS manager who was assisting in connection with the Inquiry on 20 September 2020.[22] The matter was raised again on 28 September 2020, when the same DHHS employee made enquiries with MinterEllison and/or DHHS, as to whether Exhibit 230 had been produced to the Inquiry[23]

E. At that point, it should have been clear that there was an apparent inconsistency between Exhibit 230 and the evidence previously given by Prof. Sutton. Exhibit 230 should have been promptly produced to the Inquiry both because it was (by that point at the latest) a 'critical document' and to avoid the Inquiry reaching findings based on incomplete and potentially misleading evidence. Instead, Exhibit 230 was not produced until 15 October 2020, the same day a specific request was made by the Inquiry for that particular document

F. DHHS was requested to provide an explanation as to why this document was not produced prior to 15 October 2020.[24] I do not accept the reasons advanced by DHHS in respect of the delay between 28 September and 15 October 2020. While Prof. Sutton may have advised that he did not consider he needed to correct his evidence in light of Exhibit 230, it is for me to determine how Exhibit 230 should be reconciled with Prof. Sutton's previous evidence. Further, while I accept that DHHS was busy with other matters at this time, promptly producing Exhibit 230 to the Inquiry with confirmation that an explanation would be forthcoming shortly thereafter, would have involved minimal time and effort and should have been done.

'Instructions' by Prof. Sutton on Exhibit 230

60. By letter dated 19 October 2020, MinterEllison wrote to the Inquiry (in response to my request for an explanation)[25] about the belated production of Exhibit 230 and other issues on behalf of DHHS, stating:

> Prof. Sutton instructed us he had not read the detail of the email at the time and that the evidence that he gave to the Board was truthful at the time and remains so. In other words, Prof. Sutton stands by that evidence which was provided honestly. Prof. Sutton further instructed us that he did not consider he needed to clarify his evidence and therefore the email did not need to be provided to the Board for that reason.[26] (emphasis added)

61. When specifically asked whether he had instructed MinterEllison not to produce Exhibit 230, Prof. Sutton gave affidavit evidence stating:

> It was not my role to give instructions on behalf of the Department about document production.
>
> I did not instruct MinterEllison or solicitors to the Department that the emails (in exhibit 230) not be produced. As set out in my answer to question 21, my discussion with [MinterEllison] was about the bearing of exhibit 230 on my evidence; it was not about production more generally. My natural view was it was for MinterEllison and the Department to determine what is in scope of requests issued by the Board and what was appropriate.[27]

62. In its Further Written Submissions, Counsel Assisting raised this issue and submitted that it should be the subject of further submissions from DHHS.[28]

63. In its Further Written Submissions, DHHS submitted the following:

> Counsel Assisting refer to the use of the word "instructed" in the 19 October 2020 letter, referring to a discussion with Prof. Sutton about the production of exhibit 230. That letter does not state that Prof. Sutton directed MinterEllison not to produce exhibit 230, but refers to Prof. Sutton providing factual information as to the bearing of exhibit 230 on his earlier evidence — namely, that he did not think exhibit 230 would have changed his statement or evidence and so he did not consider he needed to change, clarify or explain his evidence. That was apparent from the relevant part of the letter when it is read in context. It is in any event clear from the evidence that the Department was actively considering producing the document when the Board requested production.

> The 19 October 2020 letter is not in tension with, but is consistent with, Prof. Sutton's 4 November 2020 affidavit, when it is understood that the word "instructed" did not convey that Prof. Sutton was directing that exhibit 230 not be produced.[29]

64. I do not accept these submissions from DHHS. It was at least open, on a reasonable reading of the above extract from MinterEllison's letter dated 19 October 2020, to conclude that Prof. Sutton had *instructed* MinterEllison that Exhibit 230 'did not need to be provided to the Board'. As a very experienced law firm, MinterEllison would have been well-aware of what the term 'instructions' means as between lawyers and clients. It is well understood to mean 'what your client is telling you to do'. Had MinterEllison not intended to convey that meaning, more care should have been taken to avoid that impression when preparing and settling MinterEllison's correspondence dated 19 October 2020.

Model Litigant Guidelines

65. In its Further Written Submissions, Counsel Assisting submitted that the conduct of both DHHS and its lawyers in this Inquiry had fallen short of the standards set by the Model Litigant Guidelines.[30]

66. Having regard to the Further Written Submissions subsequently made by DHHS, I accept that, in order to make such a serious finding, there would need to be a more detailed set of specific allegations as to why that finding should be reached and a more thorough exploration of those issues. In the absence of such, I do not make such a finding.

Initial Response

67. I do, however, note with respect to DHHS's response to this Inquiry, more generally, that, putting to one side the question of document production, and taking into account the pressures under which DHHS and its lawyers were labouring more generally, I would have been assisted by DHHS providing a more forthcoming and articulated account of the internal issues arising in that Department during the Hotel Quarantine Program.

68. By way of example, in its Initial Response to this Inquiry, DHHS identified certain challenges faced by it in the Program and provided some indicators as to where these issues and challenges lay. Accepting DHHS's advice to the Inquiry that it had not had the opportunity to conduct its own forensic review of what had happened at the time the Inquiry commenced, there was enough known at that time to have caused the government decision to move the Program away from DHHS as the governing agency. It would have been more helpful to have had the offer and assistance of DHHS with identifying the detail of the shortcomings on its part more clearly, at least to the extent that such 'shortcomings' either were, or should have been, known to DHHS at the time its Initial Response was being prepared.

69. DHHS is not to be singled out on this issue, however. Similarly, the Initial Responses of the Department of Jobs, Precincts and Regions and the Department of Premier and Cabinet could also have been more reflective and forthcoming about the issues, challenges and shortcomings identified in the course of their engagement with the Hotel Quarantine Program.

Impact on the Board's work

70. As I said, in my opening remarks on 20 July 2020, for me to perform my task, I expected no less than full, frank and timely cooperation from all relevant Government departments, entities and persons.[31]

71. The belated production of documents by DHHS and others after the close of evidence resulted in the need for further Notices to Produce to be issued, Further Written Submissions to be prepared and further hearings to be convened.

72. By correspondence to the Inquiry dated 11 November 2020, DHHS and MinterEllison conceded that the belated production of documents after the close of evidence contributed to a delay in the issue of my final report, and that this was clearly a regrettable outcome.[32]

73. This concession is properly made. As stated in my request for Initial Responses, the purpose of this process was to assist the Inquiry by identifying those matters that may be uncontroversial, and that need not unnecessarily occupy the time of the Inquiry. It is unfortunate that this opportunity was not taken by DHHS, DJPR and DPC in their Initial Responses. Had they done so, and openly identified the shortcomings they had already identified by July 2020, a significant amount of time and energy could, no doubt, have been saved.

14.11 Funding

74. The Inquiry received funding of $5.7 million to carry out its work.

75. As at the time of printing this Final Report, the Inquiry had spent $4.815 million. Any unspent funds were returned to government at the conclusion of the Inquiry.

Endnotes

1 Premier of Victoria, 'Statement from the Premier' (Media Release, 7 July 2020), <https://www.premier.vic.gov.au/statement-premier-74>.
2 Premier of Victoria, 'Premier's statement on changes to Melbourne's restrictions' (Media Release, 2 August 2020) <https://www.dhhs.vic.gov.au/updates/coronavirus-covid-19/premiers-statement-changes-melbournes-restrictions-2-august-2020>.
3 See COVID-19 Hotel Quarantine Inquiry, 'Home' <https://www.quarantineinquiry.vic.gov.au/about-hotel-quarantine-inquiry>.
4 See COVID-19 Hotel Quarantine Inquiry, 'Contact us' <https://www.quarantineinquiry.vic.gov.au/contact-us>.
5 Note that these figures are an approximation and will include documents that were produced to the Inquiry multiple times by one or more Parties with Leave to Appear.
6 See COVID-19 Hotel Quarantine Inquiry, 'Transcripts' <https://www.quarantineinquiry.vic.gov.au/hearings-transcripts> ; 'Exhibits' <https://www.quarantineinquiry.vic.gov.au/exhibits>.
7 See COVID-19 Hotel Quarantine Inquiry, 'View hearings' <https://www.quarantineinquiry.vic.gov.au/hearings>.
8 Transcript of day 1 opening statements 20 July 2020, 8.
9 Premier of Victoria, 'Premier's statement on changes to Melbourne's restrictions' (Media Release, 2 August 2020), <https://www.dhhs.vic.gov.au/updates/coronavirus-covid-19/premiers-statement-changes-melbournes-restrictions-2-august-2020>.
10 Transcript of day 2 extraordinary sitting 5 August 2020, 13–16.
11 See COVID-19 Hotel Quarantine Inquiry, 'Reports' <https://www.quarantineinquiry.vic.gov.au/reports>.
12 Transcript of day 25 hearing 25 September 2020, 2186; Transcript of day 26 hearing 28 September 2020, 2190.
13 See Further Submission 01 Counsel Assisting the Board of Inquiry.
14 Further Submission 03 Department of Health and Human Services, 1 [3].
15 Ibid 3 [11]–[13].
16 Ibid 3 [14].
17 Ibid 4 [17].
18 Exhibit HQI0230_RP DHHS emails re VIC Hotel Quarantine Arrangements, DHS.0001.0123.0011–0013.
19 Further Submission 03 Department of Health and Human Services, 5 [22].
20 Ibid 5 [23].
21 Ibid 5–6 [24].
22 Letter from MinterEllison to Solicitors Assisting dated 21 October 2020; Exhibit HQI0263_P Affidavit of Ms Rebecca Bedford, 2 [6].
23 Exhibit HQI0232_P Letter from Solicitors for DHHS to Solicitors Assisting dated 19 October 2020, HQI.0001.0053.0002; Exhibit HQI0255_RP Affidavit of Mr Jason Helps, 2 [11].
24 Exhibit HQI0231_P Letter from Solicitors Assisting to Solicitors for DHHS dated 16 October 2020.
25 Ibid.
26 Exhibit HQI0232_P Letter from Solicitors for DHHS to Solicitors Assisting dated 19 October 2020, 2.
27 Exhibit HQI0249_RP First witness statement of Prof. Brett Sutton, 18 [110]–[111].
28 Further submission 01 Counsel Assisting the Board of Inquiry, 17 [59]–[63].
29 Further submission 03 Department of Health and Human Services, 6 [25]–[26].
30 Further submission 01 Counsel Assisting the Board of Inquiry, 16 [54].
31 Transcript of day 1 opening statements 20 July 2020, 10.
32 Exhibit HQI0261_P Letter from Solicitors for DHHS to Solicitors Assisting dated 11 November 2020, HQI.0001.0072.0001.

Appendices

Appendix A

List of Abbreviations

Acronym	Meaning
ABF	Australia Border Force
AC	Assistant Commissioner
Action Plan	Victorian Action Plan for Influenza Pandemic 2015
ADF	Australian Defence Force
AFP	Australian Federal Police
AHMPPI	The Commonwealth Government's Australian Health Management Plan for Pandemic Influenza
AHPPC	Australian Health Protection Principal Committee
AHS	AHS Hospitality Pty Ltd
AMC	AMC Commercial Cleaning
AO	Authorised Officer
ARTG	Australian Register of Therapeutic Goods
AV	Ambulance Victoria
CBD	Central Business District
CCC	Crisis Council of Cabinet
CCOM Guidelines	COVID-19 Case and Contact Management Guidelines for Health Services and General Practitioners
CCOMT	Case, Contact and Outbreak Management Team
CCP	Chief Commissioner of Police, State of Victoria
CDNA	Communicable Diseases Network Australia
CEA program	COVID-19 Emergency Accommodation program
CHO	Chief Health Officer, State of Victoria
Cleaning Protocol	Cleaning and disinfecting to reduce COVID-19 transmission, Tips for non-healthcare settings
COAG	Council of Australian Governments
COMDISPLAN	Australian Government Disaster Response Plan
COVID-19 PHC Division	COVID-19 Public Health Command Division
CPSU	CPSU (Community & Public Sector Union)
DCHO	Deputy Chief Health Officer, State of Victoria
DELWP	Department of Environment, Land, Water and Planning
DFAT	Department of Foreign Affairs and Trade
DHHS	Department of Health and Human Services
DJCS	Department of Justice and Community Safety

Acronym	Meaning
DJPR	Department of Jobs, Precincts and Regions
DoT	Department of Transport
DPC	Department of Premier and Cabinet
DPHC	Deputy Public Health Commander
DPHC CCOM	Deputy Public Health Commander — Case, Contact and Outbreak Management
DPHC — Planning	Also known as DPHC, Strategy and Implementation
DPHC, Strategy and Implementation	Also known as DPHC — Planning
DSC — H	Deputy State Controller — Health
DTF	Department of Treasury and Finance
EM	Emergency Management
EM Act	*Emergency Management Act 2013* (Vic)
EMC	Emergency Management Commissioner
EMLO	Emergency Management Liaison Officer
EMMV	Emergency Management Manual Victoria
EOC	Emergency Operations Centre
ERC	Expenditure Review Committee
GP	General Practitioner
Head Contracts	Contracts with security service providers Wilson, MSS and Unified
HCW	Healthcare worker
HPB	Health Protection Branch
HQP	Hotel Quarantine Program
IKON	IKON Services Australia Pty Ltd
IMT	Incident Management Team
IPA	Infection Prevention Australia
IPC	Infection Prevention and Control
IPC Consultant	Infection Prevention and Control Consultant
IPC Cell	Infection Prevention and Control Cell
MCC	Mission Coordination Committee
MDU PHL	Microbiological Diagnostic Unit Public Health Laboratory
MERS/MERS COV	Middle East respiratory syndrome caused by COVID-19
MSS	MSS Security Pty Ltd
MSS Contract	Purchase Order Contract between the Department of Jobs, Precincts and Regions and MSS Security Pty Ltd entered into on 23 April 2020
NCM	National Coordination Mechanism
OMP	Outbreak Management Plan
OMT	Outbreak Management Team
PH	Public Health
PHC	Public Health Commander

Acronym	Meaning
PH — IMT	Public Health — Incident Management Team
PHT	Public Health Team
PHW Act	*Public Health and Wellbeing Act 2008* (Vic)
POC	Purchase Order Contract
PPE	Personal Protective Equipment
RFT	Request for Tender
RSO	Residential Support Officer
SARS-CoV-2	Severe Acute Respiratory Syndrome Coronavirus 2
SCC	State Control Centre
SC — H	State Controller — Health
SCM	State Consequence Manager
SCV	Safer Care Victoria
Self-isolation Directions	Self-Quarantine following Overseas Travel Direction/Airport Arrivals Direction
SEMC	State Emergency Management Centre
SERP	State Emergency Response Plan
SH — IMT	State Health Incident Management Team
SHEMC	State Health Emergency Management Coordinator
SHERP	State Health Emergency Response Plan
Sterling	Sterling Security Group
TGA	Therapeutic Goods Administration
The Charter / Charter	*Charter of Human Rights and Responsibilities 2006* (Vic)
Trades Hall	Victorian Trades Hall Council
Unified	Unified Security Group (Australia) Pty Ltd
Unified Contract	Purchase Order Contract between the Department of Jobs, Precincts and Regions and Unified Security Group (Australia) Pty Ltd) entered into on 9 April 2020
URM	United Risk Management
VicPol	Victoria Police
Victoria Pandemic Plan	Victorian Health Management Plan for Pandemic Influenza 2014
VSB	Victorian Secretaries Board
WHO	World Health Organization
Wilson	Wilson Security Pty Ltd
Wilson Contract	Purchase Order Contract between the Department of Jobs, Precincts and Regions and Wilson Security Pty Ltd entered into on 6 May 2020

Appendix B

Glossary

Term	Meaning
Action Plan	Victorian Action Plan for Influenza Pandemic 2015
Airport Arrivals Direction	Direction issued 18 March 2020 outlining that all international travellers arriving at an airport in Victoria between 5.00pm on 18 March 2020 and midnight on 13 April 2020 must travel from the airport to a premises that is suitable for the person to reside in for a period of 14 days
Antigens	Molecules capable of stimulating an immune response
Asymptomatic	Someone who does not develop symptoms throughout the course of their disease
Authorised Officer	A person appointed under the *Public Health and Wellbeing Act 2008* (Vic) with power to enforce compliance with Detention Directions
Cases	Individuals who test positive to COVID-19
Charter	*Charter of Human Rights and Responsibilities Act 2006* (Vic)
Commonwealth Pandemic Plan	The Commonwealth Government's Australian Health Management Plan for Pandemic Influenza
Community transmission	Where a person is infected by the virus but they have not been overseas recently or been in recent contact with other confirmed cases
Contacts	Individuals who may have been exposed to COVID-19
Contact tracing	The identification, assessment and management of people who potentially have been exposed to disease (and so at higher risk of developing and spreading it) and working with them to interrupt the spread of the disease
Control agency	Agency with overall responsibility for all activities undertaken in response to an emergency
COVID-19	The coronavirus disease 2019 caused by the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) strain of coronavirus
Crisis Council of Cabinet	The core decision making forum for the Victorian Government on all matters related to the coronavirus emergency, including implementing the outcomes of the National Cabinet.
Direction and Direction Notice	A direction issued by the Chief Health Officer or their delegate under the *Public Health and Wellbeing Act 2008* (Vic) mandating an individual into quarantine
Epidemiology	The study of the patterns and determinants of disease in specific populations
Facility-based model	A quarantine model for returning international arrivals that primarily takes place in a managed facility, such as a hotel or similar facility
Fogging	The use of chlorine-based chemical (that is, bleach) to fog the rooms
Fomites	Surfaces or objects (including hands) that may become contaminated and serve as an intermediary vehicle for transmission
Genome	An organism's complete set of genes or genetic material, comprising DNA or RNA
Genomic sequencing	A process by which the whole genetic signature of a pathogen is recovered
Genomic cluster	A group of samples with a condition or disease that have some similarity, suggesting that the condition or disease was acquired from one another or has a common source or common cause
Global Victoria	An agency within DJPR which focuses on trade facilitation. The CEO of Global Victoria is Ms Gönül Serbest
Green zone	A designated 'clean' area in a quarantine facility where no PPE is to be worn

Term	Meaning
Head Contracts	Contracts with security service providers (Wilson, MSS and Unified)
Home-based model	A quarantine model for returning international arrivals that primarily takes place in the home
Home Quarantine Direction	Direction to be made under the proposed Home Quarantine Model as outlined in Section 2 of the Interim Report
Home Quarantine Model	The proposed home-based model as outlined in Section 2 of the Interim Report.
Hot hotel	Certain premises that were used exclusively to accommodate returned travellers who had tested positive to COVID-19
Hotel Quarantine Program	The original Victorian Hotel Quarantine Program which ran from 29 March to 30 June 2020 and is the subject of this Inquiry
Incubation period	The time between being exposed to a disease and the onset of symptoms
Infection prevention and control	A scientific and risk management approach designed to prevent harm caused by infection to patients and health workers
Infectious period	The length of time an individual can transmit COVID-19
International arrivals	People who may visit Victoria and be required to quarantine under the new Quarantine Program
Interim Report	COVID-19 Hotel Quarantine Inquiry Interim Report and Recommendations (6 November 2020)
Isolate / quarantine	The terms 'isolate' and 'quarantine' are given distinct and separate meanings on DHHS' website: https://www.dhhs.vic.gov.au/self-quarantine-coronavirus-covid-19#when-do-i-isolate The term 'isolate' is used to describe the process of separating people with COVID-19 from people who do not have the virus. The term 'quarantine' is used describe the process of separating and restricting the movement of people who have been or may have been exposed to COVID-19. Notwithstanding this distinction, the terms 'isolate' and 'quarantine' were often used interchangeably throughout the evidence to this Inquiry. In this report, where witness evidence containing the terms 'isolate' or 'quarantine' is quoted or otherwise referred to, the terminology adopted by that witness is used. In all other contexts, the report adopts the distinction outlined above, and uses the terms 'isolate' and 'quarantine' accordingly
Issues Paper	Victoria's Private Security Industry — Issues Paper for Consultation
June Cleaning Advice	Hotel Quarantine Response — Advice for cleaning requirements for hotels who are accommodating quarantined, close contacts and confirmed COVID-19 Guests — Updated
March Cleaning Advice	Cleaning and disinfecting to reduce COVID-19 transmission: Tips for non-healthcare settings
National Cabinet	The Australian intergovernmental decision-making forum composed of the Prime Minister and state and territory Premiers and Chief Ministers
Operation Soteria	The alternative name for the Hotel Quarantine Program.
Pandemic	The worldwide spread of a new disease
Personal protective equipment (PPE)	PPE refers to anything used or worn to minimise risk to workers' health and safety. PPE for COVID-19 includes surgical masks, particulate filter respirators (such as P2 or N95), gloves, goggles, glasses, face shields, gowns and aprons. See Department of Health website for further information: https://www.health.gov.au/news/health-alerts/novel-coronavirus-2019-ncov-health-alert/coronavirus-covid-19-advice-for-the-healthand-disability-sector/personal-protective-equipment-ppe-for-the-health-workforceduring-covid-19
Procurement	The process of finding and agreeing to terms, and acquiring goods, services or works from an external source, often via a tendering or competitive bidding process

Term	Meaning
Purchase order contract	A commercial contract between a supplier and purchaser, which outlines the terms and obligations of each party in relation to the purchase of goods or services
Quarantine Governing Body	A body that consists of appropriate senior members of the governance structure, which 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 and in respect of decisions reached as proposed in Section 1 of the Interim Report
R_0	The average number of people who are likely to contract a contagious disease, from one other person with that disease, within a sample population
Red zone	A designated area in a quarantine facility where PPE must be worn
Returned travellers	People who returned to Victoria and quarantined in the initial Hotel Quarantine Program
Safer Care Victoria	A Victorian State authority that leads quality and safety improvements in healthcare settings
SARS-CoV-2	Severe Acute Respiratory Syndrome Coronavirus 2
SCOVID	People who are suspected, but not yet proven to have COVID-19
Second wave	The increase in COVID-19 cases in Victoria in the wake of two outbreaks at the Rydges Carlton and Stamford Plaza hotels
Self-isolation Directions	Collective term to refer to both the Self-Quarantine following Overseas Travel Direction (issued 16 March 2020) and the Airport Arrivals Direction (issued 18 March 2020)
Self-Quarantine following Overseas Travel Direction	Direction issued 16 March 2020 requiring international travellers arriving at an airport in Victoria to travel from the airport to a premises that is suitable for the person to reside in for a period of 14 days
Specialised cleaning	Commercial cleaning services for rooms that have accommodated guests positive for COVID-19
State Controller — Health	The individual appointed in a Class 2 emergency to provide support to the State Control Centre and lead the emergency response in a public health emergency
State Control Centre	The Victorian operations centre for emergencies
State of Disaster	Declared if the Premier is satisfied an emergency "constitutes or is likely to constitute a significant and widespread danger to life or property in Victoria"
State of Emergency	Declared when there is a serious risk to public health
State Purchase Contract	Centralised contracts used by the Victorian Government to buy common goods and services
Super spreader	Individuals who infect a disproportionately large number of contacts
Support agency	An agency working under the direction of the department in control of the program
Swab testing	Swabbing of areas after they have undergone an infectious clean to verify the area is actually clean
Terms of Reference	The Terms of Reference of the Inquiry into the COVID-19 Hotel Quarantine Program established by the Order in Council dated 2 July 2020
Victorian Pandemic Plan	Victorian Health Management Plan for Pandemic Influenza 2014
Victorian Secretaries Board	A forum of all Department Secretaries, the Police Commissioner and the Victorian Public Sector Commissioner
Viral load	A measure of the number of virus particles in a given sample. For example, it may refer to the amount of virus present in a person's tissues or bodily fluids (such as respiratory droplets), or the amount of virus to which a person is exposed
Viral shedding	Occurs when a person who has the virus present in their body expels infectious fluid from their body; for example, by sneezing or coughing

Appendix C

Order in Council dated 2 July 2020

Inquiries Act 2014

APPOINTMENT OF A BOARD OF INQUIRY INTO THE COVID-19 HOTEL QUARANTINE PROGRAM

ORDER IN COUNCIL

The Governor in Council, on the recommendation of the Premier under section 53(1) of the **Inquiries Act 2014**, appoints the Honourable Jennifer Coate AO to constitute a Board of Inquiry to inquire into, report on and make any recommendations considered appropriate in relation to the terms of reference specified in paragraphs 1 to 6 of this Order.

This Order comes into effect on the date it is published in the Government Gazette.

BACKGROUND

Having regard to the global COVID-19 pandemic and the following:

a. Previous and current Directions on Detention, issued under section 200 of the **Public Health and Wellbeing Act 2008**, requiring returned overseas travellers to be quarantined for at least 14 days in certain hotels following their arrival in Australia as part of the Victorian government's COVID-19 hotel quarantine program (Quarantine Program);

b. The dynamic environment under which the Quarantine Program was established, including the concern at the time for the immediate safe return of Victorians from overseas areas impacted by the pandemic;

c. The use of certain hotels to facilitate the Quarantine Program;

d. The use of private sector providers, including security, transport, medical and food service providers (Private Service Providers) to administer the Quarantine Program;

e. Recent epidemiological material collected up to 15 July 2020 in relation to travellers quarantined as part of the Quarantine Program, potentially linking subsequent increases in the spreading of the COVID-19 virus from such quarantined travellers through to the broader Victorian community;

f. The Government's objective of effectively identifying, managing and containing the

OFFICIAL

spread of COVID-19 from returned overseas travellers in the Quarantine Program into the community (COVID-19 Quarantine Containment); and

g. Subsequent efforts to diagnose and treat, and to contain case numbers and the community transmission of COVID-19, as a result of the Quarantine Program.

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.

REPORTING DATES

You must report your findings and any recommendations to the Governor as soon as possible, and not later than 25 September 2020.

CONDUCTING THE INQUIRY

1. You may:
   (a) conduct your inquiry as you consider appropriate, subject to the requirements of procedural fairness;
   (b) have regard to any research relevant to your inquiry;
   (c) consult with and engage experts as necessary to provide relevant advice and assistance;
   (d) engage Australian legal practitioners to assist you as counsel.
2. You must conduct your inquiry in accordance with this Order, the **Inquiries Act 2014**, and all other relevant laws.
3. It is anticipated that in conducting your inquiry, you will:
   (a) to the extent you think it appropriate, work co-operatively with, and seek not to prejudice, any ongoing response or recovery activities or investigations;
   (b) adopt informal and flexible procedures to ascertain the relevant facts as directly and effectively as possible;
   (c) avoid unnecessary duplication; and
   (d) avoid unnecessary cost or delay.

BUDGET

4. You may incur expenses and financial obligations to be met from the Consolidated Fund up to $3 million in conducting this Inquiry.

Dated: – 2 JUL 2020

Responsible Minister:

The Hon Daniel Andrews MP
Premier

C. Chisholm
Clerk of the Executive Council

OFFICIAL

Amended Order in Council dated 5 August 2020

Inquiries Act 2014

AMENDED TERMS OF REFERENCE FOR THE BOARD OF INQUIRY INTO THE COVID-19 HOTEL QUARANTINE PROGRAM

ORDER IN COUNCIL

The Governor in Council, on the recommendation of the Premier under section 53 of the **Inquiries Act 2014**, amends the Order in Council dated 2 July 2020 establishing the Board of Inquiry into the COVID-19 Hotel Quarantine Program by:

1. For the words "25 September 2020" under the heading "Reporting Dates" **substituting** "6 November 2020".

This Order comes into effect on the date it is published in the Government Gazette.

Dated: 05 AUG 2020

Responsible Minister:

The Hon Daniel Andrews MP
Premier

C. Chisholm
Clerk of the Executive Council

Amended Order in Council dated 29 October 2020

Inquiries Act 2014

AMENDED TERMS OF REFERENCE FOR THE BOARD OF INQUIRY INTO THE COVID-19 HOTEL QUARANTINE PROGRAM

ORDER IN COUNCIL

The Governor in Council, on the recommendation of the Premier under section 53 of the **Inquiries Act 2014**, amends the Order in Council dated 2 July 2020 (as amended by a further Order in Council dated 5 August 2020) establishing the Board of Inquiry into the COVID-19 Hotel Quarantine Program by:

1. For the words "You must report your findings and any recommendations to the Governor as soon as possible, and not later than 6 November 2020" under the heading "Reporting Dates" **substituting** "You must report your interim findings and any recommendations to the Governor as soon as possible, and not later than 6 November 2020, and you must report your final findings and any recommendations to the Governor as soon as possible, and not later than 21 December 2020".

This Order comes into effect on the date it is published in the Government Gazette.

Dated: 29 OCT 2020

Responsible Minister:

The Hon Daniel Andrews MP
Premier

C. Chisholm
Clerk of the Executive Council

OFFICIAL

Appendix D

Practice Direction 1

COVID-19
Hotel Quarantine Inquiry

PRACTICE DIRECTION NO. 1

SECTION 64 NOTICES AND DOCUMENT MANAGEMENT

RELEASED 15 JULY 2020

INTRODUCTION

1 This Practice Direction (**PD-1**) relates to notices issued pursuant to s 64 of the *Inquiries Act* 2014 (Vic) (**Act**) by the Board of Inquiry into the COVID-19 Hotel Quarantine Program (**Inquiry**) and provides the Protocol for the Electronic Management of Documents.

2 This Practice Direction is issued under s 63(1) of the Act. It should be read in conjunction with the Act and with the terms of reference contained in the Order establishing the Inquiry.

3 This Practice Direction sets out the way in which the Inquiry will:

(a) deal with claims of reasonable excuse in response to a Notice to Attend, Notice to Produce or Notice to Attend and Produce (as provided for by s 64 of the Act (**Notice**)); and

(b) receive materials in response to a Notice to Produce or an informal request for information.

4 In this Practice Direction, and for the purposes of PD-1 and the attached Protocol only, reference to a **Party** (or **Parties**) means:

(a) any entity, organisation or individual that has been served with, or is the subject of a Notice; and

(b) anyone who intends to provide documents, evidence or other material to the Inquiry, including in response to a request for information.

5 The intended audience of this Practice Direction includes a Party, as well as the legal representatives and IT professionals engaged to assist Parties in responding to Notices.

6 This Practice Direction may be varied, changed or amended by the Inquiry from time to time. The Inquiry may, at any time, depart from this Practice Direction if it considers it appropriate to do so.

CLAIMS OF 'REASONABLE EXCUSE' IN RESPONSE TO NOTICES

7 Any Party who asserts that they have a reasonable excuse for failing to comply with a Notice, in whole or in part, must have regard to sections 65 and 74(3) of the Act and any notes which accompany the Notice.

8 The Inquiry will set out in each Notice the date by which a claim of reasonable excuse must be made (**Objection Date**).

9 If a Party considers that any part of a Notice concerns evidence, material or document/s that are the subject of a claim of 'reasonable excuse' by that Party, it must, by the Objection Date:

(a) notify the Inquiry in accordance with the requirements of the Notice;

(b) provide the following information to assist the Inquiry to determine whether a reasonable excuse exists:

(1) a brief general description of the subject matter of the evidence, material or document(s) to which the reasonable excuse is claimed to apply;

(2) the basis on which the claim of reasonable excuse is made;

(3) brief reasons in support of the claim of reasonable excuse; and

additionally, for documents or materials:

(4) the nature of the document (date, type etc); and

(5) the author(s) and, where applicable, the addressee(s) of the document; and

(c) inform the Inquiry whether:

(1) it claims that the reasonable excuse applies to all of the evidence, material or document(s);

(2) it claims the evidence, material or document(s) should not be adduced and/or produced at all on the grounds of the identified reasonable excuse, or

(3) whether it consents to production of the evidence, material or document(s) on appropriate terms, and if so, what those proposed terms ought to be.

10 Where a claim of reasonable excuse is made over documents or material, the Party making that claim must also comply with the requirements of the Protocol in respect of the production and coding of documents.

PROTOCOL FOR PRODUCING MATERIAL TO THE INQUIRY

11 Any material to be filed with the Inquiry should be in accessible electronic format consistent with the requirements of this Practice Direction and the Document Management Protocol (**Protocol**) attached to this Practice Direction. However, this does not preclude the Inquiry from accepting material, at its discretion, in a hard copy format or as objects.

12 All electronic material to be produced to the Inquiry must be prepared and provided in accordance with the Protocol.

PROTOCOL FOR DOCUMENTS WHERE AN ORDER IS SOUGHT FOR PROHIBITION OR RESTRICTION OF PUBLICATION

13 Any party who seeks an order prohibiting or restricting the publication of (or part of) a document must:

(a) have regard to section 73 of the Act and any notes which accompany the Notice; and

(b) comply with the requirements of the Protocol in respect of the production and coding of documents where an order is sought to prohibit or restrict publication of documents is made.

14 The Protocol provides a process for Parties to identify information as being personal identifying information. However, the existence of personal information is not, on its own, a basis on which the Inquiry will make an order prohibiting or restricting publication.

INQUIRY'S DOCUMENT MANAGEMENT SYSTEM

15 The Inquiry will maintain an electronic database using Lexel that will contain, among other things, copies of all material produced to the Inquiry including material produced in response to a Notice, informal request for information or otherwise.

QUESTIONS REGARDING THIS PRACTICE DIRECTION OR DOCUMENT MANAGEMENT PROTOCOL

16 The Inquiry accepts that some Parties producing documents to it may not be able to comply with the Protocol. These Parties should contact the person named on the Notice as the contact to discuss alternative arrangements for production.

17 Any person who has a technical question about producing material electronically to the Inquiry should also contact Solicitors Assisting at lawyers@quarantineinquiry.vic.gov.au or (03) 7017 3459.

Issue date: 15 July 2020

THE HONOURABLE JENNIFER COATE AO
Board of Inquiry into the COVID-19 Hotel Quarantine Program

COVID-19
Hotel Quarantine Inquiry

DOCUMENT MANAGEMENT PROTOCOL

RELEASED 15 JULY 2020

INTRODUCTION

1 This Document Management Protocol (Protocol) outlines the method by which documents are to be provided to the Inquiry, whether in response to a Notice to Produce (Notice) or otherwise.

2 The intended audience of this Protocol is the legal representatives and IT professionals engaged to assist Parties produce materials to the Inquiry.

3 All documents to be produced to the Inquiry must be prepared and provided in accordance with this Protocol.

4 This Protocol may be varied, changed or amended by the Inquiry from time to time. The Inquiry may, at any time, depart from this Protocol if it considers it appropriate to do so, including but not limited to circumstances where it is unreasonable or too onerous upon a party to comply with the technical specifications of this Protocol.

PRINCIPLES

1 Acceptable formats

1.1 The Inquiry will accept electronic documents in both Concordance/Relativity (.dat/.opt) and Ringtail (.mdb) formats, as outlined in Schedules 1A & 1B respectively.

1.2 Each electronic file must be produced in its native format or, alternatively, produced as a rendered PDF together with a (.txt) file containing the OCR contents of the PDF file.

2 Identification of documents

2.1 Each document must be identified with a Document ID and page numbers which are unique to each page and will be the primary means of identification of documents.

2.2 All Document IDs and page numbers are to be stamped in the top right hand corner of each page.

2.3 A Document ID must be in the following format:

PPP(P).BBBB.FFFF.NNNN_XXXX

(1) **PPP(P)** is a three (or four) letter party code that identifies a Party. A Party producing Documents should contact the Inquiry prior to production to confirm the Party codes available for use.

Party Code	Party
EHSP	Example Hotel Quarantine Services Pty Ltd
ABC	AB Corporation Pty Ltd
XYZ	XY Holdings Pty Ltd

(2) **BBBB** is a 4-digit 'box' number identifying separate collections of documents (for example in relation to a particular Notice to Produce or Summons), the number to be between 0001-9999.

(3) **FFFF** is a 4-digit 'container' number identifying further separate collections of documents, the number to be between 0001-9999.

(4) **NNNN** is a 4-digit number used to differentiate individual documents and/or individual pages. In some cases, NNNN operates as a document number rather than a page number because individual pages are not numbered (ie non-standard Native files not produced as searchable PDFs). This number is padded with zeros to consistently result in a 4 digit structure.

(5) **XXXX** is an optional 4-digit number used to identify suffix rendered PDF pages. It is only required where Parties may choose to review documents in native format in their document review platforms and render documents to PDF for the purpose of production. The suffix must be preceded by an underscore, padded with zeros to consistently result in a 4-digit number structure.

An example of the Document ID structure is set out below:

XYZ.0001.0001.0001

Where:

XYZ	Party code
0001	Unique 'box' number allocated by Party.
0001	Unique 'container' number allocated by Party.
0001	Sequential page number.

2.4 Document IDs assigned must be unique to each document and must not be re- assigned to subsequent documents produced.

2.5 If alternate numbering is required please contact the Inquiry to discuss.

2.6 It is understood and accepted that Document IDs may not be consecutive as a result of the removal of irrelevant documents during review. A Party must however identify host and attachment documents with consecutive Document IDs.

2.7 Upon production of a document, the document filename must be its Document ID.

2.8 If Parties wish to render a document at the time of production following a native file review and:

(a) the first Document ID is XYZ.0001.0001.0001; then

(b) the first page of that Document rendered PDF must be stamped with:

XYZ.0001.0001.0001 or XYZ.0001.0001.0001 _0001;

(c) the second page of that Document must be stamped with:

XYZ.0001.0001.0001_0002;

(d) the third page of that Document must be stamped with:

XYZ.0001.0001.0001_0003; and

(e) the next consecutive Document must be Document ID XYZ.0001.0001.0002.

3 Document Hosts and Attachments

3.1 Every document that is attached to or embedded within another document will be treated as an Attached Document. A document that contains at least one

OFFICIAL

Attached Document will be called a Host Document. A document that is neither a Host or Attached Document will be called a Standalone Document.

3.2 Examples of Host Documents and Attached Documents include:

(a) An email, letter or fax (Host Document) and its attachments (Attached Documents).

(b) An electronic file (Host Document) that has other files embedded within it (Attached Documents)

3.3 If an Attached Document also contains attachments, those attachments will be treated as attachments to the Host Document.

3.4 A Party must ensure that false or unnecessary relationships between Host Documents and Attached Documents are not created by:

(a) taking reasonable steps to ensure that email footers, logos, and other repeated content are not separated as Attached Documents; and

(b) ensuring that physical or digital document containers, such as hard copy folders or electronic ZIP container files, are not identified as Host Documents, unless the identification of the container as a Host Document is necessary to the understanding of the documents within that container.

3.5 Unless required to provide documents in their native structure for technical reasons, documents should be extracted from their containers and the container itself should not be produced.

4 Indexes and Load Files of documents produced to the Inquiry

4.1 All documents to be produced to the Inquiry must be:

(a) included in an itemised electronic index of documents in Microsoft Excel format (**Index**) that is provided to the Inquiry; and

(b) provided in an electronic format that is in accordance with the applicable Production Load File Specification at Schedule 1A or 1B (**Load File**).

4.2 Both the Index and the Load File must contain the following information for each document, where available:

(a) Document ID
(b) Host Document ID
(c) Document Type
(d) Document Date
(e) Document Title
(f) Author (From)
(g) Recipient (To)
(h) Recipient (CC)
(i) Recipient (BCC)
(j) Notice to Produce or Summons No.
(k) Notice to Produce Tranche No.
(l) Notice to Produce Schedule Item
(m) Withheld
(n) Withheld Reason
(o) Restriction requested
(p) Reason for restriction request
(q) LPP
(r) Personal-identifying-information

5 Document metadata

5.1 Wherever possible, a Party is to rely on the automatically identified metadata of electronic documents. Automatically identified metadata should be used when:

(a) searching for documents;
(b) itemising documents in a list; and
(c) preparing a production of documents in accordance with the Production Specification at Schedules 1A or 1B.

5.2 A Party should take reasonable steps to ensure that all appropriate document metadata is not modified or corrupted during collection and preparation of electronic documents for review and production.

5.3 Document metadata is to be automatically extracted using UTC + 10 (Sydney, Melbourne, Canberra) as the time zone in the processing application.

5.4 The Inquiry accepts that complete document metadata may not be available for all electronic documents. A Party should attempt to provide complete metadata where practicable.

5.5 Hard copy documents must be produced as PDFs, together with extracted text files together with a load file as per Schedules 1A or 1B where possible.

5.6 A Party must provide information regarding the software and procedure used to automatically identify the metadata of their electronic documents if requested by the Inquiry.

5.7 Original versions of all documents must be retained by the Party producing them.

6 De-duplication of documents

6.1 A party must take reasonable steps to ensure that duplicate documents are removed from the produced material (**de-duplication**).

6.2 The Inquiry acknowledges that there may be circumstances where duplicates need to be identified and produced for evidentiary purposes.

6.3 Duplication must be considered at a document group level. That is, all documents within a group comprising a Host Document and its attachments, will be treated as duplicates only if the entire group of documents is duplicated elsewhere. An Attached Document must not be treated as a duplicate if it is merely duplicated elsewhere as an individual standalone document that is not associated with another group of documents.

6.4 A Party must apply electronic de-duplication using a MD5 algorithm.

6.5 A Party may also determine duplicate documents by way of manual review where appropriate

7 Exclusion of unusable file types

7.1 A NIST filter is to be applied to a Party's electronic documents to remove files with no user-generated content, such as system files and executable files, so that these are excluded from searches and disclosure (to the extent possible).

7.2 Temporary internet files and cookies are to be excluded from the disclosure process.

8 Treatment of email chain correspondence

8.1 Where an email is identified as relevant and it forms part of an email chain, the Party must disclose the entire email chain.

9 Use of advanced analytics technology

9.1 Parties may use advanced analytics technologies at their own discretion, but they must maintain the integrity and context of the documents, and provide entire document groups including all attachments.

9.2 Parties may use 'Email threading' technology to minimise document review. Where this technology has been used, Parties may provide only the relevant end point email with its attachments.

9.3 Parties may use technology commonly referred to as 'TAR / Assisted Review / Predictive coding' for document review at their discretion. Parties do not need to seek agreement to use such technology, but must disclose to the Inquiry that it has been used and implement processes to ensure that they are meeting their obligations under a Notice or otherwise by providing only material identified as relevant to the Notices issued, along with their document group.

10 Data security

10.1 A Party producing data must take all reasonable steps to ensure that the data is useable and is not infected by malicious software.

11 Errors in provided documents

11.1 If errors are found in any produced documents, the Party producing must provide a corrected version of the document to the Inquiry as soon as reasonably possible once that error is identified.

11.2 If errors are found in more than 25% of the produced documents in any one tranche, the Party who produced those documents must, if requested by the Inquiry, provide a correct version of all documents within the tranche.

11.3 A written explanation setting out the reasons for the errors in the documents and describing the data affected must be provided by the Party producing if errors are found in any produced documents.

12 Electronic provision of data for productions

12.1 Unless otherwise agreed or ordered by the Inquiry, the information provided and delivered to the Inquiry must be contained on agreed electronic media, being either:

(a) SFTP services of the Party providing the documents; or

(b) USB media.

In all cases Parties must apply encryption to the zip file uploaded to the SFTP or the USB media provided and the password must be shared with the Inquiry via a separate email, at the time of confirming the delivery.

13 Claims of a reasonable excuse for not complying with a Notice

13.1 Where a Party asserts that it has a reasonable excuse for failing to produce a **whole** document, the Party must:

(a) ensure that the document is identified in the Index and Load File;

(b) code the field 'Withheld=Yes' in the Index and Load File; and

(c) select the basis for the claim in the field 'Withheld Reason' in the Index and Load File.

13.2 Where a Party asserts that a reasonable excuse exists for failing to produce **part(s)** of a document, the Party must:

(a) redact the part(s) of the document that the Party asserts it has a reasonable excuse to withhold;

(b) ensure that the document is identified in the Index and Load File;

(c) code the field 'Withheld=Part' in the Index and Load File; and

(d) select the basis for the claim in the field 'Withheld Reason' in the Index and Load File.

14 Production of documents where an order is sought for restriction on publication of information

14.1 Where a Party seeks an order to prohibit or restrict publication of a **whole**

document, the Party must:

(a) produce the document;

(b) code the field 'Restricted=Yes' in the Index and Load File; and

(c) select the basis for the claim in the field 'Restricted Reason' in the Index and Load File.

14.2 Where a Party seeks an order to prohibit or restrict publication of **part(s)** of a document, the Party must:

(a) produce the document;

(b) highlight the part(s) of the document that are the subject of the claim as set out in paragraph 14.5 below;

(c) code the field 'Restricted=Part' in the Index and Load File; and

(d) select the basis for the claim in the field 'Restricted Reason' in the Index and Load File.

14.3 Where a Party seeks an order to prohibit or restrict publication over information that is personal identifying information, the Party may:

(a) highlight any personal identifying information as set out in paragraph 14.5;

(b) code the field 'Personal identifying information=Yes' in the Index and Load File; and

(c) code the fields 'Restricted' and 'Restricted Reason' in the Index and Load File as is appropriate.

14.4 The highlight colours to be applied are set out below:

Colour	Reason for highlighting
Light Blue	Personal identifying information.
Green	Claim for prohibition or restriction on publication provided for in s 73 of the Act.

14.5 If part of any document provided to the Inquiry is highlighted in accordance with this section 14, the Party producing that document must retain a non-highlighted version of the document which must be produced to the Inquiry on request.

Schedule 1A – Production Specification for .DAT/.OPT Load File (Concordance/Relativity Compliant)

1 Production format

1.1 Documents must be provided electronically, using a .DAT/.OPT data file format and in Microsoft Excel format.

(a) The first line of the .DAT file must be a header row identifying the field names.

(b) The .DAT file must use the following Concordance® default de-limiters:

(1) Pilcrow ¶ ASCII character

(2) Quote þ ASCII character

1.2 Date fields should be provided in the format: DD-MMM-YYYY or DD/mm/YYYY

1.3 If the production includes emails and attachments, the attachment fields must be included to preserve the parent/child relationship between an email and its attachments.

1.4 Productions must include an extracted text file for each document. An OCR PATH field must be included to provide the file path and name of the extracted text file on the produced storage media. The text file must be named after the Document ID. Do not include the text in the .DAT file.

1.5 For productions that contain PDF or Native documents, a LINK field must be included to provide the file path and name of the native file on the produced storage media. The native file must be named after the Document ID.

2 Preparation of documents

2.1 A Party should avoid converting native electronic documents to paper for production to the Inquiry and must instead produce them as searchable multi-page PDF documents. For non-standard documents, such as Microsoft Excel and Audio/Video files, native document production is required.

2.2 Documents produced as searchable multi-page PDFs must be stamped with sequential page numbers in the top right hand corner of each page. The number on the first page will be the Document ID. The format must be PPP.BBBB.FFFF.NNNN, eg XYZ.0000.0000.0001

2.3 Searchable electronic documents should be rendered directly to PDF to create searchable images. Documents should not be printed to paper and scanned or

rendered to Tagged Image File Format (**TIFF**) format and then converted to PDF, unless required for the purposes of highlighting within a document review platform.

2.4 Non-searchable or image only native files should be converted to searchable PDFs, and not image only or non-searchable PDFs.

2.5 Non-standard electronic documents that do not lend themselves to conversion to PDF (for example, complex spread-sheets, databases, etc.) must be produced to the Inquiry as native electronic documents or in another format agreed with the Inquiry.

2.6 Hard copy documents should be produced as searchable, stamped, multi-page PDF documents. The minimum requirement for scanned images is 300dpi text searchable multi-page PDF.

2.7 Colour versions of documents must be created if the presence of colour is necessary to the understanding of the document. Documents which have coloured annotations or highlighting, photos, graphs or images are to be captured in colour.

2.8 If documents are highlighted or redacted for the purposes identified in sections 13 and 14 of this Protocol, Parties must provide the Inquiry with an image set (as PDF files) with documents containing redactions or highlights burnt in, accompanied by a load file complying to this Schedule.

2.9 A Party may apply Document IDs to the following paper documents where they contain relevant content:

(a) folder covers, spines, separator sheets dividers;

(b) hanging file labels; and

(c) the reverse pages of any document.

3 Document folder structure

3.1 The file name of each document must include the relevant file extension, e.g. 'DocumentID.xxx' where '.xxx' is the file extension.

3.2 The top level folder containing every document must be named '\Documents\'.

3.3 The documents folder must be structured in accordance with the Document ID hierarchy, e.g. 'Documents\ABC\."

4 Overview of metadata provided within the data (.DAT) load file

4.1 Required fields/metadata in a flat file format:

Field	Explanation – Document Types and Coding Method and possible values	
Document_ID	Document ID	
Host_Reference	If the document is an attachment, this field contains the Document ID of its host document. If a document does not have a host, this field is to be left blank\NULL.	
Document_Type	Paper Documents	Refer Document Types in Schedule 2.
	Electronic Documents (including email, email attachments, loose files etc)	Either native file type or Document Type in Schedule 2 as determined on the basis of the face of the document.
Document_Date	DD-MMM-YYYY or DD/mm/YYYY	
	Paper Documents	Determined on the basis of the date appearing on the face of the document.
	Undated Documents	Leave field blank\NULL.
	Incomplete Date (Year Only)	For example, 01-JAN-YYYY
	Incomplete Date (Month and Year Only, or Day and Month Only)	For example, 01-MMM-YYYY, DD-MMM-1900
	Emails	Email Sent Date
	Unsent Emails	Last Modified Date
	Other Electronic Documents	Last Modified Date; or Date appearing on the face of the document.
Document Date and Time	DD-MMM-YYYY HH:MM:SS (where HH is a 24 hour format)	
	Paper Documents	Determined on the basis of the date appearing on the face of the document .
	Undated Documents	Leave field blank\NULL.
	Incomplete Date (Year Only)	For example, 01-JAN-YYYY 00:00:00
	Incomplete Date (Month and Year Only, or Day and Month Only)	For example, 01-MMM-YYYY 00:00:00, DD-MMM-1900 00:00:00
	Emails	Email Sent Date and Time
	Unsent Emails	Last Modified Date and Time
	Other Electronic Documents	Last Modified Date and Time; or Date and time appearing on the face of the document.
Estimated	Yes OR No OR NULL	
	Default	No OR NULL
	Undated Documents	No OR NULL
	Incomplete Date	Yes
Title	Paper Documents	Determined on the basis of the title appearing on the face of the document .
	Email	Subject field from email metadata.
	Other Electronic Documents	Metadata file name or determined on the basis of the title appearing on the face of the document.

People and Organisations	Format 1: Person [Organisation] Format 2: Organisation Format 3: Person name or email address	
	Paper Documents	Name of person to be determined on the basis of the face of the document [Name of organisation that produced the document as determined on the basis of the face of the document]
	Emails	Electronic metadata – email addresses or email alias names.
	Other Electronic Documents	To be determined from the automatically identified metadata.
Organisations	Paper Documents	Name of organisation that produced the document as determined on the basis of the face of the document.
	Emails	Blank\NULL
	Other Electronic Documents	To be determined from the automatically identified metadata.
Persons	Paper Documents	To be determined on the basis of the face of the document.
	Emails	Electronic metadata – email addresses or email alias names.
	Other Electronic Documents	Author value to be determined from the automatically identified metadata.
Withheld	Yes OR Part OR No	
Withheld Reason	Legal professional privilege (65(2)(c)) Privilege against self-incrimination (offence) - (65(2)(a)); Privilege against self-incrimination (penalty) - (65(2)(a))); Parliamentary privilege (65(2)(b)); Public interest immunity (65(2)(d)); Prohibited by court order (65(2)(e)); Prohibited by enactment (65(2)(f)); Prohibited by enactment prescribed by regulations (65(2)(g)); or Other reason(65(1)(a))	
Restricted	Yes OR Part OR No	
Restricted Reason	Prejudice or hardship (73(2)(a)); Sensitive nature and subject matter (73(2)(b)); Possible prejudice to legal proceedings (73(2)(c)); Conduct of proceeding would be more efficient and effective (73(2)(d)); or Member should otherwise consider appropriate (73(2)(e))	
Personal-identifying information	Yes OR No	
Notice to Produce or Summons No.	Eg: NP002	Inquiry request number as identified on the Notice or Summons .
Notice to Produce Tranche No	NP002_TR01	Notice to Produce Tranche No in which the document is produced under
Notice to Produce Schedule Item	NP002-sch01	Notice to Produce Schedule item the document is relevant to

File Path	e.g. \\server\custodianname\	Source path of the original file, if available.
File Name	e.g, draft report.pdf	Source name of the original file, if available.
Date Created	DD-MMM-YYYY HH:MM:SS	Electronic metadata – created date, if available.
Date Last Modified	DD-MMM-YYYY HH:MM:SS	Electronic metadata – last modified date, if available.
MD5 Hash Value		MD5 hash value used for deduplication, if available.
File Extension	Eg: XLSX PDF	The file extension or original native file type is to be provided for all documents.
OCR TEXT file path	Documents\Text\Document_ID.TXT	Extracted text path.
Native\PDF file Path	Documents\Native\Document_ID.EXT	Native path for documents produced in native format.

4.2 Parties' information (To/From/CC/BCC) technical requirements:

(a) These fields hold the names of Parties associated with a particular document and their relationship to the document. It may also hold organisation information for these people.

(1) Describing people:

(i) A person's name may be referenced using:

A. email addresses (for example, jcitizen@xyz.com.au); or

B. Surname [space] first name initial (for example, Citizen J) where email addresses are not available; or

C. by reference to a position (for example, Private Service Provider) where email addresses or surname and first name initial are not available; or

D. by reference to an organisation associated with the person where email address, surname and first name initial and position are not available.

(2) Multiple recipients must be separated by a semicolon.

(3) Organisations must be placed into square brackets.

COVID-19
Hotel Quarantine Inquiry

Schedule 1B – Production Specification for Four-Table Microsoft Access Load File (Ringtail Compliant)

1 Production format

1.1 Documents must be produced electronically, in a cascading Windows folder structure, with the corresponding document metadata structured in a four-table Microsoft Access database format.

1.2 A Party should also include the index of documents in Microsoft Excel format.

2 Preparation of documents

2.1 A Party should avoid converting native electronic documents to paper for production to the Inquiry and must instead produce them as searchable multi-page PDF documents. For non-standard documents, such as Microsoft Excel and Audio/Video files, native document production is required.

2.2 Documents produced as searchable multi-page PDFs must be stamped with sequential page numbers in the top right hand corner of each page. The number on the first page must be the Document ID. The format must be PPP.BBBB.FFFF.NNNN, e.g. XYZ.0001.0001.0001.

2.3 Searchable electronic documents should be rendered directly to PDF to create searchable images. Documents should not be printed to paper and scanned or rendered to Tagged Image File Format (**TIFF**) format and then converted to PDF, unless required for the purposes of highlighting within a document review platform.

2.4 Non-searchable or image only native files should be converted to searchable PDFs, and not image only or non-searchable PDFs.

2.5 Non-standard electronic documents that do not lend themselves to conversion to PDF (for example, complex spread-sheets, databases, etc.) must be delivered to the Inquiry as native electronic documents or in another format agreed with the Inquiry.

2.6 Hard copy documents should be provided as searchable, stamped, multi-page PDF documents. The minimum requirement for scanned images is 300dpi text

searchable multi-page PDF.

2.7 Colour versions of documents must be created if the presence of colour is necessary to the understanding of the document. Documents which have coloured annotations or highlighting, photos, graphs or images are to be captured in colour.

2.8 If documents are highlighted for the purposes identified in section 18, 19 and 20 of this Protocol, Parties must provide the Inquiry with an image set (as PDF files) with documents containing highlights burnt in accompanied by a load file, complying to this Schedule.

2.9 A Party may apply Document IDs to the following paper documents where they contain relevant content:

(a) folder covers, spines, separator sheets dividers;

(b) hanging file labels; and

(c) the reverse pages of any document

3 Document folder structure

3.1 The file name of each document must include the relevant file extension, e.g. 'DocumentID.xxx' where '.xxx' is the file extension.

3.2 The top level folder containing every document must be named '\Documents\'

3.3 The documents folder must be structured in accordance with the Document ID hierarchy, ie "Documents\ABC\[subfolders if required]"

4 Overview of structure of four-tabled Microsoft Access database

4.1 The document metadata is to be structured into the following four Microsoft Access database tables:

Table Name	Table Description
Export	Main document information.
Parties	People and organisation information for each document.
Pages	Listing of electronic image filenames for each document. The Pages table must correspond to the files within the cascading document folder structure.
Export_Extras	Additional data fields for each document, including subjective fields populated by the Parties during review.

4.2 Export Table

Field	Data Type	Explanation – Document Types and Coding Method and possible values	
Document_ID	Text, 255	Document ID	
Host_Reference	Text, 255	If the document is an attachment, this field contains the Document ID of its host document. If a document does not have a host, this field is to be left blank\NULL.	
Document_Type	Text, 255	Paper Documents	Refer Document Types in Schedule 2.
		Electronic Documents (including email, email attachments, loose files etc)	Either native file type or Document Type in Schedule 2 as determined on the basis of the face of the document.
Document_Date	Date, 11	DD-MMM-YYYY or DD/mm/YYYY	
		Paper Documents	Determined on the basis of the date appearing on the face of the document.
		Undated Documents	Leave field blank\NULL.
		Incomplete Date (Year Only)	For example, 01-JAN-YYYY
		Incomplete Date (Month and Year Only; or Day and Month Only)	For example, 01-MMM-YYYY, DD-MMM-1900
		Emails	Email Sent Date
		Unsent Emails	Last Modified Date
		Other Electronic Documents	Last Modified Date; or Date appearing on the face of the document.
Estimated	Text, 3	Yes OR No OR NULL	
		Default	No OR NULL
		Undated Documents	No OR NULL
		Incomplete Date	Yes
Title	Text, 255	Paper Documents	Determined on the basis of the title appearing on the face of the document.
		Email	Subject field from email metadata.
		Other Electronic Documents	Metadata file name or determined on the basis of the title appearing on the face of the document.
Level_1		First subfolder level of where the document file is.	
Level_2		Second subfolder (if required) of where the document file is.	

4.3 Parties Table:

(a) This Table holds the names of people associated with a particular document and their relationship to the document. It may also hold organisation information for these people. There is a one-to-many relationship between the Export Table containing the primary document information and the Parties Table because multiple people could be associated with a single document.

Field	Data Type	Explanation	
Document_ID	Text, 255	Document ID	
Correspondence_Type	Text, 100	Paper Documents	AUTHOR, RECIPIENT BETWEEN, ATTENDEES, CC To be determined on the basis of the face of the document.
		Emails	FROM, TO, CC, BCC
		Other Electronic Documents	AUTHOR, RECIPIENT, CC To be determined from the automatically identified metadata.
Organisations	Text, 255	Paper Documents	Name of organisation that produced the document as determined on the basis of the face of the document.
		Emails	Blank\NULL
		Other Electronic Documents	To be determined from the automatically identified metadata.
Persons	Text, 255	Paper Documents	To be determined on the basis of the face of the document.
		Emails	Electronic metadata – email addresses or email alias names.
		Other Electronic Documents	Author value to be determined from the automatically identified metadata.

(b) Describing people in the Parties Table:

(1) A person's name may be referenced using:

(A) email addresses (for example, jcitizen@xyz.com.au); or

(B) Surname [space] first name initial (for example, Citizen J) where email addresses are not available; or

(C) by reference to a position (for example, Private Service Provider Manager) where email addresses or surname and first name initial are not available; or

(D) by reference to an organisation associated with the person where email address, surname, surname and first name initial and position are not available.

(2) Multiple recipients must be entered as separate rows in the Parties Table.

4.4 Pages Table

(a) There must be at least one entry in the Pages Table that relates to a single document in the Export Table. Concurrently, there must be an entry in the Pages Table for every file provided in the cascading document folder structure.

Field	Data Type	Explanation
Document_ID	Text, 255	Document ID
File_Name	Text, 128	Filename, including extension of each indexed document.
Page_Label	Text, 32	"PDF" for files produced as searchable multipage PDF documents. "Native" for documents produced as native electronic files. "Text" for the extracted text (OCR) contents of the file.
Page_Num	Number, Double	"1" for files produced as searchable multipage PDF documents. "2" for documents produced as native electronic files. "3" for the OCR text file.
Num_Pages	Number, Double	A number that represents the total number of pages of the document for files produced as searchable multipage PDF documents. "1" for documents produced as native electronic files.

4.5 Export Extras Table

(a) The Export Extras Table holds any additional metadata the Parties wish to produce that is not held in the other three Tables mentioned above. In addition to automatically identified document metadata, the Export Extras Table must also hold subjective coding information about documents that has been determined by the Parties.

Field	Data Type	Explanation
Document_ID	Text, 255	Unique Document Identifier (Document ID)
theCategory	Text, 50	Text OR Date OR Numb OR Bool OR Pick OR Memo
theLabel	Text, 255	Custom Field Name, from the List of Extras Fields below
theValue	Text, 255	Custom Field Contents from the List of Extras Fields below
Memovalue	MEMO	Custom Field Contents from the List of Extras Fields below for values more than 255 characters

(b) Required Extras Fields

Field	Data Type	Acceptable Values	Explanation
Document Date and Time	TEXT	DD-MMM-YYYY HH:MM:SS (where HH is a 24 hour format)	Document Date and Time electronically extracted using the respective processing tool (ie. Email Sent Date and Time OR Last Modified Date and Time). Where no time is electronically available the format value will be DD-MMM-YYYY 00:00:00
Withheld	PICK	Yes, Part	Only required for Documents being withheld in full or part. Single choice only
Withheld Reason	PICK	Legal professional privilege (65(2)(c)) Privilege against self-incrimination (offence) - (65(2)(a)); Privilege against self-incrimination (penalty) - (65(2)(a))); Parliamentary privilege (65(2)(b)); Public interest immunity (65(2)(d)); Prohibited by court order (65(2)(e)); Prohibited by enactment (65(2)(f)); Prohibited by enactment prescribed by regulations (65(2)(g)); or Other reason(65(1)(a))	Basis on which document is withheld. Only required for Documents marked as Withheld = Yes or Part
		(18(2)(d)); Prohibited by enactment (18(2)(e)); Prohibited by enactment prescribed by regulations (18(2)(f)) and (34(4)); or Other reason(18)(1)(a)	
Restricted	PICK	Yes, Part	Only required for documents with restrictions in full or part. Single choice only

Restriction Reason	PICK	Prejudice or hardship (73(2)(a)); Sensitive nature and subject matter (73(2)(b)); Possible prejudice to legal proceedings (73(2)(c)); Conduct of proceeding would be more efficient and effective (73(2)(d)); or Member should otherwise consider appropriate (26(2)(e))	Basis on which document is restricted. Only required for documents marked as Restricted = Yes or Part
Personal identifying information	PICK	Yes	Only required where information is highlighted as personal identifying information. Single choice only
Notice to Produce or Summons No.	PICK	Eg: N006/16	Inquiry request number as identified on the Notice or Summons.
Notice to Produce Tranche No	PICK	NP002_TR01	Notice to Produce Tranche No in which the document is produced under
Notice to Produce Schedule Item	PICK	NP002-sch01	Notice to Produce schedule item the document is relevant to
File Path	MEMO		Source path of the original file, if available.
File Name	TEXT		Source name of the original file, if available.
Date Created	TEXT	DD-MMM-YYYY HH:MM:SS	Electronic metadata – created date, if available.
Date Last Modified	TEXT	DD-MMM-YYYY HH:MM:SS	Electronic metadata – last modified date, if available.
MD5 Hash Value	TEXT		MD5 hash value used for deduplication, if available.
File Extension	TEXT	Eg: XLSX PDF	The file extension or original native file type is to be provided for all documents.

COVID-19
Hotel Quarantine Inquiry

Schedule 2 – Document Types

1 Document Types for electronic documents

Document Type	Description
Email	An email – usually contained within an email store (e.g. an email box) but may be extracted to reside within a directory or folder on a file system.
Email Attachment	An electronic document attached to an email.
Electronic File	An electronic file that is not attached to an email but rather resided in its original state in a directory on a file system.

2 Document Types for hard copy documents

2.1 Standard document types:

Document Type			
Agenda	Email	Minutes of Meeting	Transcript
Agreement/Contract/Deed	Facsimile	Notice	Web Page
Affidavit/Statement	Fax Transmission Report	Permit	
Annual Report	File Note	Photograph	
Article	Financial Document	Physical Media	
Authority	Form	Presentation	
Board Papers	Handwritten Note/Note	Receipt	
Brochure	Invoice/Statement	Report	
Certificate	Legislation/Act	RFI – RFO	
Cheque Remittance	Letter	Search/Company Search	
Court Document	List	Social Media/Messaging	
Curriculum Vitae/Identification	Manual/Guidelines	Specification	
Diary Entry	Map	Table/Spreadsheet	
Divider/File Cover	Media Article/Release	Submissions	
Diagram/Plan	Memorandum	Timesheet	

Practice Direction 2

COVID-19
Hotel Quarantine Inquiry

PRACTICE DIRECTION NO. 2

LEAVE TO APPEAR AT THE INQUIRY

15 JULY 2020

INTRODUCTION

1. This Practice Direction (**PD-2**) relates to participation in the evidentiary public hearings that will be held as part of the work of the Board of Inquiry into the COVID-19 Hotel Quarantine Program (**Inquiry**).

2. This Practice Direction is issued under s 63(1) of the *Inquiries Act 2014 (Vic)* (**Act**). It should be read in conjunction with the Act and with the terms of reference contained in the Order establishing the Inquiry.

3. This Practice Direction sets out general guidance about applications for leave to appear at the evidentiary public hearings of the Inquiry. Other information relevant to the work of the Inquiry can be found in Practice Direction 3 which relates to the taking of evidence at those public hearings.

WHEN LEAVE TO APPEAR MAY BE GRANTED

4. The Inquiry's power to grant leave to appear is contained in section 62 of the Act.

5. Having regard to the matters in that section and to the nature, purposes and timeframe of the Inquiry, it is anticipated that leave to appear may be granted to a person (including a body corporate or body politic) who has a direct or special interest in one or more of the subjects of the Inquiry. It will generally be granted where a person -

   (a) is a subject of consideration at the evidentiary public hearing;

   (b) is likely to be the subject of an adverse allegation; or

   (c) is able to demonstrate that their participation in the hearing will assist the Inquiry.

THE SCOPE OF ANY LEAVE GRANTED

6. It is unlikely that the Inquiry will grant any person unconditional leave to appear. Unless the Inquiry is otherwise persuaded in a particular case, any grant of leave will be -

   (a) limited to the particular issue or issues in which the person has the special or direct interest; and

   (b) subject to conditions.

7. A person granted leave to appear will be entitled to -

   (a) appear at and participate in the public hearing subject to the Inquiry's control and to any limitations and conditions imposed on the grant of leave;

   (b) be legally represented without the need for further or separate authorisation; and

   (c) seek leave to examine or cross examine witnesses in accordance with Practice Direction 3.

8. The Inquiry may at any time withdraw leave to appear or make a grant of leave subject to amended or additional limitations and conditions.

PROCESS FOR APPLICATIONS

9. The evidentiary public hearings will commence in August 2020 on dates to be fixed. The matters to be considered at the public hearings will be determined by the Inquiry and published on its website in advance of the hearing dates.

10. All applications for leave to appear at the evidentiary public hearings must be made -

    (a) as soon as the person becomes aware that they have a relevant interest in the matters to be considered at the public hearings;

    (b) wherever possible, no later than 3 days prior to the date of the evidentiary public hearing for which leave to appear is sought; and

    (c) on the form **attached** to this Practice Direction entitled "Application for Leave to Appear at the Public Hearings of the Inquiry".

11. The completed form must be accompanied by a short submission of no more than one page addressing the reasons why the applicant should be granted leave to appear at the evidentiary public hearing. Submissions should address:

(a) the matters referred to in section 62(2) of the Act; and

(b) the matters set out in this Practice Direction.

12. Applications for leave should be sent to Solicitors Assisting by email to: lawyers@quarantineinquiry.vic.gov.au or by post to: PO Box 24012, Melbourne VIC 3001.

13. The Inquiry will generally determine applications for leave to appear without any oral hearing and on the basis of the application and submissions provided.

14. The Inquiry will notify the applicant in writing of its determination.

CONTACTING THE INQUIRY

15. Any questions about any matters dealt with in this Practice Direction or other matters concerning the public hearings should be directed to Solicitors Assisting at: lawyers@quarantineinquiry.vic.gov.au.

Issue date: 15 July 2020

THE HONOURABLE JENNIFER COATE AO
Board of Inquiry into the COVID-19 Hotel Quarantine Program

Application for Leave to Appear at the Public Hearings of the Inquiry

Name of person or organisation seeking leave to appear	
Lawyer(s) representing the person or organisation (if any)	
Contact person(s)	
Contact address	**(State)** **(Postcode)**
Contact telephone number	**(Business)** **(Mobile)**
Contact email address(es)	

Please attach a short submission as to the reasons why the applicant should be granted leave to appear at the public hearings.

The submission must be no longer than one page and should address:

- the matters referred to in section 62(2) of the *Inquiries Act 2014* (Vic); and
- how granting leave to appear at the public hearings would assist the Inquiry in the conduct of the public hearings over and above any written submissions that the applicant may make

Please lodge this form with the attached submission by sending it via:

- email to: lawyers@quarantineinquiry.vic.gov.au; or
- post to: PO Box 24012, Melbourne VIC 3001.

Practice Direction 3

COVID-19
Hotel Quarantine Inquiry

PRACTICE DIRECTION NO. 3

CONDUCT OF PUBLIC HEARINGS

15 JULY 2020

As Amended on 20 August 2020

INTRODUCTION

1. This Practice Direction (**PD-3**) relates to the conduct of the public hearings that will be held as part of the work of the Board of Inquiry into the COVID-19 Hotel Quarantine Program (**Inquiry**).

2. This Practice Direction is issued under section 63(1) of the *Inquiries Act 2014 (Vic)* (**Act**). It should be read in conjunction with the Act and with the terms of reference contained in the Order establishing the Inquiry.

3. This Practice Direction sets out the way in which the evidentiary public hearings of the Inquiry will be conducted. Persons seeking to participate in the public hearings should consult Practice Direction 2 which relates to applications for leave to appear.

GENERAL MATTERS

4. The Inquiry will conduct evidentiary public hearings from August 2020 on dates to be fixed.

5. The Inquiry will endeavour to publish a list of the topics to be examined in the public hearings in advance. That list may be amended as the Inquiry proceeds. The Inquiry will also, from time to time, publish a list of the witnesses who will attend and give evidence at the hearings.

6. Subject to any contrary direction of the Inquiry pursuant to the Act, the public hearings will be open to the public via live streaming.

7. Subject to any changes in public heath directions made under the *Public Health and Wellbeing Act 2008*, or by leave granted by exception, only designated officers of the Inquiry, including Counsel Assisting the Inquiry (**Counsel Assisting**), will be physically

present during the public hearings. Persons granted leave to appear and their legal representatives will attend via online video platform.

WITNESSES

8. Subject to the control of the Inquiry, Counsel Assisting will determine -

   (a) who is to be called as a witness at the public hearings;

   (b) the order in which those witnesses are called; and

   (c) which documents are to be tendered.

9. The Inquiry will require witnesses to give evidence on oath or affirmation.

10. The Inquiry may require witnesses to give evidence concurrently with other witnesses.

11. All persons required to give evidence will be served with a notice under section 64 of the Act requiring their attendance to give evidence.

IDENTIFICATION AND PREPARATION OF WITNESSES

12. Counsel Assisting, with the assistance of the Solicitors Assisting the Inquiry, will:

   (a) identify and contact each individual they wish to give evidence as a witness before the Inquiry;

   (b) determine whether an individual in respect of whom a witness statement has been prepared or received will be called to give evidence at a hearing; and

   (c) obtain witness statements in accordance with this Practice Direction.

13. Unless the Inquiry otherwise determines, any witness called in the public hearings will give evidence by way of both written witness statement and oral evidence.

14. Where a proposed witness is not legally represented, Counsel Assisting and Solicitors Assisting the Inquiry will meet with the proposed witness for the purpose of preparing their witness statement.

15. Where a proposed witness is legally represented -

   (a) Counsel Assisting will prepare, and Solicitors Assisting will provide, an outline of the topics that should be addressed in a proposed witness statement;

   (b) the proposed witness will be assisted by their legal representative in the preparation of their witness statement;

   (c) the witness statement must follow, and address each topic in, the outline; and

(d) Solicitors Assisting will communicate with the witness's legal representatives about the time by which the statement will be required, and where relevant and appropriate, about conferring with the witness prior to the date on which the witness gives evidence.

EXAMINATION OF WITNESSES AT THE PUBLIC HEARING

Evidence in chief

16. All witnesses called to give evidence will be examined by Counsel Assisting who will -

(a) invite the witness to adopt their witness statement as their evidence in chief; and

(b) examine the witness on topics that are -

(A) not covered in their witness statement;

(B) the subject of different or contradictory information available to the Inquiry; or

(C) otherwise matters which the Inquiry will be assisted by being canvassed in oral evidence.

17. Where practicable, Counsel Assisting will notify witnesses in advance of the hearing of any topics on which questions will be asked of the witness that are not covered by their witness statement. Counsel Assisting may, however, ask questions of the witness irrespective of whether notice is given.

Cross examination

18. Examination or cross-examination of witnesses by any other party will be by leave only and no open-ended leave will be given.

19. Any person who has leave to appear and who wishes to examine or cross examine a witness should consult with Counsel Assisting, via email in the first instance, regarding topics to be canvassed and whether those matters are matters that can be dealt with by Counsel Assisting. Counsel Assisting can be contacted at:

Tony Neal QC – tony.neal@quarantineinquiry.vic.gov.au

Rachel Ellyard – rachel.ellyard@quarantineinquiry.vic.gov.au

Ben Ihle – ben.ihle@quarantineinquiry.vic.gov.au

Steven Brnovic - steven.brnovic@quarantineinquiry.vic.gov.au

Jess Moir - jess.moir@quarantineinquiry.vic.gov.au

20. A person who has leave to appear and who wishes to seek leave to examine or cross-examine a witness must notify Counsel Assisting in accordance with paragraph 19 at least 2 working days before the day on which the witness is scheduled to give evidence, in accordance with the timetable to be published by the Inquiry from time to time, and inform Counsel Assisting of the matters set out in paragraph 22 below.

21. If a person who has leave to appear wishes to seek leave to examine or cross examine a witness and has not given notice as required by paragraph 20, that person may nevertheless seek leave, and may be called upon to specify, in addition to the matters set out in paragraph 22, why notice was unable to be given in advance.

22. In determining whether a person has a sufficient interest to examine or cross-examine a witness, the Inquiry may call upon the party making the application to set out in writing or in oral submissions:

    (a) the purpose of the cross-examination;

    (b) the issues to be canvassed;

    (c) the proposed duration of the examination; and

    (d) details (with copies provided) of any documents to which they propose to take the witness.

23. Wherever possible the Inquiry will determine applications for leave in chambers and in advance of the date on which the witness is to be called.

24. Leave to cross examine will only be granted to the extent it will assist the Inquiry.

25. Where leave is granted -

    (a) that leave may specify the issue or issues about which questions may be asked;

    (b) questioning must be limited to matters within the scope of the Inquiry;

    (c) questioning which is repetitive of matters already raised by Counsel Assisting will not be permitted;

    (d) questions going only to credit will not be permitted;

    (e) parties with a common interest in the evidence of a witness will be expected to agree amongst themselves on the division of topics amongst them;

    (f) revisiting areas or subjects covered by earlier questioning by parties with a common interest will not be permitted; and

(g) in default of agreement the Inquiry will direct the order of questioning; and

(h) any leave granted to the legal representative of a witness to examine their client will be confined to matters not already in evidence.

26. After any questioning by other parties, Counsel Assisting may re-examine the witness.

DOCUMENTS

27. Counsel Assisting will determine, subject to the Inquiry's control, which and when documents are to be tendered.

28. Before the commencement of the public hearing, each person granted leave to appear at the hearing may at the discretion of Counsel Assisting or Solicitors Assisting be given confidential access to documents that are likely to be tendered as exhibits and which could affect that person's interests. The time at which such access will be granted is in the discretion of the Inquiry and may be granted in tranches subject to the order in which issues are to be addressed in the public hearing.

29. One purpose for which confidential access may be granted is to enable the identification of any application for a restricted publication order in relation to a document or part of a document.

30. Additional documents may be tendered by Counsel Assisting during the course of a public hearing. Copies of any such documents will be provided to persons granted leave to appear.

31. A copy of any document proposed to be put to a witness must be provided to the Solicitors Assisting the Inquiry as soon as the decision is made to use the document and in all cases prior to the date on which it is intended to be used.

32. If a person who has been granted leave to appear seeks to have a document tendered at a public hearing:

(a) that person must provide a copy of it to Solicitors Assisting the Inquiry as soon as the decision is made to place the document before the public hearing;

(b) the Inquiry may require the production of other documents to assist in determining whether the document in question should be received; and

(c) Counsel Assisting will decide whether or not the documents are to be tendered.

RESTRICTED PUBLICATION ORDERS

33. The Inquiry may restrict publication of information relating to the public hearings in accordance with section 73 of the Act.

34. Subject to section 73 and any other direction made by the Inquiry:

    (a) transcripts of the evidence at the public hearings will be uploaded onto the Inquiry's website as soon as they are available;

    (b) witness statements of witnesses called to give evidence at the public hearings will be available on the Inquiry's website as soon as practicable after the witness has given their evidence; and

    (c) documents tendered at the public hearings will be available on the Inquiry's website as soon as practicable after the document has been tendered.

35. A person who has been granted leave to appear at the public hearing and who wishes to apply for a restricted publication order in respect of any witness or any evidence to be given during a public hearing must -

    (a) give notice of the application to Solicitors Assisting as soon as the basis for the application is identified and in all cases prior to the date on which the witness or evidence is to be before the public hearing; and

    (b) in that notice set out the basis of the application in writing by reference to the matters in section 73.

36. Unless the Inquiry otherwise directs in a particular case, restricted publication order applications will be determined on the papers.

37. The Inquiry will give notice to media organisations of any application for a restricted publication order.

CONTACTING THE INQUIRY

38. Any questions about any matters dealt with in this Practice Direction or other matters concerning the public hearings should be directed to Solicitors Assisting at: lawyers@quarantineinquiry.vic.gov.au.

Issue date: 15 July 2020

THE HONOURABLE JENNIFER COATE AO
Board of Inquiry into the COVID-19 Hotel Quarantine Program

Practice Direction 4

COVID-19
Hotel Quarantine Inquiry

PRACTICE DIRECTION NO. 4

CONDUCT OF EVIDENTIARY PUBLIC HEARINGS IN A VIRTUAL ENVIRONMENT

6 August 2020

INTRODUCTION

1. This Practice Direction (**PD-4**) relates to the conduct of the evidentiary public hearings that will be held as part of the work of the Board of Inquiry into the COVID-19 Hotel Quarantine Program (**Inquiry**) in a virtual environment.

2. This Practice Direction is issued under s 63(1) of the *Inquiries Act 2014* (Vic) (**Act**). It should be read in conjunction with the Act, the terms of reference contained in the Order establishing the Inquiry, and the other Practice Directions available on the Inquiry's website (https://www.quarantineinquiry.vic.gov.au/lawyers).

3. This Practice Direction may be varied, changed or amended from time to time. The Inquiry may, at any time, depart from this Practice Direction if it considers it appropriate to do so.

VIRTUAL HEARING ROOM

4. The evidentiary public hearings will be conducted via a virtual hearing room (**Virtual Hearing Room**).

5. The software used to host the Virtual Hearing Room will be Zoom.

PARTICIPANTS

6. To maintain orderly proceedings, access to the Virtual Hearing Room will be limited to the following, subject to any contrary directions the Inquiry may make in exceptional circumstances:

   (a) Witnesses called to give evidence before the Inquiry;

   (b) The legal representatives of such witnesses, including their Counsel and/or

solicitors;

(c) The legal representatives of other parties with leave to appear, but only at such times as evidence is being given or submissions are being made to the Inquiry in respect of matters where that party has a direct or special interest in that evidence or those submissions; and

(d) If applicable, one other person representing witnesses and/or each party with leave to appear (e.g. 'clients').

(together, **Participants**).

7. All other parties or persons wishing to observe the evidentiary public hearings may do so via the livestream available on the Inquiry's website (www.quarantineinquiry.vic.gov.au).

TECHNOLOGICAL SPECIFICATIONS FOR VIRTUAL HEARING ROOM

8. Zoom is a video conferencing application that can be used on any device, including a computer, tablet or a smartphone. Zoom may be accessed through the dedicated application or through a web browser.

9. The Inquiry recommends that Participants:

(a) download the Zoom application (available free at https://zoom.us/download or in the app store for your device);

(b) familiarise themselves with Zoom using the videos and guides on the Zoom website;

(c) have their own device with Zoom installed;

(d) use a computer or tablet no smaller than an iPad (9.7"). Smartphones should not be used by Participants who will be addressing the Inquiry during the evidentiary public hearings;

(e) ensure that they access the Virtual Hearing Room from a location that has a reasonable internet speed, whether via Wi-Fi or a cellular network such as 4G;

(f) wear a headset when attending the Virtual Hearing Room to improve audio quality and reduce any audio feedback (noting that mobile phone in-ear headphones do not generally provide reliable audio).

ACCESSING THE VIRTUAL HEARING ROOM

10. In order to access the Virtual Hearing Room, Participants are required to:

(a) Prepare a list containing the names, email addresses and mobile phone numbers of each person requiring access to the Virtual Hearing Room; and

(b) Email the list at least 24 hours prior to the hearings they propose to attend to Solicitors Assisting at lawyers@quarantineinquiry.vic.gov.au using 'Proposed Participants for Virtual Hearings' as the subject line of the email.

11. Participants will then be provided with log-in details enabling them to access the Virtual Hearing Room.

DEVICE CHECKS

12. Device checks will be arranged with witnesses called to give evidence before the Inquiry, in the days before they are scheduled to give evidence, to confirm that their technology is operating effectively. Legal representatives for witnesses called to give evidence before the Inquiry are permitted to attend such device checks.

13. A final device check will be conducted immediately prior to the hearing. Witnesses and their Nominated Legal Representative (see paragraph 18, below) must log-in to Zoom using the details provided 30 minutes prior to their scheduled appearance time to complete the final device check.

ATTENDING THE VIRTUAL HEARING ROOM

14. In order to replicate the conditions of a physical hearing room, when attending the Virtual Hearing Room:

(a) all Participants must ensure that they are situated in a quiet physical location that complies with social distancing requirements in place at the time, and where they will avoid interruption; and

(b) save as may be necessary for the limited purpose of receiving technological support, and subject to any directions the Board may make from time to time, witnesses must ensure that there are no other persons present in that physical location while giving evidence before the Inquiry.

15. When logging-in to Zoom, Participants must enter '(LTA)' then their full name and the organisation they are representing (if applicable). E.g. '(LTA) John Smith – Sample Co Pty Ltd'.

16. Participants other than witnesses and their Nominated Legal Representative (see paragraph 18, below) must mute their microphones and ensure that their camera is turned off.

17. Witnesses and their Nominated Legal Representative must log-in 30 minutes prior to the scheduled commencement of the witness' evidence, with their microphone on mute and their camera turned on. Witnesses will be invited to unmute their microphone immediately prior to giving evidence, and their Nominated Legal Representative will be requested to switch off their cameras and leave their microphone on mute unless addressing the Inquiry as outlined below.

ADDRESSING THE INQUIRY

18. Only one legal representative for each witness and party who has been granted leave to appear (**the Nominated Legal Representative**) will be able to turn on their camera, unmute their microphone, and address the Inquiry during the public evidentiary hearings, subject to the following:

    (a) In accordance with standard Court etiquette, the Nominated Legal Representative must refrain from turning on their camera and unmuting their microphone while Counsel Assisting is examining a witness unless it is necessary to make an objection;

    (b) When considering the need to address the Inquiry, the Nominated Legal Representative should have regard to the following:

        (A) The need for the Inquiry to maintain orderly proceedings, and the added difficulty of maintaining orderly proceedings in a virtual environment;

        (B) Once the Nominated Legal Representative turns on their camera and unmutes their microphone, their image and voice will be broadcast within the Virtual Hearing Room and, unless the Inquiry otherwise directs, the public via the Inquiry's live-stream;

    (c) Applications for leave to re-examine or cross-examine a witness must be made in accordance with Practice Direction 3; and

    (d) The Inquiry maintains the right to conduct the evidentiary public hearings in any manner it considers appropriate in accordance with s 59 of the *Inquiries Act 2014*.

19. Witnesses will be permitted to address the Inquiry in the usual manner when responding to questions put to them.

20. Those persons who have been given access to the Virtual Hearing Room, other than the Nominated Legal representative and witnesses, will not be permitted to address the Inquiry, unless exceptional circumstances apply, and will have their camera and microphone settings disabled throughout the evidentiary public hearings accordingly.

GIVING EVIDENCE

21. Witnesses will be sworn in or affirmed by the Associate. Witnesses can choose to take an oath or affirmation via Zoom. Witnesses choosing to take an oath are not required to hold a religious text. In circumstances where a witness would like to swear an oath upon a religious text, it will be the responsibility of the witness and/or their legal representative(s) to ensure that text is available.

22. Where a witness wishes to show a document or video during the virtual hearing, the witness and/or their legal representative(s) must contact the Inquiry at least two days prior to the commencement of the hearing so that the Inquiry may make suitable arrangements for the document or video to be shown during the hearing.

ETIQUETTE

23. The Board of Inquiry is constituted by the Honourable Jennifer Coate AO. When addressing the Board of Inquiry, the appropriate terminology is 'the Board' (e.g. 'if the Board pleases').

24. Participants should remain seated when the Honourable Jennifer Coate AO enters and exits the hearings, and when addressing the Inquiry.

25. When attending the hearings, Participants are expected to be attired and behave in a manner appropriate for attendance at a Court.

26. For the avoidance of doubt, Counsel are not to be robed.

LIVE STREAM AND RECORDING

27. The evidentiary public hearings will be live streamed to the public on the Inquiry's website (www.quarantineinquiry.vic.gov.au), which will be closed-captioned and subject to a delay of five minutes.

28. All aspects of the public hearings will be audio and visually recorded.

CONTACTING THE INQUIRY

29. For any issues, including technological difficulties, that may arise during the course of the Board's hearings, please contact Solicitors Assisting, who will be monitoring emails in real-time to enable a timely response, at lawyers@quarantineinquiry.vic.gov.au.

30. Questions about any matters dealt with in this Practice Direction or other matters concerning the evidentiary public hearings should be directed to Solicitors Assisting at: lawyers@quarantineinquiry.vic.gov.au.

Issue date: 6 August 2020

THE HONOURABLE JENNIFER COATE AO
Board of Inquiry into the COVID-19 Hotel Quarantine Program

Practice Direction 5

COVID-19
Hotel Quarantine Inquiry

PRACTICE DIRECTION NO. 5

DOCUMENTARY EVIDENCE

31 August 2020

INTRODUCTION

1. This Practice Direction (**PD-5**) relates to the handling of documentary evidence produced to the Board of Inquiry into the COVID-19 Hotel Quarantine Program (**Inquiry**).

2. This Practice Direction is issued under s 63(1) of the *Inquiries Act 2014* (Vic) (**Act**). It should be read in conjunction with the Act, the terms of reference contained in the Order establishing the Inquiry, and the other Practice Directions available on the Inquiry's website (https://www.quarantineinquiry.vic.gov.au/lawyers).

3. This Practice Direction may be varied, changed or amended from time to time. The Inquiry may, at any time, depart from this Practice Direction if it considers it appropriate to do so.

ONLINE HEARING BOOK

4. The Inquiry's online Hearing Book (**Hearing Book**) is accessible to parties with Leave to Appear. Access is expressly subject to an undertaking given by the accessing party that information contained on the Hearing Book will not be published or otherwise disclosed unless and until it has been tendered at a public hearing of the Inquiry or otherwise made publicly available by the Inquiry.

5. The Inquiry's staff, including Solicitors Assisting and Counsel Assisting the Inquiry, will determine which materials provided to the Inquiry will be uploaded to the Hearing Book.

6. As a general guide, the Hearing Book will contain:

   (a) statements of witnesses;

   (b) any exhibits or attachments to the statements of witnesses;

   (c) other documents identified as being relevant to the evidence of witnesses; and

(d) transcripts of public hearings.

7. The Hearing Book folders are structured as follows:

[Hearing dates to which evidence relates]

01. Leave to Appear folder

[Name of witness to whom evidence relates]

a. Statement

b. Exhibits

c. Documents Relevant to Witness

Other relevant documents

02. Produced for Tendering folder

[Name of witness to whom evidence relates]

a. Statement

b. Exhibits

c. Documents Relevant to Witness

Other relevant documents.

03. Tendered Exhibits folder

04. Finalised Transcripts folder

HEARING BOOK PROCESS

8. Documents subject to a 'reasonable excuse' claim pursuant to s 65 of the Act will not be uploaded to the Hearing Book until such claims have been determined.

9. Documents will be uploaded by the Inquiry's staff to the Hearing Book as follows:

(a) As soon as practicable upon receipt of statements and their exhibits/attachments that are proposed to be tendered, and upon identification of any other documents relevant to witnesses, but following the resolution of any claims of 'reasonable excuse' over the documents, or parts of documents;

(b) Documents subject to an extant claim for an order pursuant to s 73 of the Act (**s 73 Order**) will be uploaded to the Leave to Appear folder along with documents that are not subject to claims;

(c) Where redacted copies of documents subject to a claim for a s 73 Order are not provided at the time the documents are produced, unredacted copies of

those documents will be uploaded to the Leave to Appear folder;

(d) Where redacted copies of documents subject to a claim for a s 73 Order are provided to the Inquiry, those documents will be uploaded in redacted and unredacted form while such claims are resolved;

(e) Where a party seeks any redaction to documents contained on the Inquiry's Hearing Book prior to them being tendered, that party is required to provide highlighted and redacted copies of the documents to Solicitors Assisting as soon as possible but at least three days prior to the hearing at which the documents are proposed to be tendered;

(f) The Inquiry's staff will endeavour to transfer documents from the Leave to Appear folder to the 'Produced for Tendering' folder at least two days prior to the hearing to which those documents relate;

(g) Once witness statements are tendered, they will be published on the Inquiry's website, generally the same day they are tendered;

(h) Once documents other than witness statements are tendered, they will be placed in the Tendered Exhibits folder. Should any further redactions to the documents be sought, the seeking party must provide the Inquiry with highlighted and redacted copies of the documents as soon as possible, but no more than two calendar days after their being uploaded to the 'Tendered Exhibits' folder;

(i) Documents contained in the 'Tendered Exhibits' folder will be published on the Inquiry's website in due course;

(j) Documents contained in the 'Produced for Tendering' folder may be publicly displayed during the Inquiry's hearings.

REDACTING DOCUMENTS

10. The Inquiry's staff are generally not in a position to make redactions on behalf of parties.

11. If a party seeks that a redaction be made, it is that party's responsibility to provide copies of:

(a) the document(s) with highlighting over those parts sought to be redacted; and

(b) the document(s) with the relevant parts redacted as sought, and

(c) an explanation in writing which justifies the redaction.

12. Failure to provide any one of (a) – (c) above will result in the application for redaction being considered void and the document may be tendered, referred to in public hearings and published on the Inquiry's website in accordance with the remaining paragraphs of this Practice Direction.

DOCUMENTS AVAILABLE TO WITNESSES

13. When giving evidence before the Inquiry, witnesses are required to have immediate access (whether in electronic or hard-copy format) to all documents contained in the 'Produced for Tendering' folder assigned to their name.

IDENTITIES OF NON-EXECUTIVE PERSONNEL

14. The Inquiry has determined that information tending to identify any non-executive personnel of a government or private agency is not generally relevant to its Terms of Reference.

15. Accordingly, unless otherwise directed by the Inquiry, parties producing documents in response to a Notice to Produce (including statements) may produce documents to the Inquiry in two forms:

    (a) an unredacted copy of the document which contains personal identifying information of non-executive personnel of government and/or private agencies; and

    (b) a form of the document where the personal identifying information is redacted from documents, and in which the redacted information may be replaced with text reflecting that person's job title or role.

16. In the instance that a party seeks to avail itself/themselves of the process afforded by paragraph 15 above, then:

    (a) only the redacted version of the statement will be placed in the 'Produced for Tendering' folder, tendered at any public hearing and placed on the Inquiry's website for public access; and

    (b) any person to whom such personal identifying information relates will be given a pseudonym by the Inquiry, and if referred to or called to give evidence at a public hearing, will give evidence under that pseudonym.

Issue date: 31 August 2020

THE HONOURABLE JENNIFER COATE AO
Board of Inquiry into the COVID-19 Hotel Quarantine Program

Appendix E

List of Parties with Leave to Appear

Alfred Health
Australian Nursing Agency
Crown Melbourne Ltd
Mr Christopher Eagle
Department of Environment, Land, Water and Planning (DELWP)
Department of Health and Human Services (DHHS)
Department of Jobs, Precincts and Regions (DJPR)
Department of Justice and Community Safety (DJCS)
Department of Premier and Cabinet (DPC)
Department of Treasury and Finance (DTF)
The Hon. Daniel Andrews MP
The Hon. Jenny Mikakos
The Hon. Lisa Neville MP
The Hon. Martin Pakula MP
Meteorite Land (Pearl River) Pty Ltd as trustee for the Meteorite Land (Pearl River) Unit Trust, trading as the Four Points by Sheraton
Melbourne Hotel Group Pty Ltd trading as Holiday Inn Melbourne Airport
Mr Michael Girgis, IKON Cleaning Services
MSS Security Pty Ltd
Onsite Doctors Pty Ltd
Professor Benjamin Howden
Rydges Hotels Ltd
Salter Brothers (Spencer Street) Hotel Pty Ltd
Chief Commissioner Shane Patton, Victoria Police
Stamford Plaza Melbourne Pty Ltd
Sterling Pixxel Pty Ltd trading as Sterling Security Group
Travelodge Hotel Docklands
Unified Security Group (Australia) Pty Ltd
United Risk Management Pty Ltd
Wilson Security Pty Ltd
Your Nursing Agency (Victoria) Pty Ltd (YNA)

Appendix F

Example letter and notice to produce documents

COVID-19
Hotel Quarantine Inquiry

[Date]

[Name of addressee]
[Position of addressee]
[Organisation]
[Organisation's address]

By email: [email address of addressee or their legal representative]

Dear [Name of addressee]

Board of Inquiry into the COVID-19 Hotel Quarantine Program – NTP-[number]

The COVID-19 Hotel Quarantine Program Inquiry was established on 2 July 2020 by Order in Council made under s 53(1) of the *Inquiries Act 2014* (Vic).

The Board of Inquiry's Terms of Reference (**Terms of Reference**) are enclosed at **Attachment 1**.

The purpose of this letter is to notify you that your organisation has been identified as an organisation of interest to the work of the Inquiry.

The Inquiry is conscious that many who will be asked to contribute to the work of the Inquiry are concurrently assisting with the ongoing efforts to respond to the COVID-19 pandemic. Whilst mindful of this, we are also conscious of the timeframes in which the Inquiry is required to undertake its task, and to furnish its report.

We now write to issue your organisation with a Notice to Produce requiring the production of documents.

Notice to Produce

Please find **enclosed** a Notice to Produce (**Notice**) issued pursuant to s 64 of the *Inquiries Act 2014* (Vic). A copy of s 64 is attached to this letter (**Attachment 2**).

The Notice is to be known as NTP-[number]. It contains important information about how the documents specified in the Schedule to the Notice are to be produced to the Inquiry and when.

The documents responsive to the Notice should be produced in accordance with Practice Direction 1: Production of Materials and Document Management Protocol, a copy of which is attached to this letter (**Attachment 3**).

When producing the documents responsive to the Notice, please include a covering letter that identifies whether the documents produced constitute complete or partial production in response to the Notice.

E lawyers@quarantineinquiry.vic.gov.au **quarantineinquiry.vic.gov.au**

OFFICIAL

Timeline

The Notice requires that you produce relevant documents to the Inquiry by **[time and date of deadline]**.

We appreciate your organisation may face difficulty in meeting this timeframe. We have factored that difficulty into the period in which production of documents is required pursuant to the Notice.

You will also note that the Inquiry is required to provide its final report to the Governor in approximately 13 weeks from now, on 6 November 2020. Accordingly, your compliance with the timeframe is required.

If you would like to discuss this, or any other matter regarding the Inquiry, please contact Solicitors Assisting at lawyers@quarantineinquiry.vic.gov.au or (03) 7017 3459.

Yours sincerely,

THE HONOURABLE JENNIFER COATE AO
Board of Inquiry into the COVID-19 Hotel Quarantine Program

NOTICE TO PRODUCE

DOCUMENTS TO A BOARD OF INQUIRY

Regulation 15

TO: [Name of addressee]
[Position title of addressee]
[Organisation]

AT: [Organisation address]

A Board of Inquiry is being held into the COVID-19 Hotel Quarantine Program, established by an Order in Council made under s 53(1) of the *Inquiries Act 2014* (Vic) (Act).

What you must do

You must produce the documents specified in the Schedule attached to this Notice (the **Schedule**). This Notice is identified as 'NTP-[number]'.

You should include with the documents a numbered index which includes:

- the document title and date; and
- any relevant commentary necessary to provide context to the document.

Where you must produce documents

The documents specified in the Schedule must be produced electronically in accordance with Practice Direction 1: Production of Materials and Document Management Protocol on or before **[time and date of deadline]**.

Objecting to this notice

You may object to this notice if you have (or will have) a reasonable excuse for failing to comply with the notice. For example, it is a reasonable excuse to fail to comply with the notice if you are prohibited from disclosing the document(s) by a court order. See section 65 of the *Inquiries Act 2014* (the **Act**) for further examples of what constitutes a reasonable excuse.

You may also object to the notice by claiming that the document(s) specified in the notice are not relevant to the subject matter of the inquiry.

If you wish to object to this notice, you must do so in writing:

To: lawyers@quarantineinquiry.vic.gov.au

By: [time and date of deadline].

Your written objection must outline your reasons for objecting and include a relevant contact person with which to liaise. If the Board of Inquiry is satisfied that your claim is made out, the Board of Inquiry may vary or revoke this notice.

Failure to comply with this notice without a reasonable excuse may constitute a criminal offence. The maximum penalty for this offence is 240 penalty units or imprisonment for two years. See section 86 of the Act.

Failure to comply with this notice without a reasonable excuse may also result in the Board of Inquiry making an application to the Supreme Court of Victoria. The Court may then order you to comply with the notice within a specified period. See section 70 of the Act.

THE HONOURABLE JENNIFER COATE AO
Board of Inquiry into the COVID-19 Hotel Quarantine Program

Date: [Date]

SCHEDULE TO NOTICE TO PRODUCE

DOCUMENTS TO A BOARD OF INQUIRY (NTP-[number])

The documents described below are required to be produced to the Board of Inquiry pursuant to s 64 of the *Inquiries Act* (Vic):

[Insert numbered list of types or categories of documents to be provided]

DEFINITIONS

For the purposes of this Notice to Produce:

[Insert definitions relevant to this notice]

Example letter and notice to produce witness statement

COVID-19
Hotel Quarantine Inquiry

[Date]

[Name of addressee]
[Position of addressee]
[Organisation]
[Organisation's address]

By email: [email address of addressee or their legal representative]

Dear [Name of addressee],

Board of Inquiry into the COVID-19 Hotel Quarantine Program

The Board of Inquiry (**Inquiry**) is inquiring into certain matters relating to the Hotel Quarantine Program and has identified you as a person with relevant evidence to give regarding one or more of those matters.

This letter is a request for a witness statement from you to assist the Inquiry with its work.

Attached to this letter are:

- A list of questions to be answered in your witness statement; and
- A Notice to Produce the statement **by [time and date of deadline]**. (**NTP-[number]**).

Powers of the Inquiry

Under the *Inquiries Act 2014* (Vic) (**Inquiries Act**) the Inquiry has the power to compel a person to attend to give evidence before a sitting of the Inquiry and to produce any document or thing. Persons who give evidence to the Inquiry enjoy certain protections under the Inquiries Act. In certain circumstances, a person may offer a reasonable excuse why they ought not be compelled to give evidence. More information can be found on the Inquiry's website and in the Inquiries Act.

Your witness statement will be your evidence in chief

The nature of the matters being inquired into and the timeframe within which the Inquiry must complete its work means that the Inquiry has determined to receive evidence in chief from all witnesses by means of a written witness statement. We are seeking your assistance in the preparation of a statement in advance of the hearings so as to enable the timely and effective receipt of relevant evidence. If you are not willing to prepare a written statement you should advise us as soon as possible so that arrangements can be made for your attendance before the Inquiry to have your evidence taken in another way.

E lawyers@quarantineinquiry.vic.gov.au **quarantineinquiry.vic.gov.au**

OFFICIAL

Not all witnesses who provide statements will also be called to give oral evidence at the public hearings. You will receive notice in advance of the public hearings if your oral evidence is required

You can get help with writing your witness statement

If you have a legal representative, you may seek their assistance in preparing your witness statement.

If you are not legally represented, you may choose to -

- seek legal representation for the purposes of preparing your witness statement; or
- prepare the statement yourself in accordance with the questions and guidance contained in this letter and attachment; or
- meet with someone from the team of Counsel Assisting the Inquiry who will assist you in the preparation of your statement. If you wish to take up this option, you should contact us immediately.

Approach to witness statement

The Inquiry requests that you take the following approach when preparing your witness statement:

1. Answer the Inquiry's questions in the order in which they are listed in the attached document;
2. List each question as a heading and answer the relevant question under that heading;
3. Draft the statement in your own words and in plain English without the use of acronyms or jargon;
4. Only include additional evidence which you consider necessary, *having regard to the terms of reference of this Inquiry*, to give context or completeness to the questions you have been asked after you have answered the Inquiry's questions;
5. Where it is necessary to refer in your statement to a document which you or your organisation have already produced to the Inquiry under a Notice to Produce, refer to the document both by its title or description and by the number assigned to it when it was produced to the Inquiry;
6. Where it is necessary to refer in your statement to a document which you have not yet produced to the Inquiry, assign it a number in accordance with Practice Direction 1, refer to the document both by its title or description and by the number it has been assigned, and produce the document or documents to the Inquiry at the same time that you produce your statement; and
7. Once completed, assign your statement its own number in accordance with Practice Direction 1.

You can find Practice Directions relating to documents and your witness statement at the Inquiry's website, www.quarantineinquiry.vic.gov.au.

Timeline for production

The Notice requests that you produce all relevant documents to the Inquiry by **[time and date of deadline]**. However, we would gratefully receive any material produced prior to that date, if it is practicable for you to do so.

If you have any questions, please contact Solicitors Assisting at lawyers@quarantineinquiry.vic.gov.au or (03) 7017 3459.

Yours sincerely,

THE HONOURABLE JENNIFER COATE AO
Board of Inquiry into the COVID-19 Hotel Quarantine Program

COVID-19
Hotel Quarantine Inquiry

IN THE MATTER OF the *Inquiries Act 2014*

AND IN THE MATTER OF a Board of Inquiry into the COVID-19 Hotel Quarantine Program

LIST OF QUESTIONS FOR [NAME OF WITNESS]

[Please include these questions in your witness statement as headings, with your answer to each question immediately beneath the relevant heading]

[Insert sample questions for Witness]

E lawyers@quarantineinquiry.vic.gov.au quarantineinquiry.vic.gov.au

NOTICE TO PRODUCE

DOCUMENTS TO A BOARD OF INQUIRY

Regulation 15

TO: [Name of addressee]
[Position title of addressee]
[Organisation]

AT: [Organisation address]

A Board of Inquiry is being held into the COVID-19 Hotel Quarantine Program, established by an Order in Council made under s 53(1) of the *Inquiries Act 2014* (Vic) (**Act**).

What you must do

You must produce the documents specified in the Schedule attached to this Notice (the **Schedule**). This Notice is identified as 'NTP-[number]'.

You should include with the documents a numbered index which includes:

- the document title and date;
- whether the document is subject to a claim for reasonable excuse; and
- any relevant commentary necessary to provide context to the document.

Where you must produce documents

The documents specified in the Schedule must be produced electronically on or before **[time and date of deadline]** in accordance with Practice Direction 1: Production of Materials and Document Management Protocol.

Objecting to this notice

You may object to this notice if you have (or will have) a reasonable excuse for failing to comply with the notice. For example, it is a reasonable excuse to fail to comply with the notice if you are prohibited from disclosing the document(s) by a court order. See section 65 of the *Inquiries Act 2014* (the **Act**) for further examples of what constitutes a reasonable excuse.

You may also object to the notice by claiming that the document(s) specified in the notice are not relevant to the subject matter of the inquiry.

If you wish to object to this notice, you must do so in writing:

To: lawyers@quarantineinquiry.vic.gov.au

By: [time and date of deadline]

Your written objection must outline your reasons for objecting and include a relevant contact person with whom to liaise. If the Board of Inquiry is satisfied that your claim is made out, the Board of Inquiry may vary or revoke this notice.

Failure to comply with this notice without a reasonable excuse may constitute a criminal offence. The maximum penalty for this offence is 240 penalty units or imprisonment for two years. See section 86 of the Act.

Failure to comply with this notice without a reasonable excuse may also result in the Board of Inquiry making an application to the Supreme Court of Victoria. The Court may then order you to comply with the notice within a specified period. See section 70 of the Act.

THE HONOURABLE JENNIFER COATE AO
Board of Inquiry into the COVID-19 Hotel Quarantine Program

Date: [Date]

SCHEDULE TO NOTICE TO PRODUCE

DOCUMENTS TO A BOARD OF INQUIRY (NTP-[number])

The documents described below are required to be produced to the Board of Inquiry into the COVID-19 Hotel Quarantine Program (**Board**) pursuant to s 64 of the *Inquiries Act 2014* (Vic):

1. The statement, along with any supporting documents annexed thereto and an index of the supporting documents, prepared or gathered in response to the list of questions in the Board's letter addressed to [name of witness] dated [day / month] 2020.

Example letter and notice to attend

COVID-19
Hotel Quarantine Inquiry

[Date]

[Name of addressee]
[Title of addressee]
[Organisation]
[Organisation's address]

By email: [email address of addressee or their legal representative]

Dear [Name of addressee],

Board of Inquiry into the COVID-19 Hotel Quarantine Program: Notice to Attend

We write further to our recent correspondence, in which you were requested to provide a written statement to the Board of Inquiry into the COVID-19 Hotel Quarantine Program (**Board**).

Notice to Attend

As foreshadowed in that letter, please find **attached** a Notice to Attend the evidentiary hearings being conducted by the Board on [date of hearing].

[Include the following two sentences only if date of hearing is not yet decided:] We expect that you will be called in the period between **[first possible hearing date] and [last possible hearing date]**. We will contact to you in the coming week providing further details in this regard.

Conduct of hearings

The evidentiary hearings will be conducted via video-link. You will not be required to physically attend the hearings, but rather, will be able to attend remotely using Zoom using log-in details that will be provided to you in advance of the hearing at which you will be called to give evidence.

In you have legal representatives, they will also be permitted to attend the hearings remotely via Zoom. Further information regarding the conduct of the evidentiary hearings is available on the Board's website in Practice Direction 4.

Publication of your statement

Consistent with its usual procedures, the Board intends to make your statement and any documents annexed thereto available on the Board's Hearing Book in advance of the hearing at which you will be called to give evidence. The Board will also make any other documents likely to be raised during your evidence available on the Hearing Book.

The Board's Hearing Book is available to parties with leave to appear before the Board, and is regularly updated with relevant documents, such as your statement and any documents annexed thereto, to ensure that parties with leave to appear have notice of the matters likely to be raised at the Board's hearings.

E lawyers@quarantineinquiry.vic.gov.au **quarantineinquiry.vic.gov.au**

Subject to any contrary orders you may seek from the Board, once your statement and any other relevant documents relating to your evidence are tendered during the Board's hearings, those documents will be published on the Board's website. Again, this is consistent with the Board's usual procedures, and ensures that the public has access to relevant evidence forming part of the Board's Inquiry.

Application for Leave to Appear

If you have not done so already, and would like access to the Board's Hearing Book or to have legal representatives attend the hearings, we ask that you apply for leave to appear in accordance with Practice Direction No.2, which is contained on the Board's website by [time and date of deadline] (https://www.quarantineinquiry.vic.gov.au/lawyers).

If you have any questions, please contact Solicitors Assisting at lawyers@quarantineinquiry.vic.gov.au or (03) 7017 3459.

Yours sincerely,

THE HONOURABLE JENNIFER COATE AO
Board of Inquiry into the COVID-19 Hotel Quarantine Program

COVID-19
Hotel Quarantine Inquiry

NOTICE TO ATTEND TO A BOARD OF INQUIRY

Regulation 15

TO: [Name of addressee]
[Title of addressee]

AT: [Organisation of addressee]
[Address]

A Board of Inquiry is being held into the COVID-19 Hotel Quarantine Program, established by an Order in Council made under s 53(1) of the *Inquiries Act 2014* (Vic) (**Act**).

What you must do

You must attend the Board of Inquiry to give evidence until excused.

Where you must attend

Where: The Board of Inquiry's hearings will be conducted by video-link using Zoom. You will be provided with login details and required to attend the hearing remotely using those details.

When: [date of hearing] at [time of hearing].

Note: You should bring this notice with you when attending the Board of Inquiry.

Objecting to this notice

You may object to this notice if you have (or will have) a reasonable excuse for failing to comply with the notice. For example, it is a reasonable excuse to fail to comply with the notice if you are prohibited from disclosing the document(s) by a court order. See section 65 of the Act for further examples of what constitutes a reasonable excuse.

You may also object to the notice by claiming that the document(s) specified in the notice are not relevant to the subject matter of the inquiry.

If you wish to object to this notice, you must do so in writing:

To: lawyers@quarantineinquiry.vic.gov.au

By: [time and date of deadline].

Your written objection must outline your reasons for objecting and include a relevant contact person with whom to liaise. If the Board of Inquiry is satisfied that your claim is made out, the Board of Inquiry may vary or revoke this notice.

Failure to comply with this notice without a reasonable excuse may constitute a criminal offence. The maximum penalty for this offence is 240 penalty units or imprisonment for two years. See section 86 of the Act.

Failure to comply with this notice without a reasonable excuse may also result in the Board of Inquiry making an application to the Supreme Court of Victoria. The Court may then order you to comply with the notice within a specified period. See section 70 of the Act.

THE HONOURABLE JENNIFER COATE AO
Board of Inquiry into the COVID-19 Hotel Quarantine Program

Date: [date]

E lawyers@quarantineinquiry.vic.gov.au quarantineinquiry.vic.gov.au

Appendix G

List of witnesses and statements received

Last name, first name	Title	Role	Date of Appearance(s)
Adams, Jamie	Mr	General Manager (Victoria and Tasmania), MSS Security Pty Ltd	3 September 2020
Aggarwal, Sorav 'Sam'	Mr	Chief Executive Officer, Sterling Services Group	2 September 2020
Alexander, Simone	Ms	Chief Operating Officer, Alfred Health	8 September 2020
Alpren, Charles	Dr	Epidemiologist	18 August 2020
Andrews, Daniel	The Hon.	Premier of Victoria	25 September 2020
Arundel, Craig	Mr	Security guard	24 August 2020
Ashford, Luke	Mr	Authorised officer	21 August 2020
Ashton, Graham	Mr	Former Chief Commissioner of Victoria Police	17 September 2020
Attalah, Mina	Mr	Managing Director, United Risk Management	2 September 2020
Bamert, Merrin	Ms	Director, Emergency Management and Health Protection, Department of Health and Human Services	11 September 2020
Banks, Dan	Mr	Director, Signal88 Security Australasia	Statement tendered[1]
Baxter, Hayley	Ms	Acting Executive Director of Strategic Sourcing, Department of Treasury and Finance	Statement tendered
Bedford, Rebecca	Ms	Partner, MinterEllison	Statement tendered
Chakik, Eddie	Mr	Business/Operations Manager, Ultimate Protective Services	Statement tendered
Chekaik, Samir	Mr	Director, Australian Protection Services Pty Ltd	Statement received[2]
Cleaves, Noel	Mr	Manager, Environmental Health Regulation and Compliance, Department of Health and Human Services	4 September 2020
Coppick, Nigel	Mr	National Operations Manager, Unified Security Group	3 September 2020
Crisp, Andrew	Comm'r	Emergency Management Commissioner, Emergency Management Victoria	15 September 2020
Crouch, Simon	Dr	Senior Medical Advisor, Department of Health and Human Services	8 September 2020
'Crowne Plaza Melbourne Executive Assistant Manager'		Executive Assistant Manager, Crowne Plaza Melbourne	Statement received

1. 'Statement tendered' denotes that a statement was formally tendered in evidence before the Board. The makers of such statements, and those who appeared before the Board's hearings, are defined as 'witnesses' throughout this Report.
2. 'Statement received' denotes that a statement was produced to the Inquiry and not tendered in evidence. As indicated in 'About this Report', the fact that a statement was not tendered does not mean that regard was not had to it by the Board for the purposes of its Inquiry.

Last name, first name	Title	Role	Date of Appearance(s)
Currie, Katrina	Ms	Executive Director, Employment Delivery, Working for Victoria; Executive Director, Department of Jobs, Precincts and Regions	27 August 2020
Curtain, Janette	Ms	Manager, Your Nursing Agency (Victoria) Pty Ltd	Statement tendered
D'Cruz, Shaun	Mr	Executive General Manager, Crown Melbourne Hotels	28 August 2020
de Kretser, Hugh	Mr	Returned traveller and Executive Director of the Human Rights Law Centre	20 August 2020
de Witts, Jacinda	Ms	Deputy Secretary, Legal and Executive Services, Department of Health and Human Services	Statement tendered
'DHHS Infection Control Consultant'		Infection Control Consultant, Department of Health and Human Services	Statement tendered
'DHHS Learning Consultant'		Learning Consultant, Department of Health and Human Services	Statement tendered
'DHHS Manager'		Manager, Department of Health and Human Services	Statement tendered
'DHHS senior project officer'		Senior project officer, Department of Health and Human Services	Statement tendered
'DJPR Administrative Officer'		Administrative Officer, Department of Jobs, Precincts and Regions	Statement received
'DJPR Operational Safety Advisor'		Operational Safety Advisor, Department of Jobs, Precincts and Regions	Statement received
'DJPR Program Manager'		Program Manager, Department of Jobs, Precincts and Regions	Statement received
Eagle, Christopher	Mr	Deputy State Controller, Health	15 September 2020
Eccles, Christopher	Mr	Former Secretary, Department of Premier and Cabinet	21 September 2020
Erasmus, Ron	Mr	Returned traveller	21 August 2020
Erasmus, Sue	Ms	Returned traveller	21 August 2020
Febey, Claire	Ms	Executive Director of the Priority Projects Unit, Department of Jobs, Precincts and Regions	27 August 2020
Ferrigno, Stephen	Mr	General Manager, Four Points by Sheraton Melbourne	28 August 2020
Garrow, Stuart	Mr	Clinical Lead Medical Practitioner, Onsite Doctor Pty Ltd	Statement tendered
Gavens, Kate	Ms	Chief Conservation Regulator, Department of Environment, Land, Water and Planning	Statement tendered
Girgis, Michael	Mr	General Manager, IKON Services Australia Pty Ltd	11 September 2020
Gordon, Rob	Dr	Psychologist	18 September 2020
Grayson, Lindsay	Prof.	Infectious diseases expert	17 August 2020
Gupta, Ishu	Mr	Managing Director, The Security Hub	2 September 2020

Last name, first name	Title	Role	Date of Appearance(s)
Helps, Jason	Mr	State Controller; Deputy Director of Emergency Operations and Capability Health, Department of Health and Human Services	17 September 2020
Henderson, Nick	Mr	General Manager, Holiday Inn Melbourne Airport	Statement tendered
'Hi8 Security Duty Manager'		Duty Manager, Hi8 Security	Statement received
Hogan, Braeden	Mr	Deputy Director, Strategy and Policy, Emergency Management Branch, Department of Health and Human Services	Statement tendered
Hogan, Shaun	Mr	National Manager, Corporate Risk, Wilson Security Pty Ltd	Statement tendered
Howden, Ben	Prof.	Medical microbiologist	17 August 2020
Hyslop, Kate	Ms	Returned traveller	20 August 2020
Krikelis, Sam	Mr	Business Manager, Event Services, MSS Security Pty Ltd	3 September 2020
Lapsley, Craig	Mr	Former Emergency Management Commissioner, Emergency Management Victoria	Statement tendered
Looker, Clare	Dr	Senior Medical Advisor, Department of Health and Human Services	Statement tendered
Loughnan, Matthew	Mr	Airport Services Manager, Melbourne, Dnata Airport Services Pty Ltd	Statement tendered
Lombardo, Matthew	Mr	Director, ACOST Security Services	Statement received
Mandyam, Ram	Mr	Hotel General Manager, Travelodge Hotel Melbourne Docklands	28 August 2020
May, Rachaele	Ms	Executive Director, Emergency Coordination and Resilience, Department of Jobs, Precincts and Regions	4 September 2020
McGuinness, Sarah	Dr	Outbreaks Lead, Outbreak Management Team, Department of Health and Human Services	8 September 2020
McLean, Andrew	Mr	Director, Elite Protection Services (Australia) Pty Ltd	Statement received
Mead, Cameron	Mr	Hotel Manager, Park Royal Hotel	Statement tendered
Menezes, Rosswyn	Mr	General Manager, Rydges on Swaston	28 August 2020
Menon, Unni	Mr	Executive Director, Aviation Strategy and Services, Department of Jobs, Precincts and Regions	31 August 2020
'Mercure Welcome Melbourne CEO'		Chief Executive Officer, Mercure Welcome Melbourne	Statement received
Mikakos, Jenny	The Hon.	Former Minister for the Coordination of Health and Human Services: COVID-19, Former Minister for Health, Former Minister for Ambulance Services	24 September
Millward, David	Mr	Director of National Operations, Unified Security Pty Ltd	Statement tendered

Last name, first name	Title	Role	Date of Appearance(s)
Murphy, Richard	Mr	Partner, MinterEllison	Statement tendered
Nagi, Mo	Mr	Victorian Operations Manager, Unified Security Pty Ltd	3 September 2020
Neville, Lisa	The Hon.	Minister for Police and Emergency Services Minister for Water Former Minister for the Coordination of Environment, Land, Water and Planning	23 September 2020
'Nurse Jen'		Nurse, Your Nursing Agency	20 August 2020
'Nurse Manager'		Nurse Manager, Alfred Health	Statement tendered
Ofli, Kaan	Mr	Returned traveller	24 August 2020
'DJPR Operations Coordinator'		Operations Coordinator, Department of Jobs, Precincts and Regions	Statement tendered
Paccioco, Rob	Mr	Director, BlackTie Security Pty Ltd	2 September 2020
Pakula, Martin	The Hon.	Minister for Racing Minister for Tourism, Sports and Major Events Minister for Industry Support and Recovery Minister for Trade Minister for Business Precincts Former Minister for the Coordination of Jobs, Precincts and Regions: COVID-19	23 September 2020
Patton, Shane	Chief Commissioner	Chief Commissioner, Victoria Police	17 September 2020
Peake, Kym	Ms	Former Secretary of Department of Health and Human Services	22, 23 September 2020
Phemister, Simon	Mr	Secretary of Department of Jobs, Precincts and Regions	22 September 2020
Pinskier, Nathan	Dr	Director, On Site Doctor Pty Ltd	Statement tendered
'Principal Policy Officer'		Principal Policy Officer, Employment, Inclusion, Department of Jobs, Precincts and Regions	Statement tendered
Rait, Julian	Dr	Associate Professor, AMA Victoria President	Statement tendered
Ratcliff, Liliana	Ms	Returned traveller	21 August 2020
'Returned traveller 1'		Returned traveller	20 August 2020
Romanes, Finn	Dr	Deputy Public Health Commander — Planning, Department of Health and Human Services. On various occasions, Dr Romanes also performed the role of Public Health Commander	Statement tendered
'Security 1'		Security guard	21 August 2020
'Security 16'		Security guard	24 August 2020
'DHHS Senior authorised officer'		Senior authorised officer, Department of Health and Human Services	Statement tendered

Last name, first name	Title	Role	Date of Appearance(s)
Serbest, Gönül	Ms	Chief Executive Officer of Global Victoria, Department of Jobs, Precincts and Regions	27 August 2020
Sinadinov, Darko	Mr	Director, Hospitality Performance Leaders Pty Ltd (T/A Nu Force Security Group)	Statement tendered
Singh, Ricky	Mr	Returned traveller	20 August 2020
Skilbeck, Melissa	Ms	Deputy Secretary, Regulation, Health Protection and Emergency Management, Department of Health and Human Services	10 September 2020
Smith, Eric	Mr	Managing Director, SwingShift Nurses	Statement tendered
Smith, Murray	Mr	Commander, COVID-19 Enforcement and Compliance, Department of Health and Human Services	10 September 2020
Spiteri, Andrea	Ms	State Controller; Health; Executive Director of Emergency Management, Department of Health and Human Services	17 September 2020
Sutton, Brett	Prof.	Chief Health Officer, Department of Health and Human Services	16 September 2020
Symonds, Terry	Mr	Deputy Secretary, Health and Wellbeing, Department of Health and Human Services	Statement tendered
Tait, Michael	Mr	Nurse, Your Nursing Agency	20 August 2020
Tully, Timothy	Cdr	Commander, Victoria Police	4 September 2020
Unterfrauner, Karl	Mr	General Manager, Stamford Plaza Melbourne	28 August 2020
van Diemen, Annaliese	Dr	Deputy Chief Health Officer, Department of Health and Human Services	16 September 2020
Verosaari, Mika	Mr	General Manager, Victoria and Tasmania, AHS Hospitality Pty Ltd	Statement tendered
'Victoria Police Superintendent'		Superintendent, Victoria Police	Statement tendered
'Victoria Police Superintendent 2'		Superintendent, Victoria Police	Statement received
'Victoria Police Inspector'		Inspector, Victoria Police	Statement received
'QSS Security Executive Manager'		Executive Manager, QSS Security	Statement received
Wallace, Euan	Prof.	Former Chief Executive Officer, Safer Care Victoria; Secretary, Department of Health and Human Services	10 September 2020
Watson, Greg	Mr	General Manager, Regional Operations (Victoria and Tasmania), Wilson Security Pty Ltd	2 September 2020
Williams, Pam	Ms	Commander, Operation Soteria, Department of Health and Human Services	11 September 2020

Appendix H

Exhibit list

Exhibit	Document Title
1	Exhibit HQI0001_P Witness statement of Prof. Lindsay Grayson
2	Exhibit HQI0002_RP Curriculum vitae of Prof. Michael Lindsay Grayson
3	Exhibit HQI0003_P Dept Health training on how to protect yourself and others from COVID-19
4	Exhibit HQI0004_P Operation Soteria PPE advice for hotel security staff and AOs in contact with quarantined individuals (Grayson)
5	Exhibit HQI0005_P Witness statement of Prof. Benjamin Howden
6	Exhibit HQI0006_P Curriculum vitae of Prof. Benjamin Howden
7	Exhibit HQI0007_P Genomic clustering graph
8	Exhibit HQI0008_RP Witness statement of Dr Charles Alpren
9	Exhibit HQI0009_RP Witness statement of 'Nurse Jen'
10	Exhibit HQI0010_RP Induction and learning modules completed by 'Nurse Jen'
11	Exhibit HQI0011_P YNA COVID-19 Staff Update re infection control training module ('Nurse Jen')
12	Exhibit HQI0012_RP Email to 'Nurse Jen' re Dept of Health infection control training
13	Exhibit HQI0013_RP Witness statement of 'Returned Traveller 1'
14	Exhibit HQI0014_RP Witness statement of Mr Michael Tait
15	Exhibit HQI0015_RP Email from Mr Michael Tait asking for assistance
16	Exhibit HQI0016_P Witness statement of Mr Hugh de Kretser
17	Exhibit HQI0017_P Hotel room photos taken by Mr Hugh de Kretser
18	Exhibit HQI0018_P Joint witness statement of Ms Kate Hyslop and Mr Ricky Singh
19	Exhibit HQI0019_P Joint witness statement of Ms Sue and Mr Ron Erasmus
20	Exhibit HQI0020_P Witness statement of Ms Liliana Ratcliff
21	Exhibit HQI0021_RP Annexures to witness statement of Ms Liliana Ratcliff
22	Exhibit HQI0022_RP Annexure to witness statement of Ms Liliana Ratcliff
23	Exhibit HQI0023_RP Witness statement of Mr Luke Ashford
24	Exhibit HQI0024_RP Witness statement of 'Security 1'
25	Exhibit HQI0025_P Wilson Security Duties and Action On ('Security 1')
26	Exhibit HQI0026_P Wilson Security Toolbox Talk re hotel quarantine work ('Security 1')
27	Exhibit HQI0027_P Witness statement of Mr Kaan Ofli
28	Exhibit HQI0028_RP Meal order information for people with food allergies (Ofli)
29	Exhibit HQI0029_P Witness statement of Mr Craig Arundel
30	Exhibit HQI0030_P Wilson Security Core duties at the hotel (Arundel)
31	Exhibit HQI0031_RP Witness statement of 'Security 16'
32	Exhibit HQI0032_P Witness statement of Ms Claire Febey

Exhibit	Document Title
33	Exhibit HQI0033(1)_RP Annexures to witness statement of Ms Claire Febey
	Exhibit HQI0033(2)_RP Audio recording of SCC Operation Soteria meeting 27 March 2020
	Exhibit HQI0033(3)_RP Audio recording of SCC Operation Soteria meeting 10.00am 28 March 2020
	Exhibit HQI0033(4)_RP Audio recording of Operation Soteria meeting 6.00pm 28 March 2020
34	Exhibit HQI0034_RP Victoria enforced quarantine planning process (Febey)
35	Exhibit HQI0035_RP Operation Soteria Operations Plan (Febey)
36	Exhibit HQI0036_RP Witness statement of Ms Katrina Currie
37	Exhibit HQI0037_RP Annexures to witness statement of Ms Katrina Currie
38	Exhibit HQI0038_RP Witness statement of Ms Gönül Serbest
39	Exhibit HQI0039_RP Annexures to witness statement of Ms Gönül Serbest
40	Exhibit HQI0040_RP Witness statement of Mr Ram Mandyam
41	Exhibit HQI0041_RP Witness statement of Mr Shaun D'Cruz
42	Exhibit HQI0042_RP Witness statement of Mr Stephen Ferrigno
43	Exhibit HQI0043_RP Witness statement of Mr Nick Henderson
44	Exhibit HQI0044_RP Witness statement of Mr Cameron Mead
45	Exhibit HQI0045_RP Witness Statement of Mr Rosswyn Menezes
46	Exhibit HQI0046_RP Annexures to witness statement of Mr Rosswyn Menezes
47	Exhibit HQI0047_RP Witness statement of Mr Karl Unterfrauner
48	Exhibit HQI0048_RP Annexures to witness statement of Mr Karl Unterfrauner
49	Exhibit HQI0049_RP Witness statement of Mr Unni Menon
50	Exhibit HQI0050_RP Annexures to witness statement of Mr Unni Menon
51	Exhibit HQI0051_RP Witness statement of Mr Sorav 'Sam' Aggarwal
52	Exhibit HQI0052_RP Witness Statement of Mr Mina Attalah
53	Exhibit HQI0053_RP Witness Statement of Mr Ishu Gupta
54	Exhibit HQI0054_RP Witness Statement of Mr Rob Paciocco
55	Exhibit HQI0055_RP Subcontract agreement between Wilson Security and Black Tie Security (Paciocco)
56	Exhibit HQI0056_RP Witness statement of Mr Darko Sinadinov
57	Exhibit HQI0057_RP Witness statement of Mr Dan Banks
58	Exhibit HQI0058_P Witness statement of Mr Eddie Chakik
59	Exhibit HQI0059_RP Witness statement of 'Principal Policy Officer'
60	Exhibit HQI0060(1)_RP Annexures to witness statement of 'Principal Policy Officer'
61	Exhibit HQI0061_RP Witness statement of Mr Gregory Watson
62	Exhibit HQI0062_RP Annexures to witness statement of Mr Gregory Watson
63	Exhibit HQI0063_RP Witness statement of Mr Shaun Hogan
64	Exhibit HQI0064_RP Annexures to witness statement of Mr Shaun Hogan
65	Exhibit HQI0065_RP Witness statement of Mr Jamie Adams
66	Exhibit HQI0066_RP Annexures to witness statement of Mr Jamie Adams
67	Exhibit HQI0067_RP Witness statement of Mr Sam Krikelis

Exhibit	Document Title
68	Exhibit HQI0068_RP Annexures to witness statement of Mr Sam Krikelis
69	Exhibit HQI0069_RP Witness statement of Mr David Millward adopted by Mr Nigel Coppick
70	Exhibit HQI0070_RP Annexures to witness statement of Mr David Millward
71	Exhibit HQI0071_RP Witness statement of Mr Mo Nagi
72	Exhibit HQI0072_RP Annexures to witness statement of Mr Mo Nagi
73	Exhibit HQI0073_P Witness statement of Ms Hayley Baxter
74	Exhibit HQI0074_RP Witness statement of Mr Matthew Loughnan
75	Exhibit HQI0075_P Witness statement of Mr Noel Cleaves
76	Exhibit HQI0076_RP Annexures to witness statement of Mr Noel Cleaves
77	Exhibit HQI0077_RP Witness statement of 'Senior AO 1'
	Exhibit HQI0077(1)_RP Annexures to witness statement of 'Senior AO 1'
78	Exhibit HQI0078_RP Witness statement of Commander Timothy Tully
79	Exhibit HQI0079_RP Annexures to witness statement of Commander Timothy Tully
80	Exhibit HQI0080_RP First witness statement of Ms Rachaele May
81	Exhibit HQI0081_RP Annexures to first witness statement of Ms Rachaele May
82	Exhibit HQI0082_RP Second witness statement of Ms Rachaele May
83	Exhibit HQI0083_RP Annexures to second witness statement of Ms Rachaele May
84	Exhibit HQI0084_RP Witness statement of 'Operations Coordinator'
85	Exhibit HQI0085_RP Witness statement of Ms Janette Curtain
86	Exhibit HQI0086_RP Annexures to witness statement of Ms Janette Curtain
87	Exhibit HQI0087_RP Annexures to witness statement of Ms Janette Curtain
88	Exhibit HQI0088_RP Witness statement of Dr Stuart Garrow
89	Exhibit HQI0089_RP Annexures to witness statement of Dr Stuart Garrow
90	Exhibit HQI0090_RP Witness statement of Mr Eric Smith
91	Exhibit HQI0091_RP Annexures to witness statement of Mr Eric Smith
92	Exhibit HQI0092_RP Witness Statement of Dr Julian Rait
93	Exhibit HQI0093_RP Annexures to the witness statement of Dr Julian Rait
94	Exhibit HQI0094_RP Witness statement of 'Nurse Manager'
95	Exhibit HQI0095_RP Witness statement of Dr Nathan Pinskier
96	Exhibit HQI0096_RP Annexures to witness statement of Dr Nathan Pinskier
97	Exhibit HQI0097_RP Witness statement of Dr Clare Looker
98	Exhibit HQI0098_RP Annexures to witness statement of Dr Clare Looker
99	Exhibit HQI0099_RP Witness statement of Ms Simone Alexander
100	Exhibit HQI0100_RP Annexures to the witness statement of Ms Simone Alexander
101	Exhibit HQI0101_P Alfred Health Model of Care COVID-19 Hotel Support Services (Alexander)
102	Exhibit HQI0102_RP MOU between DHHS and Alfred Health (Alexander)
103	Exhibit HQI0103_RP Witness statement of Dr Simon Crouch
104	Exhibit HQI0104_RP Outbreak Management Plan Rydges Swanston (Crouch)

Exhibit	Document Title
105	Exhibit HQI0105_RP Annexures to witness statement of Dr Simon Crouch
106	Exhibit HQI0106_RP Witness statement of Dr Sarah McGuinness
107	Exhibit HQI0107_RP Annexures to witness statement of Dr Sarah McGuinness
108	Exhibit HQI0108_RP Annexures to witness statement of Ms Jannette Curtain
109	Exhibit HQI0109_RP Witness statement of 'DHHS Manager'
110	Exhibit HQI0110_RP Annexures to witness statement of 'DHHS Manager'
111	Exhibit HQI0111_RP Witness statement of Ms Kate Gavens
112	Exhibit HQI0112_RP Annexures to witness statement of Ms Kate Gavens
113	Exhibit HQI0113_P Witness statement of Dr Finn Romanes
114	Exhibit HQI0114_RP Annexures to witness statement of Dr Finn Romanes
115	Exhibit HQI0115_RP Annexures to witness statement of Dr Finn Romanes
116	Exhibit HQI0116_RP First witness statement of Prof. Euan Wallace AM
117	Exhibit HQI0117_RP Annexures to first witness statement of Prof. Euan Wallace AM
118	Exhibit HQI0118_RP Second witness statement of Prof. Euan Wallace AM
119	Exhibit HQI0119_RP Annexures to second witness statement of Dr Euan Wallace AM
120	Exhibit HQI0120_RP Email from Prof. Euan Wallace AM to Ms Melissa Skilbeck
121	Exhibit HQI0121_RP PPE advice for hotel based healthcare worker
122	Exhibit HQI0122_RP Witness statement of Mr Murray Smith
123	Exhibit HQI0123_RP Annexures to witness statement of Mr Murray Smith
124	Exhibit HQI0124(1)_RP Annexures to witness statement of Mr Murray Smith
125	Exhibit HQI0125_RP Witness statement of Ms Melissa Skilbeck
126	Exhibit HQI0126(1)_RP Annexures to witness statement of Ms Melissa Skilbeck
127	Exhibit HQI0127_RP Witness statement of Mr Mika Verosaari
128	Exhibit HQI0128_RP Witness statement of Mr Michael Girgis
129	Exhibit HQI0129_RP Annexures to witness statement of Mr Michael Girgis
130	Exhibit HQI0130_RP Witness statement of Ms Pam Williams
131	Exhibit HQI0131(1)_RP Annexures to witness statement of Ms Pam Williams
132	Exhibit HQI0132_RP Email from Ms Rachaele May to Ms Pam Williams
133	Exhibit HQI0133_RP Minutes of Operation Soteria meeting 10 April 2020
134	Exhibit HQI0134_RP Operation Soteria Positive diagnosis guidance
135	Exhibit HQI0135_RP Witness statement of Ms Merrin Bamert
136	Exhibit HQI0136_RP Annexures to witness statement of Ms Merrin Bamert
137	Exhibit HQI0137_RP Email from Ms Merrin Bamert to DHHS and Safer Care Victoria
138	Exhibit HQI0138_RP DHHS emails re hotel accommodation for COVID positive passengers
139	Exhibit HQI0139_RP Email from DHHS Team Leader at Stamford Hotel to DHHS Operation Soteria
140	Exhibit HQI0140_P Witness statement of Mr Craig Lapsley
141	Exhibit HQI0141_RP Letter from the Commonwealth of Australia to the Board of Inquiry
142	Exhibit HQI0142_RP Voluntary submission from the Commonwealth of Australia

Exhibit	Document Title
143	Exhibit HQI0143(1)_RP Audio recording of SCC Operation Soteria meeting 27 March 2020
	Exhibit HQI0143(1)_RP Transcript of audio recording of SCC Operation Soteria meeting 27 March 2020
	Exhibit HQI0143(2)_RP Audio recording of SCC Operation Soteria meeting 10.00am 28 March 2020
	Exhibit HQI0143(2)_RP Transcript of audio recording of SCC Operation Soteria meeting 10.00am 28 March 2020
	Exhibit HQI0143(3)_RP Audio recording of Operation Soteria meeting 6.00pm 28 March 2020
	Exhibit HQI0143(3)_RP Transcript of audio recording of Operation Soteria meeting 6.00pm 28 March 2020
144	Exhibit HQI0144_P First witness statement of Commissioner Andrew Crisp
145	Exhibit HQI0145(1)_RP Annexures to first witness statement of Commissioner Andrew Crisp
146	Exhibit HQI0146_RP Second witness statement of Commissioner Andrew Crisp
147	Exhibit HQI0147_P Third witness statement of Commissioner Andrew Crisp
148	Exhibit HQI148(1)_RP Annexures to third witness statement of Commissioner Andrew Crisp
	Exhibit HQI0148(2)_RP Audio recording of SCC Operation Soteria Meeting 27 March 2020
149	Exhibit HQI0149_RP Witness statement of Mr Christopher Eagle
150	Exhibit HQI0150_RP Annexures to witness statement of Mr Christopher Eagle
151	Exhibit HQI0151_P Witness statement of Ms Jacinda de Witts
152	Exhibit HQI0152(1)_RP Annexures to witness statement of Ms Jacinda de Witts
153	Exhibit HQI0153_RP Witness statement of Prof. Brett Sutton
154	Exhibit HQI0154_P Annexures to witness statement of Prof. Brett Sutton
155	Exhibit HQI0155_RP Annexures to witness statement of Prof. Brett Sutton
156	Exhibit HQI0156_P Review of Australia's Health Sector Response to Pandemic (H1N1) 2009
157	Exhibit HQI0157_P Transcript of Prime Minister's Press Conference 27 March 2020
158	Exhibit HQI0158_RP Email from Dr Finn Romanes to Ms Andrea Spiteri and Mr Christopher Eagle
159	Exhibit HQI0159_RP Emails between DHHS Commanders and Prof. Brett Sutton
160	Exhibit HQI0160_P Witness statement of Dr Annaliese van Diemen
161	Exhibit HQI0161(1)_RP Annexures to witness statement of Dr Annaliese van Diemen
162	Exhibit HQI0162_P Witness statement of Ms Andrea Spiteri
163	Exhibit HQI0163(1)_RP Annexures to witness statement of Ms Andrea Spiteri
164	Exhibit HQI0164_RP Witness statement of Mr Jason Helps
165	Exhibit HQI0165(1)_RP Annexures to witness statement of Mr Jason Helps
166	Exhibit HQI0166_P Class 2 State Controller responsibilities
167	Exhibit HQI0167_RP EMV State Operational Arrangements COVID-19
168	Exhibit HQI0168_RP Emails between Ms Claire Febey and Mr Christopher Eagle
169	Exhibit HQI0169_RP Witness statement of Chief Commissioner Shane Patton APM
170	Exhibit HQI0170_RP Annexures to witness statement of Chief Commissioner Shane Patton APM
171	Exhibit HQI0171_RP Victoria Police safety officer instructions
172	Exhibit HQI0172_RP Witness statement of 'Victoria Police Superintendent'
173	Exhibit HQI0173_RP First witness statement of former Chief Commissioner Graham Ashton AM APM

Exhibit	Document Title
174	Exhibit HQI0174_RP Annexures to first witness statement of former Chief Commissioner Graham Ashton AM APM
175	Exhibit HQI0175_RP Second witness statement of former Chief Commissioner Graham Ashton AM APM
176	Exhibit HQI0176_P Witness statement of Dr Rob Gordon
177	Exhibit HQI0177_RP First witness statement of Mr Christopher Eccles
178	Exhibit HQI0178_RP Annexures to first witness statement of Mr Christopher Eccles
179	Exhibit HQI0179_RP Second witness statement of Mr Christopher Eccles
180	Exhibit HQI0180_RP Annexures to second witness statement of Mr Christopher Eccles
181	Exhibit HQI0181_RP Texts between Commissioner Andrew Crisp and Kate Houghton
182	Exhibit HQI0182_RP Working with Vic messages re good security companies
183	Exhibit HQI0183_RP Buying for Victoria webpage re security services
184	Exhibit HQI0184_RP Witness statement of Mr Simon Phemister
185	Exhibit HQI0185(1)_RP Annexures to witness statement of Mr Simon Phemister
186	Exhibit HQI0186_RP First witness statement of Ms Kym Peake
187	Exhibit HQI0187_RP Annexures to first witness statement of Ms Kym Peake
188	Exhibit HQI0188_RP Second witness statement of Ms Kym Peake
189	Exhibit HQI0189_RP Annexures to second witness statement of Ms Kym Peake
190	Exhibit HQI0190_RP Annexures to second witness statement of Ms Kym Peake
191	Exhibit HQI0191_RP Initial response to the Board of Inquiry from DHHS
192	Exhibit HQI0192_RP DHHS draft advice to National Cabinet
192	Exhibit HQI0192_RP DHHS draft advice to National Cabinet
193	Exhibit HQI0193_P Letter from the Hon. Daniel Andrews MP to Ms Kym Peake
194	Exhibit HQI0194_RP Mission Implementation Plan
195	Exhibit HQI0195_RP Witness statement of the Hon. Martin Pakula MP
196	Exhibit HQI0196_P Witness statement of the Hon. Lisa Neville MP
197	Exhibit HQI0197_RP Appointment of Ms Andrea Spiteri as a Class 2 State Controller
198	Exhibit HQI0198_RP Appointment of DHHS Class 2 Controllers
199	Exhibit HQI0199_RP DHHS emails re returning passengers from Greg Mortimer cruise
200	Exhibit HQI0200_P Protecting our Healthcare Workers
201	Exhibit HQI0201_RP Witness statement of 'DHHS Learning Consultant'
202	Exhibit HQI0202_RP Annexures to witness statement of 'DHHS Learning Consultant'
203	Exhibit HQI0203_RP Witness statement of 'DHHS Infection Control Consultant'
204	Exhibit HQI0204_RP Annexures to witness statement of 'DHHS Infection Control Consultant'
205	Exhibit HQI0205_RP Witness statement of 'DHHS Senior Project Officer'
206	Exhibit HQI0206_RP Annexures to witness statement of 'DHHS Senior Project Officer'
207	Exhibit HQI0207_P Witness statement of Mr Terry Symonds
208	Exhibit HQI0208_RP Annexures to witness statement of Mr Terry Symonds
209	Exhibit HQI0209_RP Texts between Assistant Commissioner Mick Grainger and Ms Claire Febey

Exhibit	Document Title
210	Exhibit HQI0210_P Video of press conference by the Hon. Daniel Andrews MP 27 March 2020
	Exhibit HQI0210_P Transcript of press conference by the Hon. Daniel Andrews MP on 27 March 2020
211	Exhibit HQI0211_P First witness statement of the Hon. Jenny Mikakos, former MP
212	Exhibit HQI0212_RP Annexures to the first witness statement of the Hon. Jenny Mikakos, former MP
213	Exhibit HQI0213_RP Bundle of government emails across departments
214	Exhibit HQI0214_RP Texts between Assistant Commissioner Mick Grainger and Commissioner Andrew Crisp
215	Exhibit HQI0215_RP Initial responses from parties
216	Exhibit HQI0216_P Index of initial responses
217	Exhibit HQI0217_RP Request for assistance register
218	Exhibit HQI0218_P Witness statement of the Hon. Daniel Andrews MP
219	Exhibit HQI0219_RP Annexures to witness statement of the Hon. Daniel Andrews MP
220	Exhibit HQI0220_P Video of press conference by the Hon. Daniel Andrews MP
	Exhibit HQI0220_P Transcript of press conference by the Hon. Daniel Andrews MP
221	Exhibit HQI0221_P Video of press conference by former Chief Commissioner Graham Ashton
	Exhibit HQI0221_P Transcript of press conference by former Chief Commissioner Graham Ashton
222	Exhibit HQI0222_P Second witness statement of the Hon. Jenny Mikakos, former MP
223	Exhibit HQI0223_RP Bundle of documents tendered by DHHS
224	Exhibit HQI0224_RP Annexures to witness statement of 'Operations Coordinator'
225	Exhibit HQI0225_RP Annexures to witness statement of Mr Shaun D'Cruz
226	Exhibit HQI0226_RP Bundle of notices and advices tendered by DHHS
227	Exhibit HQI0227_RP Bundle of documents tendered by DJPR
228	Exhibit HQI0228_RP Letter from MinterEllison dated 25 September 2020, responsive to questions posed to Ms Kym Peake
229	Exhibit HQI0229_RP DHHS email chain re 'Information — Chain of Command — people in detention' and 'Smoking policy — Operation Soteria' ending 2 July 2020
230	Exhibit HQI0230_RP DHHS emails re VIC Hotel Quarantine arrangements
231	Exhibit HQI0231_P Letter from Solicitors Assisting to Solicitors for DHHS dated 16 October 2020
232	Exhibit HQI0232_P Letter from Solicitors for DHHS to Solicitors Assisting dated 19 October 2020
233	Exhibit HQI0233_RP DHHS email chain re 'Information — Chain of Command — people in detention' and 'Smoking policy' — Operation Soteria' ending 1 April 2020
234	Exhibit HQI0234_RP DHHS email chain re 'Smoking policy — Operation Soteria'
235	Exhibit HQI0235_RP DHHS email chain re 'Governance of mandatory detention implementation'
236	Exhibit HQI0236_RP DHHS email chain re 'Passengers under detention having Covi swabs at hospitals'
237	Exhibit HQI0237_P Affidavit of Mr Christopher Eccles
238	Exhibit HQI0238_RP Further DPC document
239	Exhibit HQI0239_RP Affidavit of the Hon. Daniel Andrews MP
240	Exhibit HQI0240_RP Exhibit to Affidavit of the Hon. Daniel Andrews MP
241	Exhibit HQI0241_RP Text exchange between the Hon. Daniel Andrews MP and Lissie Ratcliff dated 27 March 2020

Exhibit	Document Title
242	Exhibit HQI0242_RP Premier's Private Office (PPO) Document
243	Exhibit HQI0243_P Affidavit of Mr Simon Phemister
244	Exhibit HQI0244_P Affidavit of former Chief Commissioner Graham Ashton AM APM
245	Exhibit HQI0245_RP Further Victoria Police document
246	Exhibit HQI0246_P Affidavit of the Hon. Lisa Neville MP
247	Exhibit HQI0247_RP Bundle of documents produced by DHHS in response to Notice to Produce 163
248	Exhibit HQI0248_RP Bundle of documents produced by DHHS in response to Notice to Produce 165
249	Exhibit HQI0249_RP First affidavit of Prof. Brett Sutton
250	Exhibit HQI0250_RP Exhibit to First affidavit of Prof. Brett Sutton
251	Exhibit HQI0251_RP Document referred to in the first affidavit of Prof. Brett Sutton
252	Exhibit HQI0252_P Second affidavit of Prof. Brett Sutton
253	Exhibit HQI0253_RP Exhibit to second affidavit of Prof. Brett Sutton
254	Exhibit HQI0254_RP Further document pertaining to Prof. Brett Sutton
255	Exhibit HQI0255_RP Affidavit of Mr Jason Helps
256	Exhibit HQI0256_RP Document referred to in affidavit of Mr Jason Helps
257	Exhibit HQI0257_RP Affidavit of Mr Braedan Hogan
258	Exhibit HQI0258_RP Document referred to in affidavit of Mr Braedan Hogan
259	Exhibit HQI0259_RP Affidavit of Dr Finn Romanes
260	Exhibit HQI0260_RP Document referred to in affidavit of Dr Finn Romanes
261	Exhibit HQI0261_P Letter from Solicitors for DHHS to Solicitors Assisting dated 11 November 2020
262	Exhibit HQI0262_P Affidavit of Mr Richard Murphy
263	Exhibit HQI0263_P Affidavit of Ms Rebecca Bedford

COVID-19
Hotel Quarantine Inquiry

COVID-19
Hotel Quarantine Inquiry

COVID-19
Hotel Quarantine Inquiry
Interim Report and Recommendations

WWW.QUARANTINEINQUIRY.VIC.GOV.AU