



COVID-19
Hotel Quarantine Inquiry

COVID-19 Hotel Quarantine Inquiry Final Report and Recommendations

VOLUME I

DECEMBER 2020

COVID-19 HOTEL QUARANTINE INQUIRY

Final Report and Recommendations

Volume I

The Hon. Jennifer Coate AO
Board of Inquiry

ORDERED TO BE PUBLISHED

Victorian Government Printer
December 2020

PP No 191, Session 2018–2020
(document 1 of 2)

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

Published December
2020

ISBN 978-0-6450016-1-7

Suggested citation: COVID-19 Hotel Quarantine
Inquiry, Final Report and Recommendations, Volume I
Parl paper no. 191 (2018–2020)



**COVID-19
Hotel Quarantine Inquiry**

21 December 2020

Her Excellency the Honourable Linda Dessau AC
Governor of Victoria
Government House
Melbourne VIC 3004

Your Excellency

In accordance with the Terms of Reference contained in the Order in Council made on 2 July 2020, and amended by the Order in Council of 29 October 2020, I present Volume I and Volume II of the Board of Inquiry into the COVID-19 Hotel Quarantine Program's (Inquiry) Final Report.

This Final Report contains an examination, findings and recommendations in respect of the decisions and actions taken in establishing and operating the Hotel Quarantine Program, based on evidence and information provided to the Inquiry. This Final Report is to be read in conjunction with the Interim Report presented to you on 6 November 2020.

Yours sincerely

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

Contents

Preface	10
Executive summary	12
COVID-19 Hotel Quarantine Inquiry Recommendations	38
About this report	50
Terms of reference	52
1. Background	53
1.1 Introduction	53
1.2 COVID-19 — The emergence of a pandemic	53
1.3 The Australian response to COVID-19	56
1.4 Victoria’s response to the COVID-19 pandemic	60
1.5 Conclusions	66
Endnotes	67
2. COVID-19 — The science	71
2.1 Introduction	71
2.2 The nature of COVID-19	72
2.3 Epidemiology	77
2.4 Genomic sequencing	78
2.5 Genomic sequencing, epidemiology and COVID-19 cases in Victoria	81
2.6 Conclusions	83
Endnotes	85
3. The state of pandemic planning in Australia and Victoria and the envisaged use of quarantining	87
3.1 The Commonwealth Pandemic Plan	88
3.2 The Victorian Pandemic Plan	92
3.3 Conclusions	97
3.4 Recommendations	99
Endnotes	100
4. Understanding Victoria’s decision to set up a Hotel Quarantine Program	103
4.1 Events leading to 27 March 2020	103
4.2 The basis of the decision to quarantine rather than continue or expand self-isolation for all returning travellers	105
4.3 Factors that influenced support for an enforced quarantine program for all returned travellers in Victoria	107
4.4 Alternatives to hotel quarantine	110
4.5 Conclusions	111
Endnotes	112

5. ‘The day was measured in minutes’	114
5.1 The first 72 hours of the Hotel Quarantine Program from 27–29 March 2020	114
5.2 The initial set-up of the Hotel Quarantine Program	117
5.3 DJPR becomes the lead department	118
5.4 The emergency management framework: Operation Soteria	124
5.5 Change of lead agency	126
5.6 Legal enforcement powers to direct people into quarantine	127
5.7 The use of private security companies	127
5.8 The use of the ADF	147
5.9 Conclusions on initial decision-making	153
5.10 Conclusions on the enforcement model	155
Endnotes	158
6. Private security	166
6.1 Introduction	166
6.2 The process of identifying security contractors	166
6.3 Subsequent procurement decisions	169
6.4 The role initially envisaged for private security	173
6.5 The evolving role of private security	175
6.6 The terms of the written contracts ultimately entered into, particularly as they relate to infection prevention and training, and the deficiencies associated with those terms	178
6.7 The management of security services contracts	187
6.8 Subcontracting terms were not appropriately managed	190
6.9 The security industry relies heavily on subcontracting	194
6.10 The security industry has inherent characteristics that make security guards a vulnerable cohort	195
6.11 The potential use of Victoria Police	199
6.12 Conclusions	200
6.13 Recommendations	205
Endnotes	206
7. Use of hotels and cleaners	213
Section 1 — The decision to use hotels and the terms of their contracts	213
7.1 Decision to ‘stand up’ hotels for the Hotel Quarantine Program	213
7.2 Procurement of hotels	214
7.3 Contracts with hotels	217
7.4 Contractual responsibility for risk management, worker safety and PPE	219
Section 2 — Hotel cleaning contracts, oversight and vulnerabilities	222
7.5 The cleaning of quarantine hotels	222
7.6 Contracts for cleaning of quarantine hotels	224
7.7 Procurement of commercial cleaning companies for ‘specialised cleaning’	225
7.8 Cleaning standards and expert advice	226
7.9 Vulnerabilities were created by the arrangements with hotels and commercial cleaning companies	230
7.10 Conclusions	232
7.11 Recommendations	238
Endnotes	239

8. DHHS as control agency	244
Introduction	244
Structure of this Chapter	245
Section 8.1 — The emergency management framework	245
8.1.1 Functions of the Emergency Management Commissioner	246
8.1.2 Classes of emergencies	246
8.1.3 A number of plans are in place to ‘operationalise’ the emergency management framework	247
8.1.4 Control agency	248
8.1.5 Controllers and Commanders	251
8.1.6 The declaration of a State of Emergency was part of the framework for the exercise of quarantine powers	252
Section 8.2 — DHHS governance, decision-making and Operation Soteria	252
8.2.1 Key relevant structures to the role of DHHS in the COVID-19 pandemic emergency	253
8.2.2 DHHS initial steps in its response to COVID-19 state-wide pandemic emergency	256
8.2.3 Hotel Quarantine Program is commenced	257
8.2.4 Establishment of separate roles for Regulation Health Protection and Emergency Management Division, and COVID-19 PHC Division (decision-making structures within DHHS)	265
8.2.5 Establishment of Emergency Operations Centre (EOC)	268
8.2.6 Structure and function of Public Health Command (Public Health Incident Management Team and, later, COVID-19 PHC Division)	271
8.2.7 On-site at Quarantine Hotels	275
Section 8.3 — Analysis and conclusions: faults and shortcomings within the DHHS response	279
8.3.1 The ‘control agency’ function and the Hotel Quarantine Program	280
8.3.2 Support agency role: DJPR	286
8.3.3 Not appointing Chief Health Officer as State Controller — Health	290
8.3.4 The Public Health Commander and Incident Management Team: state-wide role vs Hotel Quarantine Program	293
8.3.5 Hotel Quarantine: logistics and compliance program vs public health program	295
8.3.6 Transfer of Operation Soteria to the Emergency Operation Centre	297
8.3.7 Chain of command inside DHHS: who was in command of whom?	298
8.3.8 Liaison officer as link to respond to governance issues	301
8.3.9 Lack of oversight ‘on the ground’; who was in charge on-site?	304
8.3.10 Clinical guidance and governance on-site	307
8.3.11 Ministerial briefings	309
8.3.12 Appropriateness of EMMV and Class 2 emergency	311
Section 8.4 — Summary of conclusions	311
8.4.1 Summary of Recommendations	314
Endnotes	315

Preface

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



The Honourable Jennifer Coate AO

Chairperson

Board of Inquiry into the COVID-19 Hotel Quarantine Inquiry

Executive summary*

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

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

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

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

Within the first week of the Hotel Quarantine Program being established in Victoria, the number of returned travellers in the Program was between 1,550² and approximately 2,000.³ At any one time, there were between 1,500 and more than 4,000 individuals in quarantine across 10–16 hotels.⁴

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

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

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

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

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

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

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

The emergence of COVID-19

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

After emerging in late 2019 in Wuhan, China, COVID-19 rapidly proliferated across the globe, leading the WHO to declare the virus a ‘pandemic’ on 11 March 2020.⁸

The first Australian case of COVID-19 was reported on 25 January 2020,⁹ with 12 cases confirmed by 1 February 2020.¹⁰ Local case numbers then continued to increase with more than 3,000 confirmed cases of COVID-19 in Australia by 27 March 2020.¹¹

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

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

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

Many of the National Cabinet’s agreed measures were aimed at addressing the concern that international arrivals were fuelling the rise in domestic COVID-19 case numbers. These measures included imposing a self-isolation requirement for international arrivals and a ban on foreign cruise ships,¹⁶ as well as prohibiting the entry of non-citizens¹⁶ and non-permanent residents.¹⁷

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

The science behind COVID-19

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

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

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

- A. the virus primarily spread from person-to-person via droplets, aerosols and fomites (for example, transmission by contact with a contaminated surface)
- B. droplet transmission occurred when a person was in close contact (within one metre) with someone who had the virus
- C. airborne transmission was possible in specific circumstances and settings in which procedures or support treatments that generate aerosols were performed.¹⁹

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

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

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

Hotel quarantine’s link to the ‘second wave’

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

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

Mass quarantining and the science

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

- A. the importance of expert advice, input and ongoing supervision and oversight of infection prevention and control (discussed in chapters 8 and 9)
- B. the importance of a rapid and effective contact tracing regime (discussed in Chapter 9)
- C. the importance of an evidentiary base for the testing regime (discussed in Chapter 10).

The state of pre-pandemic planning

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

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

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

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

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

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

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

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

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

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

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

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

Pandemic planning exercises

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

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

What drove the decision for a Hotel Quarantine Program?

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

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

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

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

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

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

- A. an exponential increase in COVID-19 cases
- B. a link between returned travellers and community transmission rates
- C. perceived rates of non-compliance with Self-Isolation Directions
- D. perceived inadequacy of the Self-Isolation Directions.

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

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

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

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

The decisions made in establishing the Hotel Quarantine Program

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

Initial decision-making

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

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

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

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

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

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

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

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

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

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

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

Decisions on the enforcement model: the use of private security

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The procurement and role of private security

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

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

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

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

Failings in the procurement process

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

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

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

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

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

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

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

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

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

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

The role of private security

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

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

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

Contract development and management

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

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

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

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

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

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

Subcontracting security services

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

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

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

Private security guards should not have been engaged without close monitoring

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

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

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

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

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

The use of hotels and cleaners

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

Decision to ‘stand up’ hotels for the Hotel Quarantine Program

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

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

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

Procurement and contracting of hotels

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The importance of cleaning

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

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

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

PROCUREMENT OF COMMERCIAL CLEANING COMPANIES FOR ‘SPECIALISED CLEANING’

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

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

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

CLEANING STANDARDS AND QUALITY CONTROL

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

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

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

OVERSIGHT OF SPECIALISED CLEANING IN QUARANTINE HOTELS

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

DHHS assumed the management of all cleaning contracts (other than in relation to the Brady Hotel) in quarantine hotels from 1 July 2020.³⁹ Had DHHS taken over that function at an earlier point in time, it would likely have been more proactive in directing and managing hotels and cleaners in relation to IPC practices. The demarcation of roles resulted in a diffusion of responsibility, and led to an absence of appropriate oversight and leadership within the Program, in respect of this central tenet of IPC.

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

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

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

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

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

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

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

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

DHHS as the control agency

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

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

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

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

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

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

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

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

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

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

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

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

Prior to the commencement of the Hotel Quarantine Program, the then Secretary to DHHS, on the advice of one of her deputy secretaries, departed from the expectation of the emergency management framework that the CHO would be appointed State Controller for a public health emergency and, instead, appointed two emergency management experts as State Controllers. This was despite the CHO's disagreement with this course of action.

This decision was taken on the basis that the CHO would not have the ‘bandwidth’ to fulfil all of the functions he had in the context of the state-wide emergency, and on the basis that the role required emergency management logistics (hence, the appointment of two such experts).

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

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

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

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

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

By mid-April 2020, it was recognised that the Hotel Quarantine Program would likely be in place for 12–18 months and therefore needed to be taken out of an emergency management response structure and run as a departmental program. To that end, a centre was set up, ironically called the Emergency Operations Centre, and run by DHHS ‘commanders’. Unfortunately, DHHS did not take this opportunity to rethink its operation but, rather, continued to see itself as coordinating the day-to-day operation of the hotel sites without taking overall responsibility for the Program.

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

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

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

MINISTERIAL BRIEFINGS

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

It was a matter beyond the remit of this Inquiry to engage in an examination of the Westminster system of ministerial and public service lines of accountability and responsibility. However, evidence that emerged on this issue during the Inquiry signalled that an appropriate agency or entity should undertake an examination of what occurred to assess what action may be necessary. This is addressed in Recommendation 76.

Outbreaks at the Rydges and Stamford hotels

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

THE DESIGNATION OF A ‘HOT HOTEL’

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

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

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

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

ADDITIONAL SAFEGUARDS REQUIRED IN A ‘HOT HOTEL’ ENVIRONMENT

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

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

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

EPIDEMIOLOGICAL AND GENOMIC EVIDENCE

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

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

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

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

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

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

THE GENESIS OF EACH OUTBREAK

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

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

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

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

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

The testing regime in the Hotel Quarantine Program

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

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

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

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

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

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

The pivot to a health hotel model

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

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

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

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

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

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

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

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

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

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

THE VICTORIAN CHARTER OF HUMAN RIGHTS AND RESPONSIBILITIES

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

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

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

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

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

PSYCHO-SOCIAL IMPACTS OF QUARANTINE ON RETURNED TRAVELLERS

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

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

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

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

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

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

- A. not initially understanding, or adequately addressing the fact that:
 - I. being detained in quarantine in a hotel room for 14 days would be a very difficult and stressful experience for some
 - II. a percentage of the people held in quarantine would have significant health needs, either physical or mental, or both, and would need particular support
 - III. having no access to fresh air or exercise would be extremely difficult for some people
- B. the information provided by airlines and/or Commonwealth officials to allow the State to make proper preparations to accommodate people's health and wellbeing needs was limited and inadequate
- C. the State had no control of the numbers arriving at short or no notice, which made the health and wellbeing aspects of the Program very difficult to address adequately
- D. transport arrangements on arrival at airports created an immediate stressor for some people as PPE was not consistently available or worn and buses were reported by some to be crowded
- E. clear, consistent and accurate information was necessary but difficult to find or not available, or in a language that was not accessible. The system for acquiring and maintaining information on people in quarantine was inadequate
- F. there was no clear, consistent and communicated process for people to raise issues and concerns about health and wellbeing and receive a timely response.
- G. the process for accessing applications for leave and/or exemptions was not clear or consistent.

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

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

Victoria's Quarantine Program: future options

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

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

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

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

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

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

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

Endnotes

- 1 Prime Minister 'Update on Coronavirus Measures' (Media Release, 27 March 2020) <<https://www.pm.gov.au/media/update-coronavirus-measures-270320>>; Premier of Victoria, 'Enforced Quarantine For Returned Travellers To Combat Coronavirus' (Media Release, 27 March 2020) <<https://www.premier.vic.gov.au/enforced-quarantine-returned-travellers-combat-coronavirus>>.
- 2 Exhibit HQI0135_RP Witness statement of Ms Merrin Bamert, 27 [94].
- 3 Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 5 [15].
- 4 Exhibit HQI0135_RP Witness statement of Ms Merrin Bamert, 27 [94]; Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 5 [15].
- 5 National Review of Hotel Quarantine, 'Attachment A - Quarantine – National Statistics', 34-35 <<https://www.health.gov.au/sites/default/files/documents/2020/10/national-review-of-hotel-quarantine.pdf>>.
- 6 Exhibit HQI0005_P Witness statement of Prof. Ben Howden, 20-21 [101]-[104]; Transcript of day 3 hearing 17 August 2020, 86; Exhibit HQI0008_RP Witness statement of Dr Charles Alpren, 28 [130].
- 7 Premier of Victoria, 'Judicial Inquiry Into Hotel Quarantine Program' (Media Release, 2 July 2020) <<https://www.premier.vic.gov.au/judicial-inquiry-hotel-quarantine-program>>.
- 8 Dr Tedros Adhanom Ghebreyesus, 'WHO Director General's opening remarks at the media briefing on COVID-19' (Speech, World Health Organization, 11 March 2020) <<https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19--11-march-2020>>.
- 9 Federal Minister for Health, 'First Confirmed Case of Novel Coronavirus in Australia' (Media Release, 25 January 2020) <<https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/first-confirmed-case-of-novel-coronavirus-in-australia>>.
- 10 Prime Minister (Media Release, 1 February 2020) <<https://www.pm.gov.au/media/updated-travel-advice-protect-australians-novel-coronavirus>>.
- 11 Prime Minister 'Update on Coronavirus Measures' (Media Release, 27 March 2020) <<https://www.pm.gov.au/media/update-coronavirus-measures-270320>>.
- 12 Transcript of day 18 hearing 16 September 2020, 1536.
- 13 Premier of Victoria, 'State Control Centre Activated To Oversee COVID-19 response' (Media Release, 10 March 2020) <<https://www.premier.vic.gov.au/state-control-centre-activated-oversee-covid-19-response>>.
- 14 *Victorian Government Gazette*, No. S 129, 16 March 2020 <<http://www.gazette.vic.gov.au/gazette/Gazettes2020/GG2020S129.pdf>>.
- 15 Prime Minister, Minister for Health, Chief Medical Officer, 'Advice on Coronavirus' (Media Release, 13 March 2020) <<https://www.pm.gov.au/media/advice-coronavirus>>; Prime Minister, 'Press Conference with Premiers and Chief Ministers – Parramatta, NSW' (Transcript, 13 March 2020) <<https://www.pm.gov.au/media/press-conference-premiers-and-chief-ministers-parramatta-nsw>>.
- 16 Prime Minister 'Coronavirus Measures Endorsed by National Cabinet' (Media Release, 16 March 2020) <<https://www.pm.gov.au/media/coronavirus-measures-endorsed-national-cabinet>>.
- 17 Prime Minister 'Update on Coronavirus Measures' (Media Statement, 20 March 2020) <<https://www.pm.gov.au/media/update-coronavirus-measures-0>>.
- 18 Prime Minister 'Update on Coronavirus Measures' (Media Release, 27 March 2020) <<https://www.pm.gov.au/media/update-coronavirus-measures-270320>>.
- 19 Exhibit HQI0106_RP Witness statement of Dr Sarah McGuinness, 7 [27]; World Health Organization, 'Modes of transmission of virus causing COVID-19: implications for IPC precaution recommendations: scientific brief' (Brief, 29 March 2020) <<https://www.who.int/news-room/commentaries/detail/modes-of-transmission-of-virus-causing-covid-19-implications-for-ipc-precaution-recommendations>>.
- 20 Exhibit HQI0008_RP Witness statement of Dr Charles Alpren, 28 [130]; Transcript of day 3 hearing 17 August 2020, 86.
- 21 Ibid.
- 22 Department of Health and Ageing, Review of Australia's Health Sector Response to Pandemic (H1N1) 2009 (Report, September 2011) 41 <[https://www1.health.gov.au/internet/publications/publishing.nsf/Content/review-2011-l/\\$File/lessons%20identified-oct11.pdf](https://www1.health.gov.au/internet/publications/publishing.nsf/Content/review-2011-l/$File/lessons%20identified-oct11.pdf)>.
- 23 Transcript of day 25 hearing, 25 September 2020, 2127.
- 24 Transcript of day 25 hearing 25 September 2020, 2156.
- 25 Transcript of day 21 hearing 21 September 2020, 1770.
- 26 See Exhibit HQI0073_P Witness statement of Ms Hayley Baxter, 4 [15], 8–9 [28(c)], 12 [47].
- 27 Ibid 20 [79].
- 28 Exhibit HQI0049_RP Witness statement of Mr Unni Menon, 7 [23].

- 29 Exhibit HQI0082_RP Second witness statement of Ms Rachaele May, 3 [15].
- 30 Ibid; Exhibit HQI00049 Witness statement of Mr Unni Menon, 7 [21]-[23].
- 31 Exhibit HQI00035_RP Operation Soteria Operations Plan, DOJ.504.010.8488 (version 1.0); Exhibit HQI0126_RP Annexures to witness statement of Ms Melissa Skilbeck, DHS.0001.0001.1527 (version 2.0); DHS.0001.0001.2254 (version 3.0); Exhibit HQI0186_RP First witness statement of Ms Kym Peake, 49 [252]-[254].
- 32 Exhibit HQI0126_RP Annexures to witness statement of Ms Melissa Skilbeck, DHS.0001.0001.1525.
- 33 Exhibit HQI0160_P Witness statement of Dr Annaliese van Diemen, 4-5 [24].
- 34 Submission 03 Department of Health and Human Services, 31 [166].
- 35 Exhibit HQI0049_RP Witness statement of Unni Menon, 10 [37].
- 36 Exhibit HQI0041_RP Witness statement of Mr Shaun D’Cruz 4 [16].
- 37 Exhibit HQI0103_RP Witness statement of Dr Simon Crouch, 7 [37].
- 38 See Exhibit HQI0001_P Witness statement of Prof. Lindsay Grayson, 9 [42].
- 39 Exhibit HQI0128_RP Witness statement of Mr Michael Girgis, [13].
- 40 Transcript of day 25 hearing 25 September 2020, 2144.
- 41 Submission 03 Department of Health and Human Services, 59-64 [329]-[344].
- 42 Exhibit HQI0162_P Witness Statement of Ms Andrea Spiteri, 15 [59]; Submission 03 Department of Health and Human Services, 60 [330].
- 43 Exhibit HQI0191_RP Initial response to the Board of Inquiry from DHHS, 8; Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 8-9 [22(c)]; Exhibit HQI0075_P Witness statement of Mr Noel Cleaves, 14 [76(a)-(b)]; Transcript of day 13 hearing 4 September 2020, 912-913.
- 44 Board of Inquiry into the COVID-19 Hotel Quarantine Program (Interim Report, 6 November 2020) 24 [5] <<https://www.quarantineinquiry.vic.gov.au/reports>>.

COVID-19 Hotel Quarantine Inquiry Recommendations

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

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

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

Interim Report Recommendations (Recommendations 1–69)

The Quarantine Program (Section 1 of the Interim Report)

Purpose of the Quarantine Program

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

Control of the numbers

FACILITY-BASED MODEL

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

HOME-BASED MODEL

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

Information gathering

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

Electronic record-keeping

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

Safe and suitable physical environment for a quarantine facility

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

Governance structure

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

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

On-site role clarity

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

Appropriate mix of personnel on-site

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

Dedicated personnel

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

Infection prevention and control unit on each site

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

Training and workplace culture

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

Acquisition and use of PPE

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

Cleaning practices in quarantine facilities

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

Independent safety auditing

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

Period of quarantine

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

Cohorting of positive cases

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

Testing

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

Clinical equipment on-site

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

Safe transport arrangements

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

Contact tracing unit

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

Evacuation procedure on-site

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

Health and wellbeing of people in quarantine

Daily health and welfare checks

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

FRESH AIR AND EXERCISE BREAKS

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

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

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

Exemptions and temporary leave

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

Language is important

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

Transitioning out of quarantine facilities

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

Home quarantine model (Section 2 of Interim Report)

Home quarantine as an option

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

Control on numbers arriving

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

Assessment of risk factors for home quarantine

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

Individual engagement

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

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

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

Monitoring and compliance

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

Penalties for non-compliance

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

Additional Final Report Recommendations (Recommendations 70–81)

Pre-pandemic planning (Chapter 3)

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

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

74. The Emergency Management Commissioner clarifies the language used in the Emergency Management Manual Victoria to ensure that there is no possibility of any ambiguity about the role and responsibility of the control agency, including a more fulsome definition of what constitutes a complex emergency and the role of the designated control agency in a complex emergency.
75. The Secretary of DHHS engages in discussions with the President of the Australian Medical Association to address the availability of medical expertise to meet current and future surge and planning demands for public health emergencies.
76. That the Public Sector Commissioner examines the evidence that emerged in this Inquiry as to the lines of accountability and responsibility as between Departmental heads and Ministers and gives guidance across the public service as to the obligations, both in law and in practice, on heads of departments and senior public office holders.
77. The Emergency Management Commissioner, in collaboration with the Chief Health Officer, the Secretary of DHHS and other relevant agencies, reviews the suitability of the Emergency Management Manual Victoria framework to Class 2 public health emergencies, including how the Emergency Management Manual Victoria intersects with the *Public Health and Wellbeing Act 2008* (Vic).

Testing regime (Chapter 10)

78. To provide clarity to the Chief Health Officer and his delegates on the circumstances in which mandatory testing powers may be exercised and, to further minimise the risks of community transmission arising from the revised hotel quarantine program:
- A. the Responsible Minister should obtain detailed legal advice from the Solicitor-General on the range of circumstances in which ss 113 and 200(1)(d) of the *Public Health and Wellbeing Act 2008* (Vic) may be exercised to require that those refusing testing at the conclusion of their quarantine period undertake mandatory testing
 - B. the request for such advice should provide a detailed list of practical scenarios that commonly arise, or are expected to arise, in the context of returned travellers refusing to undergo testing in the Hotel Quarantine Program
 - C. recognising that it will not be possible to provide absolute certainty on the range of circumstances in which these powers may be available, the advice should provide practical guidance to the Chief Health Officer and Authorised Officers in their exercise of the powers under ss 113 and 200(1)(d) and consider matters including those listed above in paras 41.a–41.h
 - D. the request for advice should also include a request for a ‘checklist’ to be developed in order to assist those working in the Hotel Quarantine Program to determine when mandatory testing powers and/or the option of imposing an additional 10 days’ quarantine should be exercised
 - E. to accompany this advice, the Responsible Minister should identify an appropriate person who will be available to provide legal advice, at short notice and when required, to the Chief Health Officer and delegates, on the exercise of mandatory testing powers and/or the option of imposing an additional 10 days’ quarantine.
79. To protect against the risk of infection spreading to the community via staff or personnel working in the program who have contracted the virus from returned travellers, the Responsible Minister should ensure, or continue to ensure, that:
- A. all on-site staff and personnel, including frontline workers and cleaners, are required to undergo daily saliva testing and weekly nasal swab testing
 - B. family and household members of such frontline staff and personnel are provided with, and given support to access, voluntary testing on, at least, a weekly basis.

Returned travellers' rights and welfare (Chapter 12)

TRANSITIONING INTO QUARANTINE FACILITIES

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

About this Report

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

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

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

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

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

Evidence and information contained in this Report

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

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

Intake and Assessment Team received a considerable range of information

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

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

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

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

Terms of Reference

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

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

CHAPTER 1

Background

1.1 Introduction

1. A fair and constructive examination of what happened in Victoria with its Hotel Quarantine Program must be put into a national and international context. To do otherwise would not be helpful to the way forward, nor fair to those hundreds of people who worked tirelessly in our state to help keep us all safe. Further, to not examine the Program and its component parts measured in response to the growing threat of the novel coronavirus pandemic engulfing the world by early 2020, and the state of knowledge at that time, would be an injustice to those who were tasked with implementing and operating the Hotel Quarantine Program. I do not want that to be the legacy of this Inquiry.
2. Aspects of the Program had serious fault lines through them that need to be identified. Decisions made and not made, and actions taken and not taken, also must be examined. This Inquiry aims to do that for the benefit of all.
3. With that in mind, this section of the Report aims to set out that international and national context, in summary form, as the background to the emergence of the COVID-19 pandemic.

1.2 COVID-19 — The emergence of a pandemic

A new virus is identified in China

4. In late 2019, the world's attention was being drawn to China where reports were emerging of an unknown pneumonia-like disease.
5. On 31 December 2019, the World Health Organization (WHO) country office in the People's Republic of China was alerted to cases of 'viral pneumonia' in Wuhan City, Hubei Province, China.¹
6. By 3 January 2020, reports of 44 patients with a pneumonia of an unknown cause had been made to WHO by national authorities in China. Of the reported cases, 11 were identified as being severely ill. At this stage, the reported clinical signs of this pneumonia included fever with some patients having difficulty breathing. Chest radiographs also identified invasive lesions in both lungs.²
7. The newly identified virus, provisionally named 2019-nCoV³, was later renamed 'severe acute respiratory syndrome coronavirus 2' (SARS-CoV-2) by the International Committee on Taxonomy of Viruses.⁴ The disease caused by SARS-CoV-2 became known as COVID-19.⁵
8. The initial cluster of patients was linked to the Huanan Seafood Market in Wuhan and, at the time, no evidence of significant human-to-human transmission had been reported.⁶ While some dispute about origins of COVID-19 currently remains, the weight of available information leans towards the first case of animal-to-human transmission of the virus occurring in China.⁷

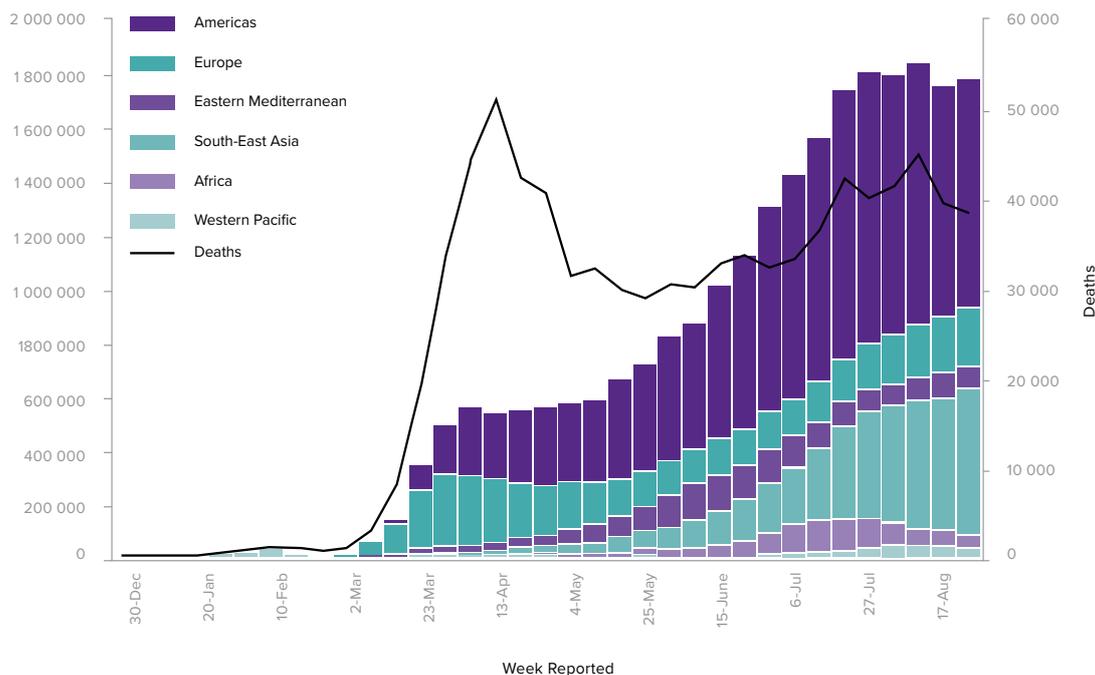
9. The WHO confirmed, on 11 January 2020, that it had received the genetic sequences for the novel coronavirus from China and expected these to soon be made publicly available. These would be used to support other countries in developing specific diagnostic kits.⁸
10. By 14 January 2020, the first case of COVID-19 outside China had been reported. The patient was linked to Wuhan and located in Thailand.⁹ The potential for human-to-human transmission between confirmed cases was also highlighted for further investigation.¹⁰
11. On 16 January 2020, the Japanese Ministry of Health, Labour and Welfare informed the WHO of a confirmed case of novel coronavirus in a person who had travelled to Wuhan.¹¹ This was the second confirmed case detected outside China. The WHO stated, not surprisingly, that, considering global travel patterns, additional cases in other countries were likely to occur.¹²
12. On 20 January 2020, Chinese authorities included COVID-19 in the notifiable report of Class B infectious diseases and border health quarantine infectious diseases, leading to the adoption of control measures such as temperature checks, healthcare declarations and quarantine at transportation depots.¹³ By that date, the WHO had been notified of 282 confirmed cases of COVID-19 in China, Japan, the Republic of Korea and Thailand.¹⁴
13. As of 22 January 2020, a total of 581 COVID-19 cases had been reported globally. Of these cases, 571 were reported in China and 375 were linked to the Hubei Province. Seventeen deaths had also been reported from the Hubei Province. Global cases were all linked to Wuhan and were reported in Thailand, Japan, Hong Kong Taipei Municipality, China, Macau, the United States of America and the Republic of Korea.¹⁵

The WHO declares a public health emergency

14. On 30 January 2020, the WHO Director-General, Dr Tedros Adhanom Ghebreyesus, convened a meeting of the Emergency Committee on the novel coronavirus under the International Health Regulations (2005). The Committee advised the Director-General that the outbreak now met the criteria for a public health emergency of international concern.¹⁶
15. At that time, there were 7,711 COVID-19 cases confirmed in China and 83 cases were reported in 18 other countries (including Australia). Confirmed cases of human-to-human transmission were reported in three countries outside China.¹⁷

COVID-19 is declared a pandemic

16. By 11 March 2020, Dr Tedros reported that the number of cases of COVID-19 outside China had increased 13-fold compared with the number of cases two weeks earlier.¹⁸ The number of affected countries had tripled. Specifically, there were 118,319 cases in 114 countries, including China, and 4,292 deaths had been recorded.¹⁹
17. Dr Tedros also noted that the number of cases, the number of deaths and the number of affected countries were expected to climb higher. It was in this context that the WHO declared COVID-19 a pandemic.²⁰

Figure 1.1: Global number of reported COVID-19 cases and deaths 30 December 2019–30 August 2020

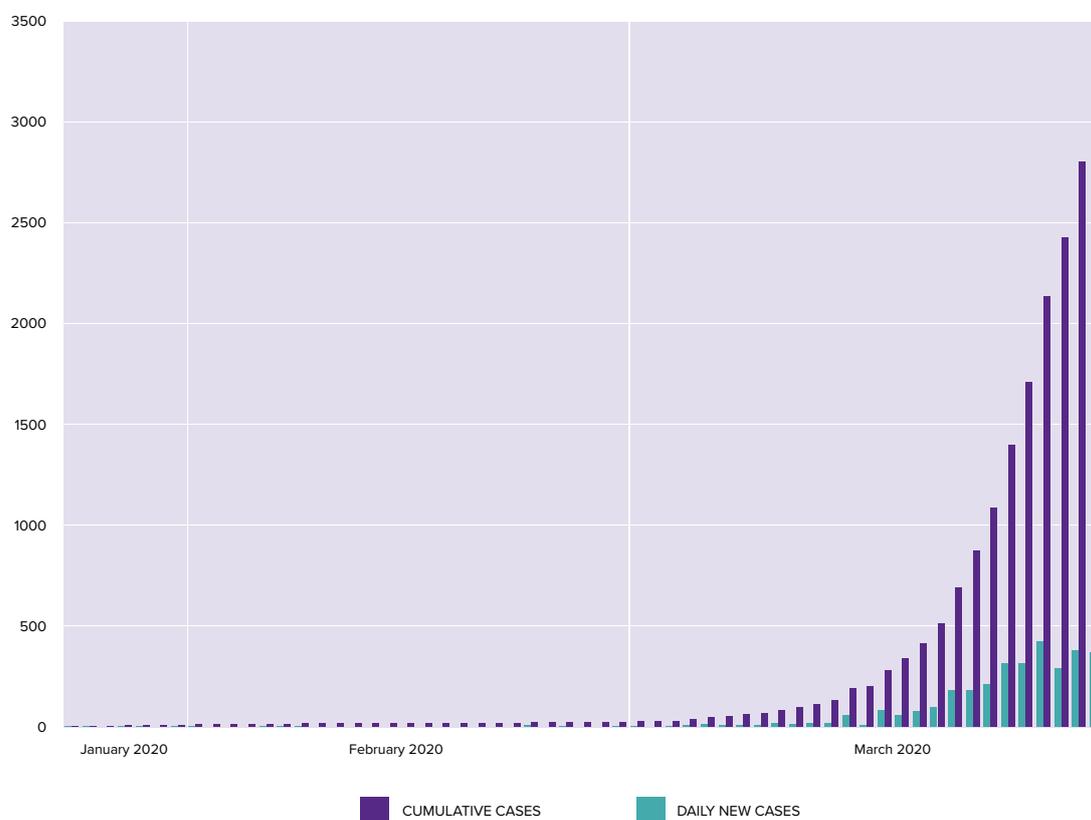
Source: WHO COVID-19 Weekly Epidemiological Update, 30 August 2020, <https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200831-weekly-epi-update-3.pdf?sfvrsn=d7032a2a_4>.

What is a pandemic?

18. A pandemic is defined by the WHO as the worldwide spread of a new disease.²¹ For example, an influenza pandemic occurs when a new influenza virus emerges and spreads around the world and most people do not have immunity.²²
19. When declaring COVID-19 a pandemic on 11 March 2020, Dr Tedros highlighted that this was the first pandemic caused by a coronavirus and noted countries would need to strike a balance between protecting health, minimising economic and social disruption, and respecting human rights in managing the virus.²³
20. The WHO called on countries to ‘detect, test, treat, isolate, trace, and mobilise their people’ to change the course of the pandemic.²⁴ In addition, and consistent with health advice provided since January 2020, the WHO reiterated basic principles to reduce the general risk of transmission, including:
 - A. avoiding close contact with people suffering from acute respiratory infections
 - B. practising socially distant greetings such as a wave, nod or bow
 - C. frequent handwashing, especially after direct contact with ill people or their environment
 - D. regular cleaning of high touch surfaces in a home environment
 - E. practising cough etiquette (maintain distance, cover coughs and sneezes with disposable tissues or clothing, and wash hands)
 - F. enhance standard infection prevention and control practices in hospitals, especially in emergency departments.²⁵

1.3 The Australian response to COVID-19

Figure 1.2: Total COVID-19 cases in Australia 25 January 2020–27 March 2020



Source: COVID-19 current situation and case numbers, Department of Health, <<https://www.health.gov.au/news/health-alerts/novel-coronavirus-2019-ncov-health-alert/coronavirus-covid-19-current-situation-and-case-numbers#daily-reported-cases>>; WHO COVID-19 Daily Situation Reports 25 January–27 March 2020: <<https://www.who.int/emergencies/diseases/novel-coronavirus-2019/situation-reports>>.

Table 1.1: Total COVID-19 cases in Australia as of 31 August 2020

Jurisdiction	Total Confirmed Cases	Deaths
Australia	25,746	652
<i>Breakdown of Figures by State and Territory</i>		
ACT	113	3
NSW	4,050	52
NT	33	0
QLD	1,122	6
SA	463	4
TAS	230	13
VIC	19,080	565
WA	655	9

Source: Department of Health, <<https://www.health.gov.au/sites/default/files/documents/2020/09/coronavirus-covid-19-at-a-glance-31-august-2020.pdf>>.

21. According to the Prime Minister, Australia had clearly been monitoring the increase in COVID-19 cases in China and other parts of the world, and was alert to the need to begin preparing for COVID-19 cases to potentially enter the country.²⁶
22. On 20 January 2020, the Australian Health Protection Principal Committee (AHPPC), which comprises the Chief Medical Officer of Australia and all state and territory Chief Health Officers, met for the purposes of considering a national response to COVID-19.²⁷
23. On 21 January 2020, the then Chief Medical Officer for the Australian Government, Professor Brendan Murphy — the Commonwealth Chief Medical Officer — in his capacity as Director of Human Biosecurity, made a written determination pursuant to s. 42 of the Commonwealth's *Biosecurity Act 2015* (Cth) that COVID-19 (designated 'human coronavirus with pandemic potential') should be included as a 'listed human disease'.²⁸ This determination provided authority for the Federal Minister for Health to impose enhanced border screening measures for all travellers entering and departing Australia.²⁹
24. On 25 January 2020, Australia confirmed its first case of COVID-19, a man from Wuhan who had travelled from Guangdong to Melbourne on 19 January 2020.³⁰
25. The Australian Government subsequently raised the level of travel advice for Wuhan and Hubei Province to 'Level 4—Do Not Travel' and introduced precautionary measures for travellers arriving in Australia from China to detect unwell travellers and to ensure all returning travellers were provided with information about COVID-19 and the steps to take should they develop symptoms.³¹
26. At the same time, Australia was advised that Chinese authorities had put a stop to transport out of Wuhan city. According to the Prime Minister, flight MU 749, which landed at Sydney Airport on the morning of 23 January 2020, was the last flight out of Wuhan to Australia. All passengers on this flight were met, on arrival, by biosecurity and health officials and received information about the virus.³²
27. According to the Prime Minister, enhanced health advice was provided at every port of entry to Australia for all modes of travel (airline and sea).³³ The Commonwealth Chief Medical Officer stated that every state and territory health department had established designated isolation and testing facilities with clearly established protocols for getting people to these facilities.³⁴ It was reported that, in Victoria, initial potential and positive cases were treated at Monash Medical Centre in accordance with infection control procedures.³⁵
28. Knowledge of symptoms of the virus had apparently progressed from a fever with some patients having difficulty breathing, as identified by the WHO on 3 January 2020,³⁶ to 'fever, cough, sore throat, vomiting and difficulty breathing'.³⁷

Escalating confirmed COVID-19 cases in Australia

29. By 1 February 2020, there were 12 confirmed COVID-19 cases in Australia.³⁸ The Department of Foreign Affairs and Trade (DFAT) upgraded its travel advice for China to 'Do Not Travel'.³⁹ Restrictions were also placed on people travelling or returning to Australia from China:

Foreign nationals (excluding permanent residents) who are in mainland China from today forward, will not be allowed to enter Australia for 14 days from the time they have left or transited through mainland China ...

Any foreign nationals who do arrive in Australia notwithstanding the prohibition, and who choose not to immediately return to their port of origin, will be subject to mandatory quarantine.

We will also be requiring Australian citizens, permanent residents and their families who do enter Australia and who have been in mainland China to self-isolate for 14 days from the time they left mainland China.⁴⁰

30. The Prime Minister announced that a plan was also established to provide assisted departures for isolated and vulnerable Australians located in Wuhan and the Hubei Province in China, with individuals to quarantine for 14 days at Christmas Island.⁴¹
31. The 14-day period was based on medical advice around the incubation period of the virus.⁴²
32. By 29 February 2020, 24 confirmed COVID-19 cases had been reported by states and territories in Australia.⁴³ Of these cases:
 - A. 15 had a direct or indirect link to Wuhan City, Hubei Province, China
 - B. nine cases were associated with the Diamond Princess repatriation flight from Japan to the Northern Territory on 20 February 2020.⁴⁴
33. An additional case with recent travel history to Iran, where the largest number of reported deaths had occurred outside of the Hubei Province in China, was also confirmed by the Prime Minister in his media release of 29 February 2020. DFAT subsequently upgraded the travel alert for Iran to 'Do Not Travel'.⁴⁵
34. In the context of increasing cases of COVID-19 in Australia, the National Cabinet was established.⁴⁶

Establishment of the National Cabinet: A governmental response to the pandemic

35. On 13 March 2020, in recognition of the unprecedented scale and potential consequences of the pandemic, the National Cabinet was established following a meeting of the Council of Australian Governments (COAG).⁴⁷
36. It was stated by the Prime Minister that the National Cabinet was created to address and ensure consistency in Australia's response to the COVID-19 pandemic. Like COAG, it comprised the Prime Minister, Premiers and Chief Ministers of the States and Territories.⁴⁸ It first met on 15 March 2020.⁴⁹
37. The key advisory bodies to the National Cabinet included the AHPPC, led by the Commonwealth's Chief Medical Officer and comprising the chief health and medical officers from each jurisdiction, and the National Coordination Mechanism (NCM), convened by the Department of Home Affairs. The work of the NCM was described as working across all jurisdictions, industry and key stakeholders to ensure a consistent approach to managing the impacts of the pandemic beyond immediate health issues.⁵⁰
38. In addition to reiterating the health advice around proper hand hygiene and social distancing measures, the National Cabinet announced a range of measures to limit or reduce the transmission of COVID-19 in Australia.

Decisions made by National Cabinet

15 MARCH 2020

39. In the wake of its first meeting on 15 March 2020, the Prime Minister announced that the National Cabinet agreed that its core objective was to slow the outbreak of COVID-19 in Australia by taking additional steps to reduce community transmission.⁵¹ To help 'stay ahead of the curve' the Commonwealth Government imposed a 'universal precautionary self-isolation requirement on all international arrivals', effective from 11.59pm that day.⁵²

40. Further, the National Cabinet implemented a ban on cruise ships from foreign ports (including round trip international cruises originating in Australia) arriving at Australian ports for an initial 30 days, from 11:59pm Sunday 15 March 2020.⁵³ Arrangements were made for cruise ships already in transit to enable Australian citizens and permanent residents to get off those ships.⁵⁴
41. The National Cabinet also endorsed the advice of the AHPPC to introduce further social distancing measures, including the requirement that non-essential, organised public gatherings of more than 500 people should not occur.⁵⁵ It should be noted that Victoria applied these decisions through its declaration of a State of Emergency on 16 March 2020.⁵⁶ Further detail on this is provided at paragraph 58 below.

17 MARCH 2020

42. At its meeting on 17 March 2020, the National Cabinet accepted AHPPC advice that non-essential indoor gatherings of greater than 100 people (including staff) no longer be permitted from Wednesday 18 March 2020.⁵⁷ This was applied in Victoria under the State of Emergency declared on 16 March 2020.⁵⁸

19 MARCH 2020

43. On the morning of 19 March 2020, the cruise ship Ruby Princess had disembarked into Sydney. It came to be understood that around 39 per cent of the ship's passengers from Australia and 17 per cent of its crew had contracted COVID-19.⁵⁹
44. The passengers from that vessel had been allowed to disperse, immeasurably compounding the task of contact tracing and infection control.
45. 28 deaths were later found to be associated with passengers from the Ruby Princess.⁶⁰

20 MARCH 2020

46. On 20 March 2020, the National Cabinet met and agreed, amongst other restrictions and safety measures, to endorse the Commonwealth Government's decision to stop the entry of non-citizens and non-permanent residents and their immediate families into Australia after 9.00pm that day.⁶¹
47. Most relevant to this Inquiry is the decision made by the National Cabinet on 27 March 2020.

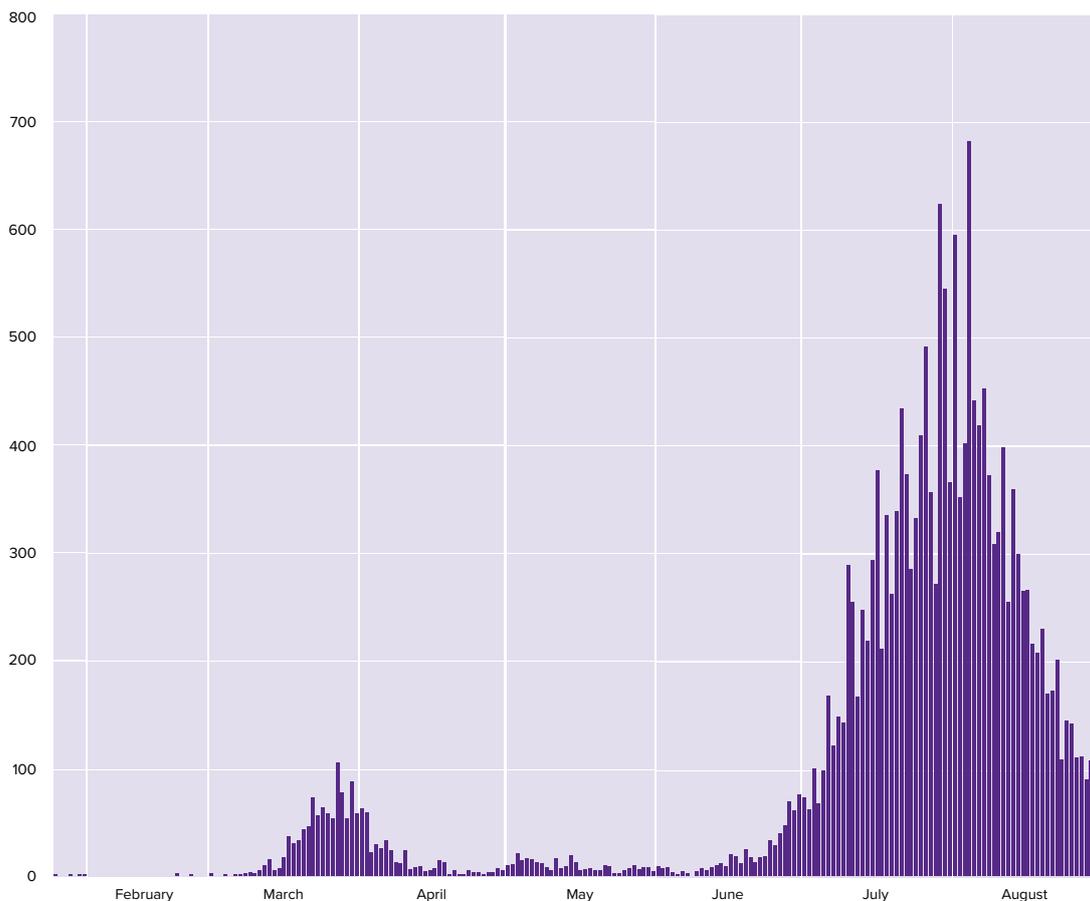
27 MARCH 2020

48. By 27 March 2020, according to information provided via the Prime Minister's media release there were more than 3,000 confirmed COVID-19 cases in Australia and 13 deaths. The majority of cases were in New South Wales, Victoria and Queensland.⁶² There was considerable concern that the majority of cases across the nation were coming in via international points of entry.
49. On 27 March 2020, the National Cabinet met and agreed to further restrict the movement of incoming travellers and increase compliance checks on travellers already self-isolating. Notably, the National Cabinet agreed that, as soon as possible, but no later than 11.59pm on 28 March 2020, all travellers arriving in Australia would be required to undertake mandatory 14-day self-isolation at 'designated facilities'.⁶³
50. Hotels were given as an example of a designated facility, but the exact facilities to be designated and the implementation of the quarantine program was a matter for each state and territory government. The National Cabinet agreed that:
 - A. travellers would be transported directly to designated facilities after appropriate immigration, customs and enhanced health checks
 - B. designated facilities would be determined by the relevant state and territory government and would ordinarily be in the city of entry where the traveller had cleared immigration, but facilities in other areas could be used if required

- C. these requirements would be implemented under state and territory legislation and would be enforced by state and territory governments, with the support of the Australian Defence Force (ADF) and Australian Border Force (ABF) where necessary
 - D. the Commonwealth would provide support through the ADF and ABF for these arrangements across Australia, with states and territories meeting the costs and determining any contributions required for travellers arriving within their jurisdictions.⁶⁴
51. Later, on 30 March 2020, the National Cabinet agreed that state and territory governments could consider exceptional circumstance exemptions to the requirement to serve the 14-day quarantine in a hotel or other designated facility in order to enable vulnerable or at-risk individuals to self-isolate at home.⁶⁵

1.4 Victoria's response to the COVID-19 pandemic

52. As early as 10 January 2020, Victoria's Chief Health Officer (CHO), Professor Brett Sutton, issued a health alert with respect to patients who had travelled to Wuhan, China and who experienced the onset of fever and respiratory symptoms within two weeks of their return. The alert acknowledged concern that what was referred to as viral pneumonia may be a novel coronavirus.⁶⁶
53. On 1 February 2020, recognising that COVID-19 (being a human disease) was a Class 2 emergency, as that term is used in the Emergency Management Acts and the Emergency Management Manual Victoria, a designated State Controller — Health was appointed.⁶⁷ Notwithstanding that, under the Victorian State Health Emergency Plan, the State Controller — Health is presumptively the CHO,⁶⁸ the Director of the Emergency Management Branch within the Department of Health and Human Services (DHHS) was actually appointed to the role.⁶⁹ The significance of this is the subject of analysis later in this report.
54. On 10 March 2020, the State Control Centre was activated to oversee and co-ordinate Victoria's response to the spread of COVID-19.⁷⁰
55. By the start of March 2020, Victorians were nightly watching distressing scenes across the world where alarming numbers of people in international locations were contracting the virus and a catastrophic number of lives were being lost.
56. Predictions about the potential for the spread of COVID-19 throughout the community were being made by experts, including Victoria's Deputy Chief Health Officer, Dr Annaliese van Diemen.
57. Dr van Diemen's evidence was that she had observed, primarily through international experience, the disease spread rapidly with very high fatality rates.⁷¹ Further, there was no vaccine, nor was there treatment to mitigate the effects of COVID-19. The virus therefore became an 'exceedingly significant risk to public health'.⁷²

Figure 1.3: Daily new COVID-19 cases in Victoria 25 January 2020–31 August 2020

Source: Department of Health and Human Services, Victorian COVID-19 data, <<https://www.dhhs.vic.gov.au/victorian-coronavirus-covid-19-data>> (data extracted from 'daily new cases in Vic' graph).

Declaration of a State of Emergency in Victoria

58. On 16 March 2020, a State of Emergency under the *Public Health and Wellbeing Act 2008* (Vic) (PHW Act) was declared in Victoria by the then Minister for Health, the Hon. Jenny Mikakos MP, on the advice of the CHO and after consultation with the Minister for Police and Emergency Services and the Emergency Management Commissioner under the *Emergency Management Act 2013* (Vic), due to the serious public health risk posed by COVID-19.⁷³ This activated the emergency management powers and enabled the CHO to issue orders and directions, including enforcing 14-day isolation requirements for all travellers entering Australia and cancelling mass gatherings of more than 500 people as agreed by the National Cabinet.⁷⁴
59. The initial State of Emergency was implemented for a four-week period, as specified in the PHW Act. Thereafter, successive sets of Directions (State and Commonwealth) were issued up to, and including, 28 March 2020 as set out below.

Table 1.2: Declarations and directions issued ahead of the Hotel Quarantine Program being established

Date	Declaration or Direction	Detail	Government (Victoria/ Commonwealth)
16 March 2020	Declaration of a State of Emergency Issued under s. 198(1), <i>Public Health and Wellbeing Act (Vic)</i>	Declaration activated the emergency management powers and enabled the Chief Health Officer to issue orders and directions, including social distancing measures and quarantining of groups of people.	Victoria
	Direction from the Chief Health Officer in accordance with emergency powers arising from declared state of emergency Issued under s. 200(1)(b) and (d), <i>Public Health and Wellbeing Act (Vic)</i>	Direction contained two parts that: <ul style="list-style-type: none"> prohibited non-essential mass gatherings (Part 1): directed persons arriving in Victoria from overseas to undertake a 14-day period of 'self-quarantine' (Part 2). 	Victoria
18 March 2020	Biosecurity (Human Biosecurity Emergency) (Human Coronavirus with Pandemic Potential) Declaration 2020 Issued under s. 475, <i>Biosecurity Act 2015 (Cth)</i> . Varied under s. 476, <i>Biosecurity Act 2015 (Cth)</i>	Declaration made by the Governor-General established that there was an existing Human Biosecurity Emergency by the name of COVID-19 or SARS-CoV-2. The declaration gave the Health Minister expansive powers to issue any direction to any person (s. 478) and set any requirements (s. 477) provided that these actions were to prevent or control the entry, emergence, establishment or spread of the outbreak (ss 477(1), 478(1)). This was the first time these powers under the <i>Biosecurity Act 2015 (Cth)</i> were used.	Commonwealth
	Airport Arrivals Direction Issued under s. 200(1)(b) and (d), <i>Public Health and Wellbeing Act (Vic)</i>	Direction replaced Part 2 of the Direction from the Chief Health Officer (Communicable Disease) in accordance with the emergency powers arising from declared State of Emergency issued on 16 March 2020. Issued to people arriving in Victoria from overseas (between 5.00pm 18 March 2020 and midnight 13 April 2020) directing that they must go into immediate compulsory isolation for 14 days at a 'premises that it suitable for the person to reside in for a period of 14 days'.	Victoria
	Mass Gatherings Direction Issued under s. 200(1)(b) and (d), <i>Public Health and Wellbeing Act (Vic)</i>	Direction replaced Part 1 of the Direction from the Chief Health Officer in accordance with emergency powers arising from declared state of emergency issued on 16 March 2020. Prohibited gatherings of 500 people or more in a single undivided outdoor space and gatherings of 100 people or more in a single undivided indoor space.	Victoria
19 March 2020	Cruise Ship Docking Direction Issued under s. 200(1)(b) and (d), <i>Public Health and Wellbeing Act (Vic)</i>	Direction applied to any person who disembarked at a port in Victoria from an international cruise ship or an Australian cruise ship between midday 19 March 2020 and midnight 13 April 2020. Directed that returnees must travel from the port in Victoria to a premises suitable for the person to reside in for a period of 14 days.	Victoria

Date	Declaration or Direction	Detail	Government (Victoria/ Commonwealth)
21 March 2020	Mass Gatherings Direction (No. 2) Issued under s. 200(1)(b) and (d), <i>Public Health and Wellbeing Act</i> (Vic)	Direction replaced the Mass Gatherings Direction made on 18 March 2020. Directed that a gathering of fewer than 100 people was only permitted in a single undivided indoor space where the space had minimum of four square metres per person or where the space was a private residence, a private vehicle or a commercial passenger vehicle.	Victoria
	Visitors to Residential Aged Care Facilities Direction Issued under s. 200(1)(b) and (d), <i>Public Health and Wellbeing Act</i> (Vic)	Direction prohibited people visiting residential aged care facilities between 6.00pm on 21 March 2020 and midnight 13 April 2020 except for certain groups of people, including: <ul style="list-style-type: none"> • employees or contractors of the facility • people visiting the facility for the purpose of providing a care and support visit to a resident (of no longer than 2 hours, by one person or two people made together) • people attending for the purpose of providing health, medical, pharmaceutical goods or services to a resident • people visiting for the purpose of providing end of life support to a resident • prospective residents. 	Victoria
23 March 2020	Non-Essential Business Closure Direction Issued under s. 190(1) (a) and 200(1)(d), <i>Public Health and Wellbeing Act</i> (Vic)	Direction prohibited the operation of the following non-essential businesses or undertakings between noon 23 March 2020 and midnight 13 April 2020: <ul style="list-style-type: none"> • businesses characterised as pubs, bars or clubs that supply alcohol • hotels, except to the extent they provided accommodation, bottle shop or meal takeaway or delivery services • gyms • indoor sports centres • casinos • cinemas, nightclubs or entertainment venues of any kind • restaurants and cafes (other than meal takeaway or delivery services) • places of worship, other than for the purposes of weddings or funerals. 	Victoria
	Hospital Visitors Directions Issued under and s. 200(1) (b) and (d), <i>Public Health and Wellbeing Act</i> (Vic)	Direction prohibited non-essential visits to hospitals in the State of Victoria between midnight 23 March 2020 and midnight 13 April 2020.	Victoria

Date	Declaration or Direction	Detail	Government (Victoria/ Commonwealth)
25 March 2020	Isolation (Diagnosis) Direction Issued under s. 200(1)(b) and (d), <i>Public Health and Wellbeing Act</i> (Vic)	Direction issued to people who have tested positive to COVID-19 between midnight 25 March 2020 and midnight 13 April 2020, requiring that they self-isolate until: <ul style="list-style-type: none"> written clearance from self-isolation had been provided by an officer of DHHS; they met criteria for discharge from self-isolation. 	Victoria
	Non-Essential Activity Direction Issued under s. 190(1) (a) and (g) and 200(1) (d), <i>Public Health and Wellbeing Act</i> (Vic)	Direction replaced the Non-Essential Business Closure Direction made on 23 March 2020, and extended and further particularised restrictions on non-essential business in the State of Victoria, including introducing restrictions to non-essential retail facilities such as beauty and personal care facilities and animal facilities such as zoos and aquariums.	Victoria
	Prohibited Gatherings Direction Issued under s. 200(1)(b) and (d), <i>Public Health and Wellbeing Act</i> (Vic)	Direction replaced the Mass Gatherings Directions (No. 2) made on 21 March 2020, and added two new categories of prohibited gatherings: <ul style="list-style-type: none"> social sport gatherings weddings and funerals. 	Victoria
25 March 2020	Biosecurity (Human Biosecurity Emergency) (Human Coronavirus with Pandemic Potential) (Overseas Travel Ban Emergency Requires) Determination 2020 Issued s. 477(1) of the <i>Biosecurity Act 2015</i> (Cth)	Determination prohibited Australian citizens and permanent residents from leaving Australian territory by air or sea as a passenger. It also prohibited the operator of an outgoing aircraft or vessel from leaving Australian territory with an Australian citizen or permanent resident on board as a passenger. This overseas travel ban did not apply to the following persons: <ul style="list-style-type: none"> a person who was ordinarily a resident in a country other than Australia a person who was a member of a crew of an aircraft or vessel but was travelling as a passenger on another aircraft or vessel a person engaged in the day-to-day conduct of inbound and outbound freight a person whose travel is associated with essential work at an offshore facility (for example, offshore oil rigs) a person who was travelling on official government business (including a member of the Australian Defence Force). This entered into force at noon 25 March 2020, 15 hours after it was announced following a meeting of the National Cabinet.	Commonwealth
26 March 2020	Non-Essential Activity Direction (No. 2) Issued under s. 190(1) (a) and (g) and 200(1) (d), <i>Public Health and Wellbeing Act</i> (Vic)	Direction replaced the Non-Essential Activity Direction made on 25 March 2020, and: <ul style="list-style-type: none"> removed hair salons and barber shops from the list of non-essential retail facilities, as well as the 30-minute time limit, thereby permitting those facilities to operate so long as they comply with the density, cleaning and signage requirements added 'sex on premises' venues to the list of non-essential entertainment facilities. 	Victoria

Date	Declaration or Direction	Detail	Government (Victoria/ Commonwealth)
28 March 2020	Revocation of Airport Arrivals Direction and Cruise Ship Docking Direction Issued under s. 200(1)(b) and (d), <i>Public Health and Wellbeing Act (Vic)</i>	Direction revoked the Airport Arrivals Direction and Cruise Ship Docking Direction with effect from midnight 28 March 2020. If the Airport Arrivals Direction or the Cruise Ship Docking Direction, as the case required, applied to a person before the revocation of that Direction by subclause (1), the direction continued to apply to the person after that revocation as if the Direction had not been revoked.	Victoria
	Direction and Detention Notice (No. 3) Issued under s. 200, <i>Public Health and Wellbeing Act (Vic)</i>	Direction issued to people arriving in the State of Victoria from overseas (on or after 11:59pm on 28 March 2020) advising that they must go into immediate compulsory quarantine for 14 days. It noted that the person was detained due to the serious risk posed by COVID-19 and the fact that their detention was reasonably necessary for the purpose of eliminating or reducing the serious public health risk. Direction also outlined that: <ul style="list-style-type: none"> • detainees must not leave their room under any circumstances unless they had permission • detainees must not permit any other person to enter their room, unless the person was authorised to be there for a specific purpose (for example food or medical reasons) • a person's detention be revisited every 24 hours to determine that it was still necessary. 	Victoria

Source: Victorian Government Gazette Archives <http://www.gazette.vic.gov.au/gazette_bin/gazette_archives.cfm?bct=homelsearchgazetteslrecentgazetteslgazettearchives>; Federal Register of Legislation — Legislative Instruments <<https://www.legislation.gov.au/Browse/ByTitle/LegislativeInstruments/InForce/0/0/Principal/>>

Victoria's hotel quarantine program commences

60. It was in this context that Victoria's Hotel Quarantine Program, later known as 'Operation Soteria', was established, following the National Cabinet's decision on 27 March 2020 requiring returned travellers to undertake mandatory quarantine.
61. The Deputy Chief Health Officer issued Direction and Detention Notice No. 3 on 28 March 2020, as set out in the Table 1.2 above, thus creating the detention orders that mandated all international arrivals into Victoria into hotel quarantine after 11.59pm on 28 March 2020. The detail of the set up for Victoria's Hotel Quarantine Program, over the weekend of 28 and 29 March 2020, is contained in Chapter 3.

1.5 Conclusions

62. Following its emergence in late 2019, COVID-19 rapidly proliferated across the globe, leading the WHO to declare the virus a pandemic on 11 March 2020.⁷⁵
63. The first Australian case of COVID-19 was reported on 25 January 2020,⁷⁶ with 12 cases confirmed by 1 February 2020.⁷⁷ Local case numbers then continued to increase, with there being more than 3,000 confirmed cases of COVID-19 by 27 March 2020.⁷⁸
64. Understandably, as these numbers continued to swiftly rise, so too did concern among government, the medical and scientific community, and the general public. In the view of Dr van Diemen, the anticipated trajectory of the virus posed a significant risk to public health.⁷⁹
65. At a state level, the Victorian response included the appointment of a State Controller — Health,⁸⁰ the activation of the State Control Centre⁸¹ and a declaration of a State of Emergency.⁸² At the federal level, the National Cabinet was established on 13 March 2020, with the stated aim of ensuring consistency in Australia’s response to the COVID-19 pandemic.⁸³
66. Many of the National Cabinet’s agreed measures were aimed at addressing the concern that international arrivals were fuelling the rise in domestic COVID-19 case numbers. These measures included imposing a self-isolation requirement for international arrivals and a ban on foreign cruise ships,⁸⁴ as well as prohibiting the entry of non-citizens and non-permanent residents.⁸⁵
67. It was in this context that the National Cabinet, at a meeting on 27 March 2020, resolved to implement a mandatory 14-day quarantine period for international arrivals,⁸⁶ setting the wheels in motion for the establishment of Victoria’s Hotel Quarantine Program.

Endnotes

- 1 World Health Organization, 'Pneumonia of unknown cause — China' (Disease Outbreak News Release, 5 January 2020) <<https://www.who.int/csr/don/05-january-2020-pneumonia-of-unknown-cause-china/en/>>.
- 2 Ibid.
- 3 World Health Organization, *Novel Coronavirus (2019-nCoV) Situation Report 1* (21 January 2020) 1 <<https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200121-sitrep-1-2019-ncov.pdf>>.
- 4 This name was announced on 11 February. World Health Organization, 'Naming the Coronavirus Disease (COVID-19) and the Virus that Causes It' *Technical Guidance* (web page) <[https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-\(covid-2019\)-and-the-virus-that-causes-it](https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-(covid-2019)-and-the-virus-that-causes-it)>.
- 5 Dr Tedros Adhanom Ghebreyesus, 'WHO Director-General's Remarks at the Media Briefing on 2019-nCoV' (Speech, World Health Organization, 11 February 2020) <<https://www.who.int/dg/speeches/detail/who-director-general-s-remarks-at-the-media-briefing-on-2019-ncov-on-11-february-2020>>.
- 6 World Health Organization, 'Pneumonia of unknown cause — China' (Disease Outbreak News Release, 5 January 2020) <<https://www.who.int/csr/don/05-january-2020-pneumonia-of-unknown-cause-china/en/>>.
- 7 World Health Organization, How WHO is working to track down the animal reservoir of the SARS-CoV-2 virus, (web page, 6 November 2020) <<https://www.who.int/news-room/feature-stories/detail/how-who-is-working-to-track-down-the-animal-reservoir-of-the-sars-cov-2-virus>>.
- 8 World Health Organization, *Timeline of WHO's response to COVID-19*, (web page, 9 September 2020) <<https://www.who.int/news-room/detail/29-06-2020-covidtimeline>>.
- 9 Ibid.
- 10 Ibid.
- 11 World Health Organization, 'Novel Coronavirus — Japan (ex-China)' (Disease Outbreak News Release, 16 January 2020) <<https://www.who.int/csr/don/16-january-2020-novel-coronavirus-japan-ex-china/en/>>.
- 12 World Health Organization, *Timeline of WHO's response to COVID-19* (web page, 9 September 2020) <<https://www.who.int/news-room/detail/29-06-2020-covidtimeline>>.
- 13 World Health Organization, 'Report of the WHO-China Joint Mission on Coronavirus Disease 2019 (COVID-19)' (Final Report, 16–24 February 2020) 14–15 <<https://www.who.int/docs/default-source/coronaviruse/who-china-joint-mission-on-covid-19-final-report.pdf>>.
- 14 World Health Organization 'Novel Coronavirus (2019-nCoV) Situation Report 1' (Situation Report, 21 January 2020) 1 <<https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200121-sitrep-1-2019-ncov.pdf>>.
- 15 World Health Organization, 'Novel Coronavirus (2019-nCoV) Situation Report 3' (Situation Report, 23 January 2020) 1 <https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200123-sitrep-3-2019-ncov.pdf?sfvrsn=d6d23643_8>.
- 16 World Health Organization, 'Statement on the second meeting of the International Health Regulations (2005) Emergency Committee regarding the outbreak of novel coronavirus (2019-nCoV)' (Media Release, 30 January 2020) <[https://www.who.int/news-room/detail/30-01-2020-statement-on-the-second-meeting-of-the-international-health-regulations-\(2005\)-emergency-committee-regarding-the-outbreak-of-novel-coronavirus-\(2019-ncov\)](https://www.who.int/news-room/detail/30-01-2020-statement-on-the-second-meeting-of-the-international-health-regulations-(2005)-emergency-committee-regarding-the-outbreak-of-novel-coronavirus-(2019-ncov))>; World Health Organization, 'Novel Coronavirus (2019-nCoV) Situation Report 11' (Situation Report, 31 January 2020) 1 <https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200131-sitrep-11-ncov.pdf?sfvrsn=de7c0f7_4>.
- 17 Statement on the second meeting of the International Health Regulations (2005) Emergency Committee regarding the outbreak of novel coronavirus (2019-nCoV), 30 January 2020, <[https://www.who.int/news-room/detail/30-01-2020-statement-on-the-second-meeting-of-the-international-health-regulations-\(2005\)-emergency-committee-regarding-the-outbreak-of-novel-coronavirus-\(2019-ncov\)](https://www.who.int/news-room/detail/30-01-2020-statement-on-the-second-meeting-of-the-international-health-regulations-(2005)-emergency-committee-regarding-the-outbreak-of-novel-coronavirus-(2019-ncov))>.
- 18 Dr Tedros Adhanom Ghebreyesus, 'WHO Director General's opening remarks at the media briefing on COVID-19' (Speech, World Health Organization, 11 March 2020) <<https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19--11-march-2020>>.
- 19 World Health Organization, 'Coronavirus disease 2019 (COVID-19) Situation Report 51' (Situation Report, 11 March 2020) 1 <https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200311-sitrep-51-covid-19.pdf?sfvrsn=1ba62e57_10>.
- 20 Dr Tedros Adhanom Ghebreyesus, 'WHO Director General's opening remarks at the media briefing on COVID-19' (Speech, World Health Organization, 11 March 2020) <<https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19--11-march-2020>>.
- 21 World Health Organization, *What is a pandemic?* (web page, 24 February 2010) <https://www.who.int/csr/disease/swineflu/frequently_asked_questions/pandemic/en/>.

- 22 Ibid.
- 23 Dr Tedros Adhanom Ghebreyesus, 'WHO Director General's opening remarks at the media briefing on COVID-19' (Speech, World Health Organization, 11 March 2020) <<https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020>>.
- 24 Ibid.
- 25 World Health Organization, 'Coronavirus disease 2019 (COVID-19) Situation Report 51' (Situation Report, 11 March 2020) 1 <https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200311-sitrep-51-covid-19.pdf?sfvrsn=1ba62e57_10>; World Health Organization, 'Coronavirus disease (COVID-19) advice for the public' (16 November 2020) 1 <<https://www.who.int/emergencies/diseases/novel-coronavirus-2019/advice-for-public>>.
- 26 Prime Minister (Press Conference, 23 January 2020) <<https://www.pm.gov.au/media/press-conference-parliament-house-0>>.
- 27 Exhibit HQI0155_RP Annexures to witness statement of Prof. Brett Sutton, DHS.5000.0056.3664.
- 28 Biosecurity (Listed Human Diseases) Amendment Determination 2020 (Cth) schedule 1.
- 29 *Biosecurity Act 2015* (Cth) chapter 2, part 2, division 2.
- 30 Federal Minister for Health, 'First Confirmed Case of Novel Coronavirus in Australia' (Media Release, 25 January 2020) <<https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/first-confirmed-case-of-novel-coronavirus-in-australia>>.
- 31 Ibid.
- 32 Prime Minister (Media Release, 23 January 2020) <<https://www.pm.gov.au/media/press-conference-parliament-house-0>>.
- 33 Ibid.
- 34 Ibid; Federal Minister for Health, 'First Confirmed Case of Novel Coronavirus in Australia' (Media Release, 25 January 2020) <<https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/first-confirmed-case-of-novel-coronavirus-in-australia>>.
- 35 Department of Health and Human Services, Health.Vic, 'First Novel Coronavirus Case in Victoria' (Media Release, 25 January 2020) <<https://www2.health.vic.gov.au/about/media-centre/MediaReleases/first-novel-coronavirus-case-in-victoria>>; Department of Health and Human Services, Health.Vic, 'Second Novel Coronavirus Case in Victoria' (Media Release, 29 January 2020) <<https://www2.health.vic.gov.au/about/media-centre/MediaReleases/second-novel-coronavirus-case-victoria>>.
- 36 World Health Organization, 'Pneumonia of Unknown Cause' (Disease Outbreak News Release, 5 January 2020) <<https://www.who.int/csr/don/05-january-2020-pneumonia-of-unkown-cause-china/en/>>.
- 37 Federal Minister for Health (Media Release, 25 January 2020) <<https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/first-confirmed-case-of-novel-coronavirus-in-australia>>.
- 38 World Health Organization, 'Coronavirus disease 2019 (COVID-19) Situation Report 12' (Situation Report, 1 February 2020) 4 <https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200201-sitrep-12-ncov.pdf?sfvrsn=273c5d35_2>.
- 39 Prime Minister (Media Release, 1 February 2020) <<https://www.pm.gov.au/media/updated-travel-advice-protect-australians-novel-coronavirus>>.
- 40 Ibid.
- 41 Prime Minister (Transcript, 29 January 2020) <<https://www.pm.gov.au/media/press-conference-australian-parliament-house-act-3>>; Prime Minister (Media Release, 1 February 2020) <<https://www.pm.gov.au/media/updated-travel-advice-protect-australians-novel-coronavirus>>.
- 42 Prime Minister (Transcript, 29 January 2020) <<https://www.pm.gov.au/media/press-conference-australian-parliament-house-act-3>>.
- 43 Department of Health, 'Daily and cumulative number of reported COVID-19 cases in Australia' Coronavirus (COVID-19) current situation and case numbers <<https://www.health.gov.au/news/health-alerts/novel-coronavirus-2019-ncov-health-alert/coronavirus-covid-19-current-situation-and-case-numbers#daily-reported-cases>>; World Health Organization, Novel Coronavirus (COVID-19) Situation Report — 40 (29 February 2020) <https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200229-sitrep-40-covid-19.pdf?sfvrsn=849d0665_2>.
- 44 Prime Minister (Media Release, 29 February 2020) <<https://www.pm.gov.au/media/update-novel-coronavirus-covid-19-australia>>.
- 45 Ibid.
- 46 Ibid.
- 47 Prime Minister, Minister for Health, Chief Medical Officer, 'Advice on Coronavirus' (Media Release, 13 March 2020) <<https://www.pm.gov.au/media/advice-coronavirus>>; Prime Minister, 'Press Conference with Premiers and Chief Ministers — Parramatta, NSW' (Transcript, 13 March 2020) <<https://www.pm.gov.au/media/press-conference-premiers-and-chief-ministers-parramatta-nsw>>.

- 48 Prime Minister, Minister for Health, Chief Medical Officer, 'Advice on Coronavirus' (Media Release, 13 March 2020) <<https://www.pm.gov.au/media/advice-coronavirus>>.
- 49 Ibid; Prime Minister, 'Press Conference' (Transcript, 15 March 2020) <<https://www.pm.gov.au/media/transcript-press-conference>>.
- 50 Prime Minister Minister for Health, Chief Medical Officer, 'Advice on Coronavirus' (Media Release, 13 March 2020) <<https://www.pm.gov.au/media/advice-coronavirus>>.
- 51 Prime Minister 'Coronavirus Measures Endorsed by National Cabinet' (Media Release, 16 March 2020) <<https://www.pm.gov.au/media/coronavirus-measures-endorsed-national-cabinet>>.
- 52 Ibid.
- 53 Ibid.
- 54 Ibid.
- 55 Ibid.
- 56 Victorian Government Gazette, No. S 129, Monday 16 March 2020, <<http://www.gazette.vic.gov.au/gazette/Gazettes2020/GG2020S129.pdf>>.
- 57 Prime Minister, 'Update on Coronavirus Measures', (Media Release, 18 March 2020), <<https://www.pm.gov.au/media/update-coronavirus-measures>>.
- 58 Premier of Victoria, 'More Restrictions Put in Place in the Fight Against COVID-19' (Media Release, 18 March 2020) <<https://www.premier.vic.gov.au/more-restrictions-put-place-fight-against-covid-19>>; Victoria Government Gazette, No. S 129, 16 March 2020 <<http://www.gazette.vic.gov.au/gazette/Gazettes2020/GG2020S129.pdf>>.
- 59 Special Commission of Inquiry into the Ruby Princess (Final Report, 14 August 2020), 265 [14.2].
- 60 Ibid 265 [14.3].
- 61 Prime Minister 'Update on Coronavirus Measures' (Media Statement, 20 March 2020) <<https://www.pm.gov.au/media/update-coronavirus-measures-0>>.
- 62 Prime Minister, 'Update on Coronavirus Measures' (Media Release, 27 March 2020) <<https://www.pm.gov.au/media/update-coronavirus-measures-270320>>.
- 63 Ibid.
- 64 Ibid.
- 65 Prime Minister, 'Update on Coronavirus Measures' (Media Statement, 30 March 2020) <<https://www.pm.gov.au/media/statement-update-coronavirus-measures>>.
- 66 Department of Health and Human Services, Health.Vic, 'Pneumonia cluster in Wuhan, China', <<https://www2.health.vic.gov.au/about/news-and-events/healthalerts/pneumonia-cluster-china>>; Exhibit HQI0155_RP Annexures to witness statement of Prof. Brett Sutton, DHS.5000.0057.9657.
- 67 Exhibit HQI0125_RP Witness statement Melissa Skilbeck, 4 [20].
- 68 Emergency Management Victoria, State Health Emergency Response Plan, (4th ed, 2017), 23-24, <<https://www2.health.vic.gov.au/-/media/health/files/collections/policies-and-guidelines/s/state-health-emergency-response-plan-edition-4-pdf.pdf?la=en&hash=B2AA0AFAD30854022645E4A9A2F3D>>.
- 69 Exhibit HQI0162_P Witness statement of Ms Andrea Spiteri, 2 [7].
- 70 Premier of Victoria, 'State Control Centre Activated To Oversee COVID-19 response' (Media Release, 10 March 2020) <<https://www.premier.vic.gov.au/state-control-centre-activated-oversee-covid-19-response>>.
- 71 Transcript of day 18 hearing 16 September 2020, 1536.
- 72 Ibid.
- 73 Victorian Government Gazette, No. S 129, 16 March 2020 <<http://www.gazette.vic.gov.au/gazette/Gazettes2020/GG2020S129.pdf>>.
- 74 Exhibit HQI0155_RP Annexures to witness statement of Prof. Brett Sutton, DHS.5000.0055.3880.
- 75 Dr Tedros Adhanom Ghebreyesus, 'WHO Director General's opening remarks at the media briefing on COVID-19' (Speech, World Health Organization, 11 March 2020) <<https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020>>.
- 76 Federal Minister for Health, 'First Confirmed Case of Novel Coronavirus in Australia' (Media Release, 25 January 2020) <<https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/first-confirmed-case-of-novel-coronavirus-in-australia>>.
- 77 Prime Minister (Media Release, 1 February 2020) <<https://www.pm.gov.au/media/updated-travel-advice-protect-australians-novel-coronavirus>>.
- 78 Ibid.
- 79 Transcript of day 18 hearing 16 September 2020, 1536.
- 80 Exhibit HQI0125_RP Witness statement of Ms Melissa Skilbeck, 4 [20].
- 81 Premier of Victoria, 'State Control Centre Activated To Oversee COVID-19 response' (Media Release, 10 March 2020) <<https://www.premier.vic.gov.au/state-control-centre-activated-oversee-covid-19-response>>.

- 82 Victorian Government Gazette, No. S 129, 16 March 2020 <<http://www.gazette.vic.gov.au/gazette/Gazettes2020/GG2020S129.pdf>>.
- 83 Prime Minister, Minister for Health, Chief Medical Officer, 'Advice on Coronavirus' (Media Release, 13 March 2020) <<https://www.pm.gov.au/media/advice-coronavirus>>; Prime Minister, 'Press Conference with Premiers and Chief Ministers — Parramatta, NSW' (Transcript, 13 March 2020) <<https://www.pm.gov.au/media/press-conference-premiers-and-chief-ministers-parramatta-nsw>>.
- 84 Prime Minister, 'Coronavirus Measures Endorsed by National Cabinet' (Media Release, 16 March 2020) <<https://www.pm.gov.au/media/coronavirus-measures-endorsed-national-cabinet>>.
- 85 Prime Minister, 'Update on Coronavirus Measures' (Media Statement, 20 March 2020) <<https://www.pm.gov.au/media/update-coronavirus-measures-0>>.
- 86 Prime Minister 'Update on Coronavirus Measures' (Media Release, 27 March 2020) <<https://www.pm.gov.au/media/update-coronavirus-measures-270320>>.

CHAPTER 2

COVID-19 — The science

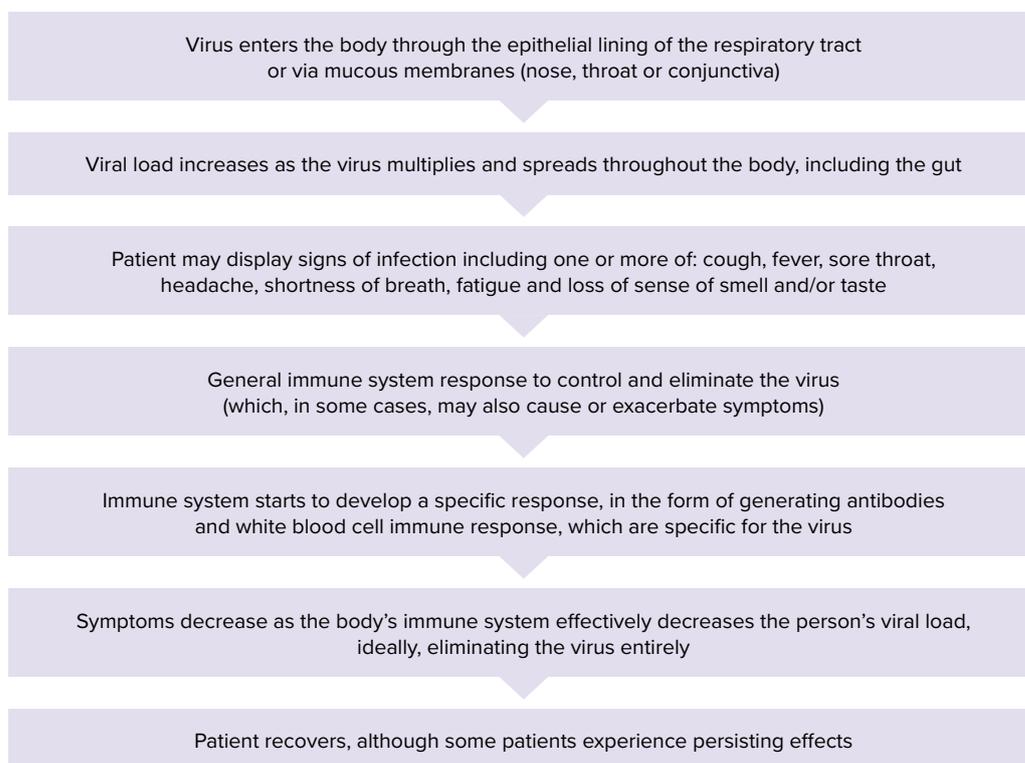
2.1 Introduction

1. As highlighted in the Background section of this report, SARS-CoV-2 is a new virus and information about it continues to emerge as the pandemic progresses. While the scientific and medical communities across the world work to learn more about the virus, the current general understanding of what it is, how it spreads and how it can broadly affect people is useful to set out here, particularly to give context as to why it was that the Hotel Quarantine Program was considered necessary.
2. Further, to assist in ascertaining the links between what has become known as the ‘second wave’ of COVID-19 cases in Victoria and the Hotel Quarantine Program, it was necessary to understand the science behind the COVID-19 virus, as it is currently understood, and the appropriate mechanisms for managing and controlling it.
3. To do that, evidence was called on 17 and 18 August 2020 from three scientific and medical experts regarding the nature of the COVID-19 disease, infection control, epidemiology and genomic sequencing.
4. The scientific and medical experts were:
 - A. Professor Lindsay Grayson — a clinical physician specialising in infectious diseases and infection control. Prof. Grayson provided evidence based upon his years of clinical experience, current scientific and medical information and his first-hand experience managing infection control for COVID-19 at Austin Health as Director of the Infectious Diseases Department, a role he has held since 2000¹
 - B. Professor Ben Howden — a medical microbiologist with expertise in genomic sequencing. Since 2014, Prof. Howden has been the Director of the Microbiological Diagnostic Unit Public Health Laboratory (MDU PHL) at the University of Melbourne. In his role as Director, he leads a team of scientists, computer scientists and epidemiologists who conduct genomic sequencing and analyse and report on genomic sequencing data in Victoria²
 - C. Dr Charles Alpren — an expert epidemiologist. Since June 2019, Dr Alpren has been employed by the Department of Health and Human Services (DHHS) as an epidemiologist and is one of the leads in the Intelligence Section (Intelligence) of the COVID-19 Public Health Incident Management Team. His role is to oversee the entry, management, epidemiological analysis, interpretation and reporting of data pertaining to COVID-19 that is collected through the DHHS notifiable diseases surveillance system. He reports to the Deputy Public Health Commander for Intelligence.³
5. The evidence and expertise of these three witnesses was not contested during the Inquiry’s hearings. I accept their evidence regarding genomic sequencing, the nature of COVID-19, quarantine and associated testing and infection control protocols relating to COVID-19.

2.2 The nature of COVID-19

6. The proceeding paragraphs summarise the current state of knowledge about the COVID-19 virus, how it spreads, for how long people are infectious, the effect on different age groups and what is currently known about immunity. It must be noted, however, as was observed regularly during the Inquiry, that state of knowledge is still developing.

Figure 2.1: Lifecycle of the virus



Source: Exhibit HQI0001_P Witness statement of Prof. Lindsay Grayson, 5 [23].

What is COVID-19?

7. Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) is the strain of coronavirus that causes coronavirus disease 2019 (COVID-19). Prof. Grayson gave evidence that coronaviruses are a family of viruses thought to only affect mammals.⁴
8. COVID-19 is considered to be highly infectious, particularly as it can be transmitted before the onset of symptoms and because those who are infectious may be entirely asymptomatic or have only trivial symptoms.⁵
9. Prof. Grayson's evidence was that COVID-19 is in the same family of viruses as SARS and MERS-CoV, the Middle Eastern coronavirus. He explained that SARS in 2003 was different to the current COVID-19 virus strain in that almost all patients who contracted the virus were very symptomatic and it had a substantially higher death rate.⁶ Likewise, while MERS exhibited some asymptomatic carriage, person-to-person transmission was relatively low.⁷

Symptoms of COVID-19

10. It was Prof. Grayson's evidence that respiratory symptoms are a common feature of COVID-19 and can include fever, dry cough, sore throat, tiredness and shortness of breath.⁸ An additional, unique symptom is the loss of both smell and taste. Prof. Grayson noted that a loss of sense of smell is common when one has any upper respiratory tract viral infection, but to lose sense of smell *and* taste is definitive of this particular infection. While it does not occur in all cases, when it does, it has been shown in various studies to be highly suggestive of COVID-19.⁹
11. Dr Alpren stated that approximately 17.9 per cent of cases experience asymptomatic infection. This means that some people who are infected will not experience any symptoms and may not know they are sick. He explained that, as symptomology can vary throughout the course of the infection, the overall proportion of cases that remain asymptomatic throughout the course of infection is unknown.¹⁰

What is known about the infectious nature of COVID-19?

12. Prof. Grayson's evidence was that, for COVID-19 illness to occur, a person must be exposed to a sufficient amount (the viral load) of the SARS-CoV-2 (also referred to as the COVID-19 virus). Exposure occurs through *viral shedding*.¹¹
13. He stated that viral load is 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.¹²
14. He explained that 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.¹³
15. Those with the virus are thought to be at their most infectious (the maximum point of viral load) for up to 48 hours before they show any symptoms, for those who have symptoms. However, Prof. Grayson noted that this timeframe is variable amongst different people; some may be infectious for a longer period before symptom onset and others for a shorter period. Notwithstanding this variability, 48 hours is considered to be a reasonable average timeframe and is similar to many other viral infections.¹⁴

Incubation period

16. Prof. Grayson agreed with the generally-held medical opinion that the COVID-19 virus has an incubation period of up to 14 days, with an average incubation period of about five to seven days.¹⁵ This means that for those who are exposed to the virus, the majority will develop symptoms (where symptoms show) within 14 days of exposure to the virus. He explained that there have been reports of some individuals not showing symptoms for up to 24 days after exposure to the virus, but 14 days is considered the upper limit for the majority of patients.¹⁶
17. Prof. Grayson stated that most symptomatic COVID-19 patients resolve their symptoms in approximately 10–14 days and are considered likely to be non-infectious at the end of that time.¹⁷ As noted by Prof. Grayson, '[a]lthough statistics vary from country to country, present data suggests that, for every 100 Australians who test positive for the virus, up to 20 per cent may require admission to hospital, up to 10 per cent may require intensive care support, and between 1.4 to 3.4 per cent may die'.¹⁸

Modes of transmission

18. The issue of the modes of transmission of the virus is still the subject of varying expert opinions, particularly as between aerosol and fomite transmission. Fomites are defined by Prof. Grayson as surfaces or objects (including hands) which may become contaminated (e.g. through contact with an infected person) and serve as an intermediary vehicle for transmission. According to Prof. Grayson, COVID-19 enters the body through mucous membranes, including the conjunctiva of the eyes and the membranes of the nose and the mouth, and via the lining of the lungs.¹⁹
19. He explained that the COVID-19 virus can be transmitted through direct contact with infected people via respiratory secretions (droplets and aerosols). It can also be transmitted through fomites. Examples of fomites cited by Prof. Grayson included thermometers or other shared equipment.²⁰
20. Prof. Grayson explained in evidence that COVID-19 is a predominantly respiratory virus.²¹ That is, it mainly transmits when ‘a person inhales droplets or particles that have been expelled by an infected person, either from coughing, sneezing, talking, singing or by breathing. In each case, the virus particle is suspended in the saliva or mucous particles (in droplet or aerosol form) which are ordinarily expelled by each of these actions’.²²
21. He stated that while the COVID-19 virus may be airborne (particularly when expelled in aerosol format), it appears to have less potential for distant transmission (for example, via an air conditioning system where air is partially recirculated such as in large office buildings, hospitals or hotels). There have been reports of airborne transmission in places that are crowded and likely to be inadequately ventilated, such as restaurants and fitness classes, but Prof. Grayson noted that short-range aerosol transmission cannot be ruled out in these instances. It was his view that were the COVID-19 virus capable of substantial distant airborne transmission, localised outbreaks that are larger than what have been experienced would likely have occurred.²³
22. Prof. Grayson stated that, regarding fomites, studies have demonstrated that the COVID-19 virus could survive on certain surfaces (such as plastic, cardboard and stainless steel), outside of a body, for up to 72 hours. As an example of how transmission may occur via a fomite, Prof. Grayson said that ‘an infected person may cough on a door handle, which is then touched by another person. Should that second person then touch their mouth, there is transmission from the infected person to the second person’.²⁴
23. It is relevant to note that, while medical and scientific experts are continuing to develop an understanding of the COVID-19 virus and its modes of transmission, the evidence provided to the Inquiry about the possible modes of transmission of COVID-19 was known as of 29 March 2020, at the time the Hotel Quarantine Program was established. Guidance provided by the WHO on 29 March 2020 and titled ‘Modes of transmission of virus causing COVID-19: implications for IPC precaution recommendations: scientific brief’ was drawn upon by DHHS staff to inform their knowledge of COVID-19.²⁵
24. The WHO guidance stated:

According to current evidence, COVID-19 virus is primarily transmitted between people through respiratory droplets and contact routes ... Droplet transmission occurs when a person is in close contact (within 1 m) with someone who has respiratory symptoms (e.g. coughing or sneezing) and is therefore at risk of having his/her mucosae (mouth and nose) or conjunctiva (eyes) exposed to potentially infective respiratory droplets. Transmission may also occur through fomites in the immediate environment around the infected person. Therefore, transmission of the COVID-19 virus can occur by direct contact with infected people and indirect contact with surfaces in the immediate environment or with objects used on the infected person ... In the context of COVID-19, airborne transmission may be possible in specific circumstances and settings in which procedures or support treatments that generate aerosols are performed ...²⁶

Rate of transmission — the concept of R_0

25. Prof. Grayson explained the concept of R_0 in his witness statement as follows:

R_0 is the average number of people who are likely to contract a contagious disease, from one other person with that disease, within a sample population. For a contagious disease to maintain spread throughout a population, R_0 needs to be greater than 1. A R_0 of 1 means that, in a community of people, one person is likely to infect only one other person. If that occurs, the virus remains in the community, as it is passed along a chain of infected persons. Where the R_0 is greater than 1, the infection is spreading.²⁷

26. Essentially, R_0 provides a value to assess transmissibility in the broader community to guide decisions about what precautions and policies should be implemented. Precautions taken in the community are considered fundamental to reducing the R_0 value for COVID-19.²⁸
27. The COVID-19 virus is considered to have a potential R_0 value of approximately 2–3, noting that this can vary based on region, health standards and controls. As at 1 August 2020, the R_0 value for COVID-19 in Australia was estimated to be about 1.05, although the R_0 value for Victoria, where the pandemic was changing rapidly, was not publicly available as of that date.²⁹
28. As a comparison, Prof. Grayson stated in his witness statement that measles is considered to have an R_0 value of between 12 and 18. That is to say, that for every one person who has measles, an average of between 12–18 other people will be infected (where they are not vaccinated).³⁰
29. The evidence was that the R_0 represents an average rate of transmission in the community. It does not define an individual's actual potential for infecting others. Some individuals will have a rate of transmissibility that is higher than the average.³¹ These individuals are referred to as 'super spreaders' as defined in paragraphs 30–32 below.

'Super spreaders' and asymptomatic transmission

30. The concept of 'super spreaders' refers to individuals who infect a disproportionately large number of contacts.³² These individuals may have a higher viral load, and are therefore likely to be more infectious, or they may be asymptomatic and therefore less likely to self-isolate as they may be unaware that they have COVID-19. Prof. Grayson stated that some recent overseas studies have suggested that possibly 10–20 per cent of COVID-19 infected patients may be responsible for 80 per cent of all cases.³³
31. Super spreaders are not unique to COVID-19. In his witness statement, Prof. Grayson highlighted that during the SARS-CoV outbreak in 2003, the index patient of the Hong Kong epidemic was associated with at least 125 secondary cases.³⁴
32. The concept of asymptomatic super spreaders raises important issues that go to the complexity of COVID-19 from an infection control and testing perspective, particularly in a quarantine environment. Prof. Grayson noted that testing for COVID-19 is crucial given that up to approximately 20 per cent of cases can be asymptomatic.³⁵

33. The rationale for a 14-day quarantine period, as noted above, is that most people will develop symptoms within 14 days of exposure to the virus, although some individuals have not shown symptoms until up to 24 days after exposure.³⁶ This variation in incubation period, and given what is known about asymptomatic COVID-19 cases, led Prof. Grayson to conclude that it would be sensible to test all people at the end of their quarantine period to see whether they were infected with the virus, irrespective of symptoms. He noted that if the sole determinant for whether people were released from quarantine was that they were not showing symptoms after 14 days, a proportion of those who were infected with the virus and potentially infectious, but who remained asymptomatic, could be released into the community.³⁷ The testing regime that developed throughout the course of the Hotel Quarantine Program is discussed in more detail in Chapter 10.
34. It is important to note that, while knowledge of COVID-19 continues to develop, and evidence of asymptomatic transmission has developed more recently, there was knowledge of asymptomatic transmission as early as 29 January 2020.³⁸ Indeed, an AHPPC statement on COVID-19, published on 29 January 2020, indicated knowledge 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’.³⁹

Effect of COVID-19 on different age groups

35. In general terms, Prof. Grayson stated that the current state of learning is that children are less affected by COVID-19 (asymptomatic or experience mild symptoms) compared with adults. Observations suggest that about a third of younger people may be asymptomatic or only trivially symptomatic.⁴⁰
36. As noted by Prof. Grayson, adults and those with a weakened immune system appear to be more affected in terms of symptoms and associated severity of illness. The older one is, the more one’s mortality is impacted. But Prof. Grayson stated that it is unclear, at this stage, whether COVID-19 affects older members of the community simply due to age or whether the immune system in general weakens as one gets older.⁴¹

Immunity

37. According to Prof. Grayson, an immune response is triggered when there is a foreign substance in the body. He explained that, generally speaking, antibodies interact with proteins on the surface of the foreign particles, known as antigens, which are specific to the type of foreign substance detected. Once the body recognises an antigen (either as new or because it has already been exposed to it in the past) it triggers the production of antibodies and enlists the assistance of key white blood cells to fight the infection and develop immunity.⁴²
38. Prof. Grayson noted that antibodies also remain in the body to enable it to continuously detect the antigen and eliminate future infections. This is why the body is generally more effective in eliminating foreign particles to which it has been exposed in the past (either via infection or vaccination).⁴³
39. The evidence is that work continues to be undertaken to understand the nature and spread of the COVID-19 virus (including asymptomatic transmission), and the body’s immune response (including possible reinfection), to support vaccine development.⁴⁴
40. Indeed, as Prof. Grayson noted in his witness statement, current data seems to indicate that some of the vaccines in development may only be effective (in terms of an adequate antibody response) for a limited period of some months, but this varies with the nature of the candidate vaccine, the number of ‘booster’ doses given and the adequacy of the recipient’s immune system to respond to the vaccine. After that time, the immune system’s ‘memory’ wanes, meaning that the COVID-19 specific antibodies may not remain in the body at adequate immediate concentrations and need either time to recover (via immune ‘memory mechanisms’) or further ‘booster’ vaccinations.⁴⁵

41. Prof. Grayson stated that it is not yet clear whether a person who has been infected with, and recovered from, COVID-19 will not be infected again. Some examples have arisen where an individual has been infected with the virus, recovered and contracted the virus again with the same symptoms. However, further work needs to be undertaken on whether, in these cases, the infected people caught the same virus strain twice.⁴⁶
42. Prof. Grayson highlighted in his evidence that each virus and each disease is different, which makes vaccine development an interesting but complex field. In terms of vaccine development for COVID-19, he explained that part of the challenge is creating a vaccine that is effective for the relevant strain and any subsequent variants, and provides immunity for an extended period of time.⁴⁷
43. The next step in understanding the science of COVID-19 for the Inquiry's purposes related to epidemiology and genomic sequencing.

2.3 Epidemiology

What is it and why is it undertaken?

44. Dr Charles Alpren, epidemiologist, defined epidemiology, in a general sense, as the study of the patterns and determinants of disease in specific populations. Medically speaking, he noted that epidemiology and public health medicine are different from patient-specific medicine 'as they advise and implement broad interventions on large groups of people to achieve overall health benefit'.⁴⁸
45. Dr Alpren stated that epidemiologists play a role in both understanding and controlling the spread of communicable diseases (diseases that can spread from person-to-person) by:
 - A. analysing data to look for patterns that can forecast the trajectory of disease
 - B. informing interventions to alter that trajectory.⁴⁹
46. As outlined by Dr Alpren, epidemiologists integrate key facts about a disease, including mechanisms of transmission, incubation and the infectious period, with the spatial and temporal patterns observed within a population.⁵⁰
47. As an example, Dr Alpren noted that the work of epidemiologists could 'involve a group of infected people in a defined location with disease onset between set dates. An analysis of that group and the circumstances of their interactions can reveal how diseases spread, which can then allow us to understand and inform changes ...'.⁵¹ By understanding how and why disease is spread, advice can be provided on how to interrupt the spread of disease.⁵²
48. Dr Alpren explained that epidemiology informs an understanding of the risk factors that are characteristic of people or environments that place individuals at higher risk of acquiring or becoming affected by disease. It can, therefore, make broad predictions about people or circumstances that present a higher risk of disease. It can also predict disease trajectory under known parameters and assumptions, and outline what could happen if, for example, restrictions are placed on a population.⁵³

What are epidemiological methods used for?

49. Epidemiology supports the detection, surveillance and control of communicable diseases. This involves the collection and analysis of information and data, with the outcomes of this analysis informing contact and communications with people affected by an outbreak, advising next steps and required actions.⁵⁴

50. Dr Alpren explained that inside DHHS, broadly in Victoria, this work is split into streams including: (1) Intelligence and (2) Case, Contact and Outbreak Management. At a high level, Intelligence is responsible for data collection, entry and classification, undertaking data analysis and modelling, and providing associated advice within the Department and to government to support decision-making and planning.⁵⁵
51. Work undertaken by Intelligence supports the work of the Case, Contact and Outbreak Management Team where contact tracing is undertaken. Contact tracing involves the ‘identification, assessment and management of people who have potentially been exposed to disease and are at a higher risk of developing and spreading disease’.⁵⁶
52. Dr Alpren explained that contact tracers work with people to interrupt the spread of a disease by ascertaining who might have been exposed to a disease (via interviews with possible contacts and examination of data sources, such as employment rosters) and informing them of their responsibility to quarantine. Contact tracers also work with epidemiologists to identify patterns and risk factors involved in disease transmission.⁵⁷ Difficulties with contact tracing in the context of Victoria’s hotel quarantine outbreaks is discussed in more detail in Chapter 9.

2.4 Genomic sequencing

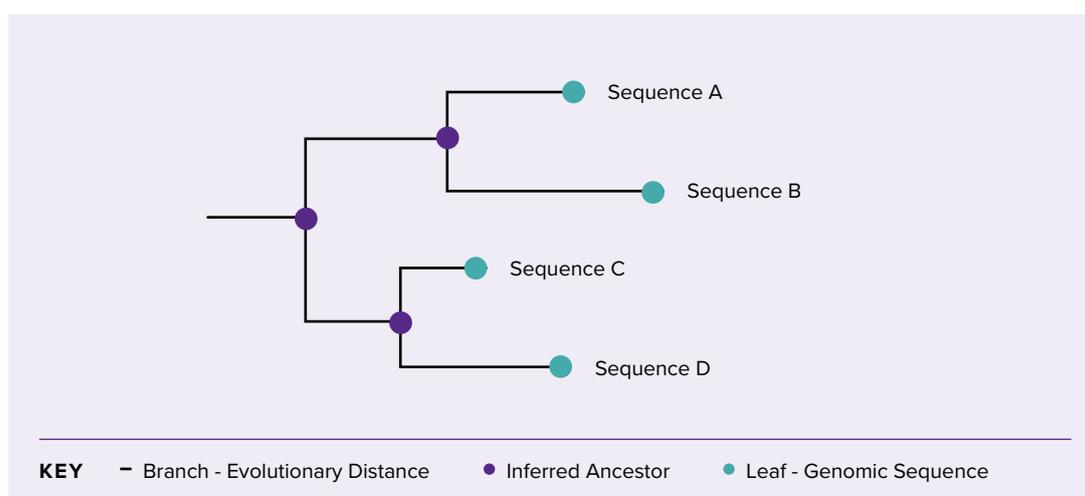
What is genomic sequencing?

53. Prof. Howden gave evidence about the science of genomic sequencing, a process by which the whole genetic signature of a pathogen is recovered. A pathogen is defined as a microorganism that can cause a disease, such as a virus.⁵⁸
54. A genome is defined by Prof. Howden as an organism’s complete set of genes or genetic material, comprising DNA or RNA. COVID-19, which is a viral genome, is made up of RNA, whereas the human genome, bacterial genomes and some viral genomes are made up of DNA.⁵⁹
55. As outlined in Prof. Howden’s statement, whole genome sequencing is the process to determine the complete sequence (DNA or RNA) of an organism’s genome and can be broken down into two distinct processes:
- first, there is an analytical process undertaken in a specialised genome sequencing laboratory, using sophisticated laboratory hardware, to determine the complete genome of an organism in a single reaction
 - then, this genome sequence is investigated and compared with other genome sequences using bioinformatic software.⁶⁰
56. Regarding COVID-19, Prof. Howden explained that this virus has a genome size of approximately 30,000 bases, which is effectively 30,000 letters in a row. When undertaking genomic sequencing of the virus, the aim is to recover the majority of the 30,000 letters in their correct sequence, providing the genetic code.⁶¹ He explained that the sequencing process can recover and reconstruct up to 99.8 per cent of the SARS-CoV-2 genome, but this percentage varies based on several biological and testing factors.⁶²

Why is genomic sequencing undertaken?

57. Through the process of genomic sequencing, inferences can be made about genomic clusters and the presence of any mutations.⁶³ This creates an understanding of where a virus sample may have originated and relationships between virus samples. Further, for COVID-19, there is no alternative to genomic sequencing to identify, and discriminate between, clusters.⁶⁴
58. As explained by Prof. Howden, if there are two virus samples that have the same sequence, they would cluster together during the analysis stage. In a genomic context, this means that the samples are identical or highly related.⁶⁵ Where sequences are highly genomically related, then an epidemiological link is likely; for example, cases where the virus has been transmitted between members of a household.⁶⁶ The interaction between genomic sequencing and epidemiology is discussed from paragraph 67.
59. Prof. Howden explained that, by contrast, sequences that have different patterns of mutations are not closely related by genomics; for example, as seen with returned travellers who acquired COVID-19 in different countries.⁶⁷
60. A genetic mutation is a permanent alteration in the genetic makeup of an organism and plays a role in the evolution of the organism.⁶⁸ All pathogens acquire mutations over time at different rates.⁶⁹
61. As an example of genetic mutation, Prof. Howden explained that if one exposes bacteria to an antibody it will develop a mutation that helps it survive in the case of an antibiotic.⁷⁰ With COVID-19, mutations could occur at any point in the 30,000 letters of the genome. As mutations accumulate over time, and Prof. Howden notes that mutations in the COVID-19 genome have been occurring slowly,⁷¹ they can act like a ‘passport stamp’ for the virus. This allows bioinformatic analysis to determine where a virus sample may have been previously.⁷²
62. Prof. Howden outlined that ‘once a mutation occurs in the genome of a virus, it is copied to and shared by all its descendant copies, creating groups of viruses that share a mutation because of their shared ancestry’⁷³
63. This shared ancestry informs phylogenetic analysis, used to understand the evolutionary history of an organism.⁷⁴ Figure 2.2, provided by Professor Howden, is an example of a phylogenetic tree, which is a visual representation of the likely evolutionary relationships between samples or sequences.

Figure 2.2: Annotated phylogenetic tree describing the evolutionary relationships between sequences



Source: Exhibit HQI0005_P Witness Statement of Prof. Ben Howden, 8 [46].

64. In Figure 2.2, the green dots are explained by Prof. Howden as the leaves of the tree and represent a sample or a sequence. The branches represent the genetic distance between the sequence and its inferred ancestral or parent sequences. The distance between the leaves (samples) on the horizontal lines represents the genomic distance between the samples. In this example, sequence A has a much shorter horizontal distance from sequence B, compared with sequences C or D. This means that sequence A is much more closely related, at a genomic level, to sequence B than it is to sequence C or D.⁷⁵

What is genomic sequencing used for?

65. Prof. Howden explained that MDU PHL uses genomic sequencing of SARS-CoV-2 to identify genomic clusters that are likely to be epidemiologically linked.⁷⁶
66. More broadly, as explained by Prof. Howden, genomic sequencing is used for pathogen surveillance and outbreak detection and investigation. It also supports findings around the resistance of a pathogen to antibiotics, how a pathogen is evolving, whether a pathogen is bringing in new genes and what the disease-causing potential is of a given pathogen.⁷⁷

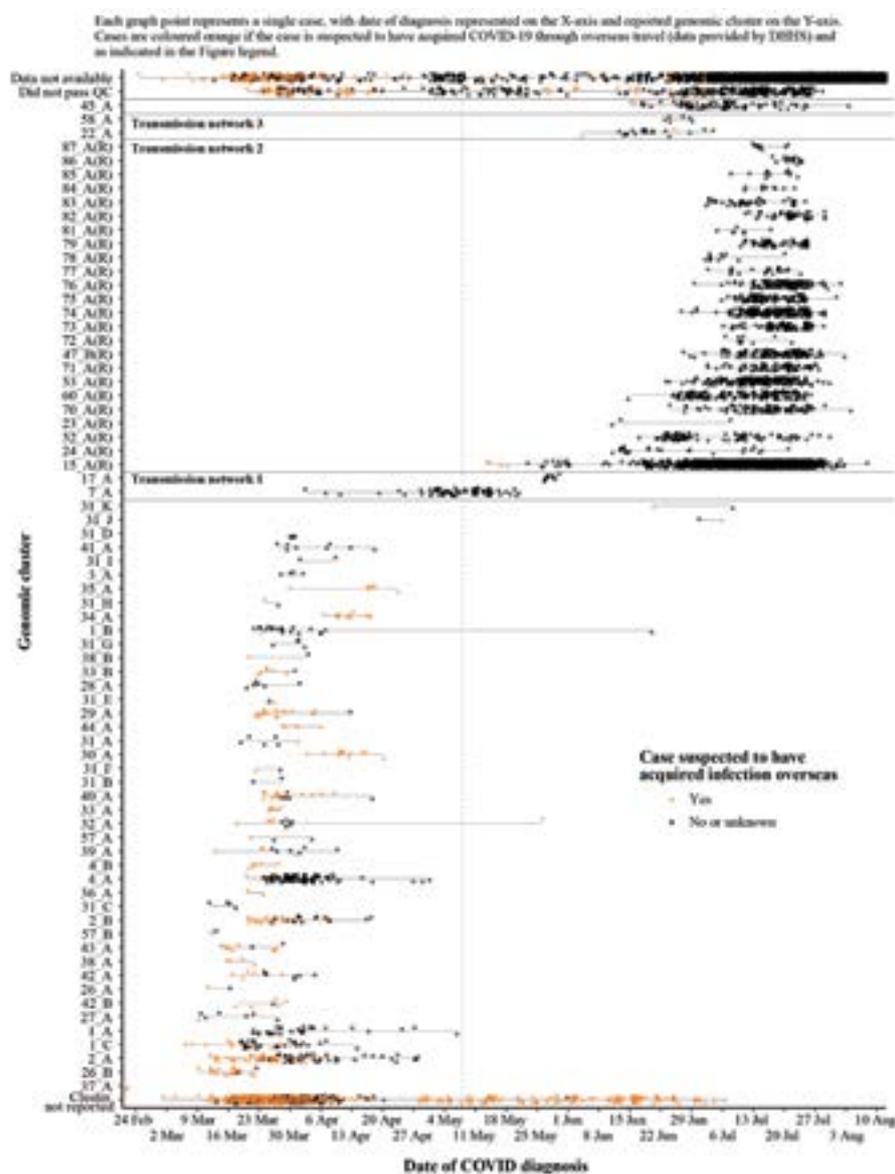
The interaction between genomic sequencing and epidemiology

67. Dr Alpren and Prof. Howden explained that genomic sequencing and epidemiology go hand-in-hand, and genomic sequencing data is not fully informative without epidemiological data. Genomic sequencing supports the identification of possible transmission networks and the likely origin of cases. Epidemiological investigations support the hypotheses generated by genomic sequencing.⁷⁸
68. Incorporating information from epidemiological investigation (contact tracing) with genomic science allows further inferences to be drawn about transmission networks and the mechanisms and risks associated with viral transmission. As an example, Dr Alpren stated healthcare workers are known to be at higher risk than others in the community for acquisition of COVID-19.⁷⁹
69. Identifying genomic and epidemiologic clusters supports targeted investigation of cases within the cluster to identify and remove the source of infection or disrupt transmission chains. In this context, a cluster refers to a group of people or samples with a condition or disease that share some similarity, suggesting they may have acquired the condition from each other, from a common source or due to a common cause.⁸⁰
70. A detailed definition of epidemiological and genomic clusters was provided by Prof. Howden, as follows:
- **Epidemiological clusters** are based on similarity in the epidemiological characteristics of person (for example, demographics), place (for example, attending the same location) and time or a combination of these.
 - **Genomic clusters** are based on the degree of genomic similarity between the pathogens (such as a virus or a bacteria). Genomic clusters indicate the sequences contained within the cluster are more related to each other than they are to any other sequences in the dataset.⁸¹

2.5 Genomic sequencing, epidemiology and COVID-19 cases in Victoria

71. Prof. Howden provided his uncontested expert opinion as to the results of the genomic sequencing completed by the MDU PHL of COVID-19 cases in Victoria between 21 February and 11 August 2020.
72. Figure 2.3 below, produced by Prof. Howden, represents COVID-19 cases in Victoria during this timeframe. Prof. Howden explained that each dot represents a case, with orange dots representing cases likely to have acquired infection overseas and the black dots representing cases that are likely to have been locally acquired (via community transmission). The date of diagnosis for each case is located on the X-axis and the reported genomic cluster is located on the Y-axis.

Figure 2.3: Genomic clustering of Victorian COVID-19 cases diagnosed between 21 February and 11 August 2020



73. Figure 2.3 was provided by Prof. Howden when giving his oral evidence on 17 August 2020 and is an updated version of the graph that appeared in his witness statement (dated 4 August 2020), which contained data from 21 February to 23 July 2020. As at 29 July 2020, 65 genomic clusters had been identified, ranging in size from 2 to 1,071 cases (with a median of 10 cases per cluster).⁸²
74. As at 14 August 2020, 72 genomic clusters had been identified (as located on the Y-axis in Figure 2.3 above), with the additional seven clusters included since 29 July linked to transmission network 2.
75. Reported genomic clustering on the graph is broadly categorised into two periods, represented by the vertical dotted line running through the graph:
- A. **Period 1** — which contains cases from 1 March to 7 May and is characterised by many diverse genomic clusters with each cluster containing a small number of cases.
 - B. **Period 2** — which contains cases from 8 May onwards and is characterised by the expansion of three transmission networks and an additional new cluster (45_A). Each transmission network is a group of closely related genomic clusters with a common recent ancestor and is believed to represent a single importation of the virus into Victoria, supported by epidemiological clustering and travel history data.⁸³
76. Each transmission network, marked on the graph by the dark horizontal lines, is categorised as follows:
- A. **Transmission network 1** — first identified in March and expanded rapidly throughout May. No further cases have been identified within this transmission network since 30 May 2020
 - B. **Transmission network 2** — first identified in mid-May in a group of returned travellers (as identified by the orange dots). Additional cases were identified within this transmission network throughout June and July. This network included 24 clusters that appeared to have originated from the earliest cluster (15_A) based on the data available to date
 - C. **Transmission network 3 and cluster 45_A** — both first identified in returned travellers during June, with additional cases identified throughout June and into July.⁸⁴
77. As identified on the graph, and subsequently confirmed by Prof. Howden during his oral evidence, more than 99 per cent of all cases in Victoria as of August 2020, where genomic sequencing data was available, were derived from transmission network 2, predominantly, as well as transmission network 3 and cluster 45_A.⁸⁵
78. Of note was the increase in cases that were likely to have been acquired locally during Period 2 (from 8 May onwards) compared with Period 1 (1 March–7 May), where a significant proportion of cases were attributed to infection acquired overseas.
79. The question that remained was what caused the significant increase in locally acquired cases? The answer lay with the epidemiology and the contact tracing methods used to ascertain the source of a case.

Increase in COVID-19 cases in Victoria and links to the Hotel Quarantine Program

80. Through the combination of genomic sequencing and epidemiological investigation undertaken by DHHS, Dr Alpren concluded that Victorian COVID-19 cases, as at 4 August 2020, were connected with times, transmission events or locations related to the Hotel Quarantine Program, noting that since this transmission occurred further community transmission may also have been exacerbated in additional settings, such as public housing towers and aged care homes.⁸⁶
81. Specifically, Dr Alpren concluded that approximately 99 per cent of COVID-19 cases in Victoria, as at 4 August 2020, had arisen from outbreaks at the Rydges Hotel in Carlton (Rydges) or the Stamford Plaza Hotel (Stamford).

Endnotes

- 1 Ibid 20 [101]–[103].

Endnotes

- 1 Ibid 21 [104].

82. What led to the outbreaks, and their impact, is considered in detail at Chapter 9. For present purposes, the outbreak at Rydges can be traced back to a family of four that returned to Australia on 9 May 2020. Each member of that family eventually tested positive to COVID-19 and were moved to Rydges where, 10 days later, two security guards and one member of staff working at Rydges became symptomatic and were subsequently diagnosed with COVID-19.⁸⁷
83. The Stamford outbreak can be traced back to a traveller returning to Australia on 1 June 2020 and entering quarantine at Stamford. That traveller became symptomatic and was diagnosed with COVID-19.⁸⁸ On 10 June 2020, a member of staff became symptomatic.⁸⁹ A day later, a couple, who were returned travellers quarantining at the Stamford, became symptomatic. Those two travellers and the staff were diagnosed with COVID-19 over the course of 14–16 June 2020.⁹⁰
84. While Dr Alpren noted that he cannot be precise in the exact number or proportion to have arisen from each outbreak separately, he stated that it was likely that the large majority — approximately 90 per cent or more — of COVID-19 infections in Victoria as of 4 August 2020 could be traced to Rydges. It is likely that a small proportion — approximately 10 per cent or less — of COVID-19 infections in Victoria as of 4 August 2020 could be traced to Stamford.⁹¹

2.6 Conclusions

85. While acknowledging that there is a continuous state of learning with respect to the COVID-19 virus, the weight of the current expert knowledge is that the COVID-19 virus has an incubation period of up to 14 days for the majority of patients, with most patients being non-infectious at the end of that 14-day period. On this basis, the 14-day quarantine period imposed for the purposes of the Hotel Quarantine Program was a reasonable and appropriate period.
86. The evidence established that, while scientific and medical communities continue to develop an understanding of the modes of transmission for the COVID-19 virus, including what asymptomatic transmission may mean in terms of testing in a quarantine environment, there was a general understanding of the modes of transmission of the virus as at 29 March 2020 among the experts. This included that:
- the virus primarily spread from person-to-person via droplets, aerosols and fomites
 - droplet transmission occurred when a person was in close contact (within one metre) with someone who had the virus
 - airborne transmission may have been possible in specific circumstances and settings in which procedures or support treatments that generated aerosols were performed.⁹²
87. These methods of transmission were of critical importance when considering the use of hotels as facilities for mass quarantine, what adaptations needed to be made to ensure the safety of those being placed in quarantine and those working on-site at the hotels, and what needed to be put in place by way of appropriate infection prevention and control standards to address and minimise the risk of the virus spreading in quarantine hotels.
88. Asymptomatic transmission (including by way of super spreaders) led to particular complexities for infection control and testing regimes in the Hotel Quarantine Program. The public health community had knowledge of the risk of asymptomatic transmission of the virus by March 2020.
89. The weight of the current expert evidence to the Inquiry was that between 17 and 20 per cent of cases experienced asymptomatic transmission, which had flow-on impacts in terms of appropriate testing requirements. That evidence led to the conclusion that to address the risk inherent in asymptomatic spread of the virus, it is necessary to require testing of all people at the end of their quarantine period regardless of whether they are reporting symptoms.

Hotel quarantine’s link to the ‘second wave’

90. Dr Alpren’s evidence, based on genomic testing, was that 99 per cent of Victoria’s second wave of COVID-19 cases in the community have come from transmission events from returned travellers infected with the virus to people working at the Rydges and the Stamford hotels. The movement of the virus from these infected workers into the community was characterised by high rates of local transmission.⁹³
91. Prior to the second wave, Victoria’s COVID-19 cases were largely attributable to infection acquired overseas. All cases in transmission network 1 had ceased by 30 May 2020.⁹⁴

Mass quarantining and the science

92. The conclusions that could be drawn from the scientific evidence provided to the Inquiry were that three fundamental safety features needed to be built into any program that sought to house together potentially infected people in a quarantine facility. They were:
- A. the importance of expert advice, input and ongoing supervision and oversight of infection prevention and control
 - B. the importance of an evidentiary base for the testing regime
 - C. the importance of a rapid and effective contact tracing regime.
93. Each of these areas were important topics in and of themselves and subject to their own conclusions. Accordingly, they are dealt with in more substance throughout this Report:
- A. the importance of expert advice, input and ongoing supervision and oversight of those within the Hotel Quarantine Program, is dealt with in chapters 8 and 9, in the context of the outbreaks at the Rydges and Stamford and the structure and governance of the Program
 - B. the importance of a rapid and effective contact tracing regime, is also dealt with in Chapter 9
 - C. the importance of an evidentiary basis for the testing regime, is considered in Chapter 10.

Endnotes

- 1 Exhibit HQI0001_P Witness statement of Prof. Lindsay Grayson, 1–3; Exhibit HQI0002_RP Curriculum vitae of Prof. Lindsay Grayson.
- 2 Exhibit HQI0005_P Witness statement of Prof. Ben Howden, 1–4; Exhibit HQI0006_P Curriculum vitae of Prof. Ben Howden.
- 3 Exhibit HQI0008_RP Witness statement of Dr Charles Alpren, 1–3.
- 4 Exhibit HQI0001_P Witness statement of Prof. Lindsay Grayson, 3 [9]–[10].
- 5 Ibid 10–11 [47(c)].
- 6 Transcript of day 3 hearing 17 August 2020, 33.
- 7 Exhibit HQI0001_P Witness statement of Prof. Lindsay Grayson, 10 [47(b)].
- 8 Ibid 3 [14].
- 9 Transcript of day 3 hearing 17 August 2020, 34.
- 10 Transcript of day 4 hearing 18 August 2020, 100; Exhibit HQI0008_RP Witness statement of Dr Charles Alpren, 14 [57(d)].
- 11 Exhibit HQI0001_P Witness statement of Prof. Lindsay Grayson, 3 [12], 4 [17]–[18].
- 12 Ibid 4 [17].
- 13 Exhibit HQI0001_P Witness statement of Prof. Lindsay Grayson, 4 [18]; Transcript of day 3 hearing 17 August 2020, 35.
- 14 Exhibit HQI0001_P Witness statement of Prof. Lindsay Grayson, 4–5 [20].
- 15 Transcript of day 3 hearing 17 August 2020, 36; Exhibit HQI0008_RP Witness statement of Dr Charles Alpren, 14 [57(b)].
- 16 Transcript of day 3 hearing 17 August 2020, 36; Exhibit HQI0001_P Witness statement of Prof. Lindsay Grayson, 12 [55].
- 17 Exhibit HQI0001_P Witness statement of Prof. Lindsay Grayson, 4 [20]–[22].
- 18 Ibid 5 [24].
- 19 Ibid 3 [11].
- 20 Ibid 8–9 [38]–[42].
- 21 Transcript of day 3 hearing 17 August 2020, 39.
- 22 Exhibit HQI0001_P Witness statement of Prof. Lindsay Grayson, 8 [39].
- 23 Ibid 9 [44]–[45].
- 24 Ibid 9 [42].
- 25 Exhibit HQI0106_RP Witness statement of Dr Sarah McGuinness, 7 [27].
- 26 Ibid, quoting World Health Organization, 'Modes of transmission of virus causing COVID-19: implications 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>>.
- 27 Exhibit HQI0001_P Witness statement of Prof. Lindsay Grayson, 7 [33].
- 28 Ibid 8 [36]–[37].
- 29 Ibid 7 [34].
- 30 Ibid 8 [35].
- 31 Ibid 8 [36].
- 32 Transcript of day 3 hearing 17 August 2020, 35.
- 33 Exhibit HQI0001_P Witness statement of Prof. Lindsay Grayson, 4 [19].
- 34 Ibid, citing Riley et al, 'Transmission Dynamics of the Etiological Agent of SARS in Hong Kong: Impact of Public Health Interventions' (2003) 300(5627) *Science* 1961.
- 35 Transcript of day 3 hearing 17 August 2020, 43.
- 36 Exhibit HQI0001_P Witness statement of Prof. Lindsay Grayson, 12 [55].
- 37 Ibid 12 [55]–[56].
- 38 Australian Health Protection Principal Committee (AHPPC) statement on novel coronavirus on 29 January 2020 <<https://www.health.gov.au/news/australian-health-protection-principal-committee-ahppc-statement-on-novel-coronavirus-on-29-january-2020-0>>.
- 39 Ibid.
- 40 Exhibit HQI0001_P Witness statement of Prof. Lindsay Grayson, 4 [16].
- 41 Transcript of day 3 hearing 17 August 2020, 34.
- 42 Exhibit HQI0001_P Witness statement of Prof. Lindsay Grayson, 6 [26]–[28].
- 43 Ibid 6 [29]; Transcript of day 4 hearing 18 August 2020, 100.
- 44 Ibid 7 [32].

- 45 Ibid 7 [31].
- 46 Transcript of day 3 hearing 17 August 2020, 37–38.
- 47 Ibid 38, Exhibit HQI0001_P Witness statement of Prof. Lindsay Grayson, 7 [32].
- 48 Exhibit HQI0008_RP Witness statement of Dr Charles Alpren, 3 [17].
- 49 Ibid 3 [18].
- 50 Ibid.
- 51 Transcript of day 4 hearing 18 August 2020, 5.
- 52 Exhibit HQI0008_RP Witness statement of Dr Charles Alpren, 3–4 [18]–[20].
- 53 Ibid 4 [21]–[22].
- 54 Transcript of day 4 hearing 18 August 2020, 95.
- 55 Exhibit HQI0008_RP Witness statement of Dr Charles Alpren, 5 [27].
- 56 Ibid 9 [38].
- 57 Ibid 9–10 [38]–[44].
- 58 Transcript of day 3 hearing 17 August 2020, 74–75.
- 59 Exhibit HQI0005_P Witness statement of Prof. Ben Howden, 4 [22].
- 60 Ibid 4 [24]–[25].
- 61 Transcript of day 3 hearing 17 August 2020, 76.
- 62 Exhibit HQI0005_P Witness statement of Prof. Ben Howden, 6 [35].
- 63 Ibid 4 [28].
- 64 Ibid 5 [30].
- 65 Transcript of day 3 hearing 17 August 2020, 76.
- 66 Exhibit HQI0005_P Witness statement of Prof. Ben Howden, 7 [39].
- 67 Ibid 7 [40].
- 68 Ibid 5 [31]–[33].
- 69 Transcript of day 3 hearing 17 August 2020, 76.
- 70 Ibid.
- 71 Exhibit HQI0005_P Witness statement of Prof. Ben Howden, 6 [36].
- 72 Transcript of day 3 hearing 17 August 2020, 76.
- 73 Exhibit HQI0005_P Witness statement of Prof. Ben Howden, 5–6 [33].
- 74 Ibid.
- 75 Ibid 8 [47]; Transcript of day 3 hearing 17 August 2020, 78.
- 76 Exhibit HQI0005_P Witness statement of Prof. Ben Howden, 9 [52].
- 77 Ibid 9 [51].
- 78 Exhibit HQI0005_P Witness statement of Prof. Ben Howden, 9 [52]–[54]; Exhibit HQI0008_RP Witness statement of Dr Charles Alpren, 12–13 [49]–[53]; Transcript of day 4 hearing 18 August 2020, 98.
- 79 Exhibit HQI0008_RP Witness statement of Dr Charles Alpren, 12 [50].
- 80 Exhibit HQI0005_P Witness statement of Prof. Ben Howden, 7 [41]–[44].
- 81 Ibid 7 [42]–[43].
- 82 Exhibit HQI0005_P Witness statement of Prof. Ben Howden, 18 [95].
- 83 Ibid 20 [101]–[103].
- 84 Ibid 21 [104].
- 85 Transcript of day 3 hearing 17 August 2020, 86.
- 86 Exhibit HQI0008_RP Witness statement of Dr Charles Alpren, 19 [78].
- 87 Ibid 20 [86].
- 88 Ibid 21 [95].
- 89 Ibid 22 [97].
- 90 Ibid 21–22 [96].
- 91 Ibid 28 [130].
- 92 Exhibit HQI0106_RP Witness statement of Dr Sarah McGuinness, 7 [27]; World Health Organization, ‘Modes of transmission of virus causing COVID-19: implications for IPC precaution recommendations: scientific brief’ (Brief, 29 March 2020) <<https://www.who.int/news-room/commentaries/detail/modes-of-transmission-of-virus-causing-covid-19-implications-for-ipc-precaution-recommendations>>.
- 93 Exhibit HQI0008_RP Witness statement of Dr Charles Alpren, 28 [130]; Transcript of day 3 hearing 17 August 2020, 86.
- 94 Exhibit HQI0006_P Witness statement of Prof. Ben Howden, 21 [104].

CHAPTER 3

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

1. Any proper analysis of the decision to adopt a mandatory quarantine program for all international arrivals, to commence within a period of some 36 hours, cannot be divorced from an understanding of Victoria's planning for, and readiness to undertake, such a program.
2. The possibility of an epidemic or pandemic, particularly with a highly contagious viral infection, had been recognised for decades both in Victoria and nationally. Since 1999, state and territory governments and the Australian Government had developed and refined a series of plans to guide Australia's response to an influenza pandemic.¹
3. The *Commonwealth Government's Australian Health Management Plan for Pandemic Influenza* (the Commonwealth Pandemic Plan) is intended to provide overarching guidance and a framework for a nationally consistent approach to managing an influenza pandemic.² The guidance provided in the Commonwealth Pandemic Plan is reflected in state and territory pandemic plans, which are tailored to local contexts.³ In Victoria, the relevant plans are the *Victorian Health Management Plan for Pandemic Influenza 2014* (the Victorian Pandemic Plan)⁴ and the *Victorian Action Plan for Influenza Pandemic 2015*.⁵ Plans at both levels of government (Commonwealth and State) sit within a complex framework of emergency management strategies, plans and guidelines.
4. Professor Lindsay Grayson, Director of Infectious Diseases and Microbiology at Austin Health, gave evidence that most pandemic planning had focused on strategies aimed at influenza, given the history of the Spanish Flu a century ago and more recent outbreaks of avian influenza (H5N1) and swine flu (H1N1). However, despite that focus, Prof. Grayson stated that the principles and operational framework of these influenza pandemic plans were known to be applicable to other respiratory viral infections, including COVID-19.⁶
5. Given the existence of pandemic plans at the Victorian and Commonwealth level, a question before the Inquiry was whether, prior to the announcement and establishment of the Hotel Quarantine Program in Victoria, there was planning for a mass quarantine program that could have informed this Program.
6. In short, there was not. That was despite a review of the Commonwealth's response to the (H1N1) pandemic, published in 2011, recommending an examination of the policy on quarantine and isolation. This matter is examined in further detail in the context of the Commonwealth and Victorian pandemic plans.

3.1 The Commonwealth Pandemic Plan

7. The Commonwealth Pandemic Plan describes pandemics as unpredictable and presenting a significant risk to Australia.⁷ The report states that pandemics have the potential to cause high levels of disease and death and disrupt the community, both socially and economically.⁸ The Commonwealth Pandemic Plan, which was developed in consultation with states, territories and health sector stakeholders, outlines Australia's strategy to manage an influenza pandemic and minimise its impact on the health of Australians and the health system.⁹ To support the management of an influenza pandemic, the Commonwealth Pandemic Plan seeks to:
 - A. clarify the roles and responsibilities within the health sector of the Australian Government and state and territory governments
 - B. identify areas where national guidance and coordination will be provided and how this will be achieved
 - C. support decision-makers to respond in a manner that is flexible, informed and proportionate to the circumstances at the time.¹⁰
8. The Commonwealth Pandemic Plan recognises that the operational aspects of public health responses sit with state and territory governments. Some examples of the operational aspects of a public health response include implementing social distancing measures as per national recommendations and local risk assessment, implementing infection control guidelines and healthcare safety and quality standards, and undertaking contact tracing.¹¹
9. The Commonwealth Pandemic Plan also sets out an ethical framework to guide health sector responses and actions taken under it. Some principles or values to be taken into account include providing care in an equitable manner, ensuring that the rights of the individual are upheld as much as possible and ensuring that measures taken are proportionate to the threat.¹²
10. Given states and territories have operational responsibility for public health responses, the Commonwealth Pandemic Plan notes that the majority of operational detail will be found in state and territory plans.¹³ The Victorian plans are considered below.

Context and legal framework for the Commonwealth Pandemic Plan

11. The Commonwealth Pandemic Plan sits under the *Emergency Response Plan for Communicable Disease Incidents of National Significance*, which is one of four plans under the *Australian National Health Emergency Response Arrangements*. It also supports the *Emergency Response Plan for Communicable Disease Incidents of National Significance: National Arrangements*.¹⁴
12. The Commonwealth Pandemic Plan sets out measures to respond to an influenza pandemic, some of which rely on the exercise of coercive powers conferred by statute onto the Commonwealth Government. It identifies the following statutes as relevant to supporting pandemic actions:¹⁵
 - A. The *Biosecurity Act 2015* (Cth) — which authorises activities used to prevent the introduction and spread of target diseases into Australia.
 - B. The *National Health Security Act 2007* (Cth) — which authorises the exchange of public health surveillance information (including personal information) between the Australian Government, states and territories and the World Health Organization.

- C. The International Health Regulations 2005 (incorporated into Australian law through the *Biosecurity Act 2015* (Cth) and the *National Health Security Act 2007* (Cth)) — which commits Australia and other signatory countries to take action to prevent, protect against, control and provide a public health response to the international spread of disease. As a signatory, Australia has a range of obligations, including reporting and maintaining certain core capacities at designated points of entry.
13. Those statutes are part of the suite of legislation available to the Commonwealth to support pandemic response activities. In addition, state and territory governments have powers under their respective jurisdiction's legislation to implement biosecurity arrangements within their borders, and which complement Commonwealth Government biosecurity arrangements. States and territories have a broad range of public health and emergency response powers available under legislation for responding to public health emergencies. Further detail on relevant legislation in Victoria is provided at paragraph 40.

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

14. The Commonwealth Pandemic Plan does not provide specific guidance for a program of mandatory detention or quarantine for returned travellers. It does not refer to a mass program of mandatory quarantine to the scale of the Hotel Quarantine Program.
15. It does, however, provide guidance and analysis regarding *voluntary* isolation of ill travellers who do not require hospitalisation, and possible quarantine of contacts of ill travellers at the border (though this option is not recommended).¹⁶

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

16. The objective and rationale for voluntary isolation of ill travellers, as outlined by the Commonwealth Pandemic Plan, is to reduce exposure to the disease by managing the entry of ill travellers at the border.¹⁷
17. It states that returning Australians may isolate at home, but other arrangements would be required for other travellers.¹⁸ The Commonwealth Pandemic Plan also states that voluntary isolation should commence when notified of sustained human-to-human transmission of a novel virus and that it must be used early to be effective in limiting entry of the disease into the community.¹⁹
18. The Plan considers voluntary self-isolation experiences during the SARS outbreak and the pandemic (H1N1) in 2009. It notes that compliance with self-isolation during the outbreak was high in most countries.²⁰ Notwithstanding that, the Commonwealth Pandemic Plan identifies that isolation may be difficult to enforce, self-regulated isolation may not be complied with and support for isolated cases is resource intensive.²¹
19. The Commonwealth Pandemic Plan identifies that the use of hotels to quarantine returned travellers is **problematic** (emphasis added), though it does not go so far as to say why this is so. Costs are noted as high if travellers are isolated in hotels; this is attributed to accommodation, food, servicing, medical support, security, entertainment and a support system to monitor people isolated.²²

20. Voluntary self-isolation of cases more broadly (cases not limited to travellers) is recommended as a measure, particularly as the clinical severity of the disease increases. The Commonwealth Pandemic Plan states it is to be used in conjunction with infection control measures to reduce the risk of transmission to household contacts. Voluntary self-isolation is said to be most likely to influence the course of the pandemic when clinical severity is high and transmissibility is low.²³
21. In the case of COVID-19, Prof. Grayson stated that COVID-19 is considered to be 'highly infectious, particularly as it can be transmitted before the onset of symptoms and because those who are infectious may be entirely asymptomatic or have only trivial symptoms'.²⁴ The nature of COVID-19 is discussed in detail in Chapter 2.

Quarantine of contacts not recommended

22. The Commonwealth Pandemic Plan does not recommend quarantining contacts of ill travellers at the border²⁵ in the context of pandemic influenza.
23. That is because, according to that Plan, quarantining contacts has minor effectiveness, imposes a significant burden on health and other systems, and places high costs and significant imposts on travellers and services. The Commonwealth Pandemic Plan states that extensive infrastructure would be needed, including databases, information and surveillance hotlines, and staff, to enforce quarantine.²⁶
24. The Plan states that it would be highly complex to arrange and maintain a quarantine program, and that ethical issues may arise from confining individuals, as well as stress arising as a result of confinement. Notwithstanding this point, the Commonwealth Pandemic Plan provides that, if quarantining contacts of ill travellers at the border is to be used as a response strategy, the agency controlling the health response should commence its operation when it is 'notified of sustained human-to-human transmission of a novel virus. It must be used early to be effective...'²⁷
25. Voluntary quarantine of contacts more broadly (cases not limited to travellers) is recommended as a measure, particularly where consequences of infection are high.²⁸
26. Overall, the Commonwealth Pandemic Plan notes that the effectiveness of isolation and quarantine depends on a number of factors. Specifically, as the Plan deals with voluntary isolation and quarantine, it considers that factors influencing its effectiveness include perception and understanding of risk associated with infection and illness, and financial considerations.²⁹ It also states that early and transparent communication to the public is an important component of implementation.³⁰
27. While these factors are relevant in the context of a voluntary program, they are obviously important in a program of mandatory quarantine with respect to both those placed into mandatory quarantine and those working at quarantine sites.

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

28. The most recent version of the Commonwealth Pandemic Plan was updated on 21 August 2019.³¹ The Commonwealth Department of Health notes that this version of the Plan incorporates minor amendments, such as incorporation of the decommissioned 'Fluborderplan' throughout the document, and updated references to legislation, terminology and committee names.³²

29. Prior to the most recent update, the Plan went through a significant update in 2014 following the Commonwealth Department of Health and Ageing's *Review of Australia's Health Sector Response to Pandemic (H1N1) 2009*, which was published in 2011.³³
30. This review recommended a substantial change to the approach of the Commonwealth Pandemic Plan. Some of the key aspects of the new approach included:
 - A. wherever possible, using existing systems and governance mechanisms, particularly those for seasonal influenza, as the basis of the response
 - B. applying a flexible approach, which can be scaled and varied to meet the needs experienced at the time
 - C. making decisions based on available evidence
 - D. linking with emergency response arrangements
 - E. emphasising communication activities as a key tool in management of the response
 - F. provision of detailed guidance on the collection of national surveillance data.³⁴

Recommendations from previous reviews regarding quarantine and isolation

31. What was of particular interest in the *Review of Australia's Health Sector Response to the (H1N1) Pandemic 2009* was the recommendation for an examination of the policy on quarantine and isolation, including management, support systems and communication.³⁵
32. This was because the Australian response to the (H1N1) outbreak in 2009 identified that quarantining non-residents arriving in Australia was an issue, as:
 - A. many hotels refused to provide accommodation to individuals under quarantine
 - B. the purpose of voluntary quarantine was not well understood, was inconvenient, unappealing and difficult to enforce
 - C. policy and operational plans for managing people in quarantine had not been finalised (at the state, territory and national level) when the pandemic emerged
 - D. information provided to people in quarantine was insufficient and conflicting, and support was slow to be provided to them.³⁶
33. The review found:

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

34. Professor Brett Sutton, Victoria's Chief Health Officer, gave evidence that no work had been done, nationally or in any jurisdiction of Australia, to implement this recommendation since it was made in 2011.³⁸ The implications of this work not being undertaken are discussed further at paragraphs 53–55.

3.2 The Victorian Pandemic Plan

35. The Victorian Health Management Plan for Pandemic Influenza (the Victorian Pandemic Plan) is the local reflection, and replicates much, of the Commonwealth Pandemic Plan.³⁹ The stated aim of the Victorian Pandemic Plan is to provide an effective health response framework to minimise transmissibility, morbidity and mortality associated with an influenza pandemic and its impacts on the health sector and community.⁴⁰
36. The Victorian Pandemic Plan describes activities needed to reduce the impact of an influenza pandemic in Victoria, including:
- A. surveillance systems to rapidly and efficiently identify the emergence of new strains of influenza in the Victorian community
 - B. timely implementation of measures seeking to limit or prevent the transmission of pandemic influenza in the various stages of a pandemic
 - C. continuing surveillance to monitor the status of the outbreak
 - D. maximising the use of resources
 - E. public health strategies to best meet the needs of the current situation based on the best surveillance data
 - F. informing staffing needs and requirements
 - G. implementing policies on the use of personal protective equipment (PPE) and antivirals
 - H. communicating accurate, consistent and comprehensive information about the situation to the general public, the media, our partners in the health sector and other key stakeholders.⁴¹
37. The *Victorian Action Plan for Influenza Pandemic 2015* (Action Plan) is the Emergency Management Victoria pandemic plan. It articulates Victoria's strategic approach to reducing the social and economic impacts and consequences of pandemic influenza on communities.⁴² It is, effectively, a plan to help manage the operations of government departments and other organisations in a pandemic.
38. The Action Plan is stated to help departments and organisations complete or review their pandemic influenza plans. It sets out:
- A. Victorian arrangements for pandemic influenza planning and response
 - B. key agencies and their roles and responsibilities
 - C. relevant governance structures
 - D. incident response guidance for departments and agencies.⁴³
39. In February 2020, with the onset of COVID-19 infections in Victoria, the Department of Health and Human Services (DHHS) developed the *COVID-19 Pandemic Plan for the Victorian Health Sector*.⁴⁴ This plan, which was published on 10 March 2020, set out a four-stage response to COVID-19 for the health sector that included initial containment, targeted action, peak action and stand down and recovery.⁴⁵

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

40. As with the Commonwealth Pandemic Plan, State Acts and Regulations authorise actions under the Victorian Pandemic Plan and the Action Plan. In addition to the national legislation set out at paragraph 12, the key pieces of Victorian legislation available to support pandemic actions in Victoria include:
- A. the *Public Health and Wellbeing Act 2008* (Vic) and *Public Health and Wellbeing Regulations 2009* — which aim to protect the health and wellbeing of the population and establish provisions for managing infectious diseases
 - B. the *Emergency Management Act 1986* (Vic) — which authorises authorities to take control of specific aspects of an emergency when declared by the Premier
 - C. the *Emergency Management Act 2013* (Vic) — which implements a series of reforms such as establishing the State Crisis and Resilience Council, Emergency Management Victoria and the Emergency Management Commissioner.⁴⁶
41. The Victorian Pandemic Plan is also guided by the same ethical framework established under the Commonwealth Pandemic Plan to guide health sector responses and actions taken.⁴⁷
42. The Victorian Pandemic Plan and the Action Plan interact. They relate to a specific type of pandemic. Victoria's pandemic response arrangements, more generally, involve the following key plans (in addition to the Commonwealth Pandemic Plan):⁴⁸
- A. the State Emergency Response Plan (SERP) as contained in the Emergency Management Manual Victoria. The State Emergency Response Plan describes the arrangements for controlling a response to specified types of emergencies, and the roles of the agencies who control and support the control of that response. The Emergency Management Manual Victoria also sets out the arrangements for emergency management in Victoria more generally⁴⁹
 - B. the State Health Emergency Response Plan (SHERP) — a sub-plan of the State Emergency Response Plan that outlines the arrangements for coordinating a health response to health emergency incidents that go beyond day-to-day business arrangements.⁵⁰ The details of the Victorian emergency management framework, its use and how it worked in the Hotel Quarantine Program are discussed in detail in Chapter 8.

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

43. As is the case with the Commonwealth Pandemic Plan, the Victorian Pandemic Plan does not provide specific guidance for a program of mandatory detention or quarantine for returned travellers, nor does it refer to a mass program of mandatory quarantine to the scale of the Hotel Quarantine Program.
44. The Victorian Pandemic Plan states, consistent with the Commonwealth Pandemic Plan, that voluntary isolation of ill travellers and voluntary quarantine of contacts can assist to control the transmission of disease into the community.⁵¹

45. It provides that, voluntary and home-based isolation should be considered as part of the preparedness, initial and targeted-response stages.⁵² The Plan states that in the targeted response stage, benefits will be reassessed contingent on evidence as to the transmissibility of the virus and severity of the illness. The Victorian Pandemic Plan also refers to the Commonwealth Pandemic Plan for further details on isolation and quarantine.⁵³
46. The *COVID-19 Pandemic Plan for the Victorian Health Sector* also does not envisage the involuntary, large scale detention of people arriving from interstate or overseas. As with the Victorian Pandemic Plan, its focus, with regard to isolation or quarantine, is on the *voluntary* isolation of people in their own homes.⁵⁴
47. Notably, it states the following under the heading of Quarantine:

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

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

48. The Victorian Pandemic Plan was prepared in 2007 and updated in 2014 in line with the Commonwealth Pandemic Plan, and in response to lessons learned from the (H1N1) pandemic, based on the *Review of Australia's Health Sector Response to Pandemic (H1N1) 2009*.⁵⁶
49. As noted at paragraphs 31 to 34, the review recommended that an examination of the policy on quarantine and isolation, including management, support systems and communication, be undertaken.⁵⁷ Prof. Sutton gave evidence to the Inquiry that this work had not been undertaken, either nationally or at the state or territory level. When questioned on this matter by Counsel Assisting the Inquiry, Prof. Sutton agreed that had this work been undertaken, it would have been very useful for establishing the Hotel Quarantine Program in a pandemic situation.⁵⁸
50. Dr Annaliese van Diemen's (Deputy Chief Health Officer for Victoria) evidence was that she had never turned her mind to the concept of a large-scale quarantine program for returned travellers prior to late March 2020.⁵⁹ Before this point in time, and as illustrated by the evidence in the preceding paragraphs of this section, pandemic plans considered isolation or quarantine in the context of a home-based program for cases or contacts.⁶⁰
51. It was only following the announcement of a quarantine program by National Cabinet and during subsequent conversations about implementing the decision did Dr van Diemen consider the concept of a mandatory, mass quarantine program.⁶¹
52. In a similar vein, not surprisingly, Ms Kym Peake, the then Secretary of DHHS since November 2015, gave evidence that, prior to late March 2020, she had not turned her mind to such a concept and only did so for the very first time following National Cabinet's announcement.⁶² Ms Peake stated that, in her view, the Commonwealth Constitution envisages that quarantine will primarily sit as a responsibility of the Commonwealth Government.⁶³ As such, as at March 2020, it was not 'on the radar' for DHHS in Victoria that there would be a mass quarantine program required at a state level.⁶⁴

53. Notwithstanding the Commonwealth's (H1N1) review in 2011 noting that the roles and responsibilities of all governments for the management of people in quarantine during a pandemic should be clarified,⁶⁵ this recommendation had not been addressed by the Commonwealth, which provided the model for the states and territories to adopt.⁶⁶ (See Recommendation 70 below.)
54. Despite updates having been made recently to the Victorian Pandemic Plan (and the Commonwealth Pandemic Plan) to reflect lessons learned from the (H1N1) pandemic, a key recommendation to review the policy on quarantine and isolation (Recommendation 13)⁶⁷ was left unaddressed. Evidence provided by Prof. Sutton provides some insight as to why this may have been the case.
55. During his evidence, Prof. Sutton stated that, in his view (with the benefit of hindsight), it was an issue that the pandemic plans prior to the COVID-19 pandemic gave insufficient consideration of the pandemic potential of a coronavirus and no explicit consideration of a program of quarantine to keep a jurisdiction entirely free of the virus.⁶⁸
56. Prof. Sutton noted that it was always an assumption that a pandemic influenza (the basis of the Commonwealth plans) would reach every country and the purpose of quarantine was to minimise the peak of the pandemic and the resulting pressures on the health system.⁶⁹ Prof. Sutton stated that, following what happened in Wuhan, and reflecting that the COVID-19 pandemic had the greatest severity seen since the Spanish Flu, the impetus was for a quarantine program that would keep the virus out of the community to the fullest extent possible. Prof. Sutton's evidence, in this regard, was that prior pandemic planning was directed to minimising transmission, rather than eliminating transmission via a system of quarantine.⁷⁰

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

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

Pandemic planning exercises

59. Under the *Emergency Management Act 2013* (Vic), major health emergencies and biosecurity emergencies (unless linked to an act of terrorism) are defined as a 'Class 2' emergency.⁷²
60. According to the evidence of Ms Peake, Class 2 emergencies have been comparatively rare in Victoria.⁷³ Ms Peake stated that DHHS 'regularly undertakes emergency incident exercises where the emergency management regime and the State Health Emergency Response Plan are performed'.⁷⁴ The evidence of DHHS witnesses was that such exercises are undertaken on a regular basis and often include other agencies.⁷⁵
61. According to Prof. Sutton, pandemic planning exercises are an opportunity to test the efficacy of the arrangements and to practice performing the roles, activities and deliverables of each person and agency with responsibilities.⁷⁶

62. The Inquiry has heard evidence of exercises that featured infectious disease scenarios. While it may be so that it is not possible to predict the exact nature, scale and type of an infectious disease emergency and to rehearse a response to that emergency, Prof. Sutton stated that these exercises, nevertheless, have the benefit of testing the efficacy of response arrangements, practising the performance of allocated roles and to engage all areas and agencies in doing so.⁷⁷
63. The evidence as to the most recent exercises undertaken in relation to an infectious disease pandemic included:
- A. 'Exercise Teapot' — undertaken in September 2019 and led by the Health Protection Branch and Emergency Management Branch in DHHS, with representatives from more than 16 agencies.⁷⁸ This was described as a discussion exercise that explored a complex multiagency emergency involving widespread outbreaks including of Middle Eastern Respiratory Syndrome coronavirus.⁷⁹
 - B. 'Exercise Alchemy' — undertaken in August 2018 and led by Emergency Management Victoria.⁸⁰ The stated purpose of this exercise was to assess state-level communications processes during a biosecurity emergency that transitioned to a pandemic emergency.⁸¹
64. Feedback from Exercise Alchemy identified that the role and function of any team or structure needed to be clearly defined and practical given that Class 2 emergencies have unique challenges.⁸² In the context of the Hotel Quarantine Program, given the time constraints and lack of an overarching plan for mass, mandatory quarantine, the lessons from Exercise Alchemy were not applied when they should have been. The implementation of the Hotel Quarantine Program is discussed further in chapters 5 and 8.
65. Whereas Ms Peake and Prof. Sutton gave evidence that emergency incident exercises specifically related to infectious disease pandemics are undertaken regularly, there were views expressed by doctors outside DHHS about not being sufficiently included in pandemic planning exercises for the medical profession more broadly. Dr Nathan Pinskiier, director of Onsite Doctor Pty Ltd, which was engaged to assist with the provision of medical services and support to returned travellers in the Hotel Quarantine Program,⁸³ raised questions about pandemic planning exercises across the health sector more broadly.
66. Dr Pinskiier is a Melbourne-based GP with nearly 40 years of involvement in primary health, tertiary care, digital health, accreditation, medical deputising services and practice management.⁸⁴ Dr Pinskiier stated that, in the course of his professional life, the occurrence of a pandemic had never been discussed at any of the professional forums he had attended across Australia, other than a 'zombie apocalypse' workshop he attended in October 2014 that dealt broadly with the issue of a pandemic.⁸⁵
67. Based on this experience, Dr Pinskiier concluded that 'given the lack of ongoing systemic planning, no-one was remotely prepared for the pandemic and when it did arise the response was, in consequence, cobbled together in an ad hoc manner'.⁸⁶
68. Dr Julian Rait, President of the Australian Medical Association (AMA) gave evidence in the form of a statement to the Inquiry⁸⁷ in which he, too, raised concerns about the level of engagement from DHHS with the medical profession more broadly in the context of emergency medicine. This subject is outside the Terms of Reference of this Inquiry. Nevertheless, given the evidence of such an experienced GP who was engaged in the Hotel Quarantine Program in his professional capacity and the concerns and issues expressed by Dr Rait as the President of the AMA, I consider that the issues raised by Dr Pinskiier and Dr Rait as to the engagement of DHHS with the medical profession and the medical profession's ability to collaborate with DHHS and be a source of potential resources to DHHS in public health emergencies, should be the subject of follow up by DHHS (see Recommendation 71).

3.3 Conclusions

69. The Commonwealth Pandemic Plan describes pandemics as unpredictable and presenting a significant risk to Australia and having the potential to cause high levels of disease and death and disrupt the community, both socially and economically. The Commonwealth Pandemic Plan, which was developed in consultation with states and territories, outlines Australia's strategy to manage an influenza pandemic and minimise its impact on the health of Australians and the health system.
70. The Plan is intended to provide overarching guidance and a framework for a nationally consistent approach to managing an influenza pandemic. The guidance provided in the Commonwealth Pandemic Plan, consistent with this intention, is reflected in Victoria's relevant plans. It is the responsibility of the states and territories for the majority of the operational detail to be in their plans.
71. The Commonwealth Pandemic Plan does not provide any specific guidance for a program of mandatory detention or quarantine for returned travellers. It does not refer to a mass program of mandatory quarantine.
72. It does provide guidance and analysis regarding *voluntary* isolation of ill travellers who do not require hospitalisation, and possible quarantine of contacts of ill travellers at the border (though this option is not recommended).
73. The Plan considered voluntary self-isolation experiences during the SARS outbreak and the pandemic (H1N1) in 2009. It notes that compliance with self-isolation during the outbreak was high in most countries. Notwithstanding that, the Commonwealth Pandemic Plan identifies that isolation may be difficult to enforce, self-regulated isolation may not be complied with, and support for isolated cases is resource intensive.
74. The Commonwealth Pandemic Plan specifically identifies that the use of hotels to quarantine returned travellers is **problematic** (emphasis added), though it does not go so far as to say why this is so. Costs are noted as high if travellers are isolated in hotels, attributable to the costs of accommodation, food, servicing, medical support, security, entertainment and a support system to monitor people isolated.⁸⁸
75. The Plan states that it would be highly complex to arrange and maintain a quarantine program, and that ethical issues may arise from confining individuals, as well as stress arising as a result of confinement. Notwithstanding this point, the Commonwealth Pandemic Plan provides that, if quarantining contacts of ill travellers at the border is to be used as a response strategy, the agency controlling the health response should commence its operation when it is 'notified of sustained human-to-human transmission of a novel virus and that it must be used early to be effective.
76. Voluntary quarantine of contacts more broadly (cases not limited to travellers) is recommended as a measure, particularly where consequences of infection are high.
77. The Commonwealth Pandemic Plan notes that the effectiveness of isolation and quarantine depends on a number of factors. Specifically, as the Plan deals with voluntary isolation and quarantine, it considers that factors influencing its effectiveness include perception and understanding of risk associated with infection and illness, and financial considerations.
78. It is clear that both the State and Commonwealth governments were aware, prior to 2020, of the possibility of a pandemic and its potentially devastating consequences.
79. However, none of the existing Commonwealth or State pandemic plans contained plans for mandatory, mass quarantine. Indeed, the concept of hotel quarantine was considered problematic and thus, no plans existed in the overarching Commonwealth plans for hotel quarantining.

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

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

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

82. While this Inquiry has no remit or jurisdiction to examine any action or inaction by the Commonwealth, given the role of the Commonwealth through the Commonwealth Pandemic Plan and the lead that it provides to the states and territories, it would be unfair to judge Victoria's lack of planning for a mandatory quarantining program given the Commonwealth, itself, had neither recommended nor developed such a plan.
83. Significantly, the Commonwealth undertook a review of its health sector response in the wake of the (H1N1) pandemic in 2009. The Commonwealth's *Review of Australia's Health Sector Response to Pandemic (H1N1) 2009* recommended that the roles and responsibilities of all governments for the management of people in quarantine, both at home and in other accommodation, during a pandemic should be clarified. The review further recommended that a set of nationally consistent principles could form the basis for jurisdictions to develop operating guidelines, including plans for accommodating potentially infected people in future pandemics and better systems to support people in quarantine. Further, this review recommended an examination of the policy on quarantine and isolation, including management, support systems and communication.⁹⁰
84. Despite the Commonwealth Pandemic Plan and the Victorian Pandemic Plan being updated following the *Review of Australia's Health Sector Response to Pandemic (H1N1) 2009* to ensure evidence-based decision-making; use of existing governance mechanisms; a scalable and flexible approach and to emphasise communication activities, an important piece of work regarding the policy on quarantine and isolation, including management, support systems and communication and the roles and responsibilities of all governments for the management of people in quarantine during a pandemic to be clarified, the evidence to the Inquiry is that this work was not undertaken.
85. Had the work proposed by the review been undertaken, there would likely have been, at least, a set of guiding principles and a framework to support the establishment of the Hotel Quarantine Program, thus avoiding the program needing to be set up in an ad hoc manner during a pandemic.
86. Just two weeks before the National Cabinet agreement to mass quarantining, Victoria published its 10 March 2020 *COVID-19 Pandemic Plan for the Victorian Health Sector*. It did not envisage the involuntary detention of people arriving in from overseas. As with the Victorian Pandemic Plan, its focus with regard to isolation or quarantine was on the *voluntary* isolation of people in their own homes.
87. The lack of a plan for mandatory mass quarantining meant that the Hotel Quarantine Program was conceived and implemented 'from scratch' to be operational within 36 hours from concept to operation. This placed incredible strain on the resources of the State and, more specifically, on those Departments and people required to give effect to the decision of the National Cabinet. This was a most unsatisfactory situation from which to develop such a complex and high-risk program.

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

PANDEMIC PLANNING EXERCISES

89. The evidence shows emergency incident exercises, specifically related to infectious disease pandemics, are undertaken regularly. These exercises consider associated public health and emergency management plans and are undertaken within DHHS and with other agencies.
90. 'Exercise Alchemy' in August 2018 identified that the role and function of any team or structure needed to be clearly defined and practical, given that Class 2 emergencies have unique challenges. The need for clarity in roles and structure was a valuable result from the exercise which was an opportunity to address this issue. Given the conclusions from this Inquiry, it should be given due focus when developing future emergency response activities. (See Recommendation 72 and see also Chapter 8 for issues more generally as to role clarity).
91. There was a perceived gap in terms of provision of pandemic planning across the broader health sector. There can be no doubt that there is a role for the broader health sector to play in health emergency planning. DHHS should review its pandemic planning processes and activities so as to consider an appropriate level of involvement from the broader health sector (see Recommendation 73).

3.4 Recommendations

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

Endnotes

- 1 Department of Health, Australian Health Management Plan for Pandemic Influenza (Plan, August 2019) 14 [2.2]. <[https://www1.health.gov.au/internet/main/publishing.nsf/Content/519F9392797E2DDCCA257D47001B9948/\\$File/w-AHMPPPI-2019.PDF](https://www1.health.gov.au/internet/main/publishing.nsf/Content/519F9392797E2DDCCA257D47001B9948/$File/w-AHMPPPI-2019.PDF)>.
- 2 Department of Health, Australian Health Management Plan for Pandemic Influenza (Plan, August 2019) <[https://www1.health.gov.au/internet/main/publishing.nsf/Content/519F9392797E2DDCCA257D47001B9948/\\$File/w-AHMPPPI-2019.PDF](https://www1.health.gov.au/internet/main/publishing.nsf/Content/519F9392797E2DDCCA257D47001B9948/$File/w-AHMPPPI-2019.PDF)>.
- 3 Ibid 29 [4.1.1].
- 4 Exhibit HQ1011451_RP Annexures to first witness statement of Commissioner Andrew Crisp, DOJ.600.001.0325; Department of Health and Human Services, Victorian Health Management Plan for Pandemic Influenza (Plan, October 2014) <<https://www2.health.vic.gov.au/about/publications/policiesandguidelines/Victorian-health-management-plan-for-pandemic-influenza---October-2014>>.
- 5 Exhibit HQ10153_RP Witness statement of Prof. Brett Sutton, 10 [46]; Department of Health and Human Services, Victorian Action Plan for Influenza Pandemic (Plan, October 2014) <<https://files-em.em.vic.gov.au/public/EMV-web/Victorian-action-plan-for-pandemic-influenza.pdf>>.
- 6 Exhibit HQI0001_P Witness statement of Prof. Lindsay Grayson, 11 [49].
- 7 Department of Health, Australian Health Management Plan for Pandemic Influenza (Plan, August 2019) 3, 13 <[https://www1.health.gov.au/internet/main/publishing.nsf/Content/519F9392797E2DDCCA257D47001B9948/\\$File/w-AHMPPPI-2019.PDF](https://www1.health.gov.au/internet/main/publishing.nsf/Content/519F9392797E2DDCCA257D47001B9948/$File/w-AHMPPPI-2019.PDF)>.
- 8 Ibid.
- 9 Ibid 13 [2.1].
- 10 Ibid.
- 11 Ibid 31 [4.1.4].
- 12 Ibid 18 [2.6].
- 13 Ibid 16 [2.4].
- 14 Ibid.
- 15 Ibid 16–17 [2.5].
- 16 Ibid 40, 116, 129, 139, 150.
- 17 Ibid 139.
- 18 Ibid.
- 19 Ibid.
- 20 Ibid.
- 21 Ibid.
- 22 Ibid.
- 23 Ibid 150.
- 24 Exhibit HQI0001_P Witness statement of Prof. Lindsay Grayson, 10–11 [47(c)].
- 25 Department of Health, *Australian Health Management Plan for Pandemic Influenza* (Plan, August 2019) 140 <[https://www1.health.gov.au/internet/main/publishing.nsf/Content/519F9392797E2DDCCA257D47001B9948/\\$File/w-AHMPPPI-2019.PDF](https://www1.health.gov.au/internet/main/publishing.nsf/Content/519F9392797E2DDCCA257D47001B9948/$File/w-AHMPPPI-2019.PDF)>.
- 26 Ibid.
- 27 Ibid.
- 28 Ibid 151.
- 29 Ibid 143.
- 30 Ibid.
- 31 Department of Health, Australian Health Management Plan for Pandemic Influenza (Web Page, 12 December 2019) <<https://www1.health.gov.au/internet/main/publishing.nsf/Content/ohp-ahmppi.htm>>.
- 32 Ibid.
- 33 Department of Health and Ageing, Review of Australia's Health Sector Response to Pandemic (H1N1) 2009 (Report, September 2011) <[https://www1.health.gov.au/internet/publications/publishing.nsf/Content/review-2011-l/\\$File/lessons%20identified-oct11.pdf](https://www1.health.gov.au/internet/publications/publishing.nsf/Content/review-2011-l/$File/lessons%20identified-oct11.pdf)>.
- 34 Department of Health, Pandemic Influenza (web page, 5 September 2014) <<https://www1.health.gov.au/internet/main/publishing.nsf/Content/ohp-pandemic-influenza.htm>>; Department of Health, Australian Health Management Plan for Pandemic Influenza (Plan, August 2019) Ministerial Foreword, 3 <[https://www1.health.gov.au/internet/main/publishing.nsf/Content/519F9392797E2DDCCA257D47001B9948/\\$File/w-AHMPPPI-2019.PDF](https://www1.health.gov.au/internet/main/publishing.nsf/Content/519F9392797E2DDCCA257D47001B9948/$File/w-AHMPPPI-2019.PDF)>.
- 35 Department of Health and Ageing, Review of Australia's Health Sector Response to Pandemic (H1N1) 2009 (Report, September 2011) 41 <[https://www1.health.gov.au/internet/publications/publishing.nsf/Content/review-2011-l/\\$File/lessons%20identified-oct11.pdf](https://www1.health.gov.au/internet/publications/publishing.nsf/Content/review-2011-l/$File/lessons%20identified-oct11.pdf)>.

- 36 Ibid 40.
- 37 Ibid.
- 38 Transcript day 18 hearing 16 September 2020, 1472.
- 39 Department of Health and Human Services, Victorian Health Management Plan for Pandemic Influenza (Plan, October 2014) 1 <<https://www2.health.vic.gov.au/about/publications/policiesandguidelines/Victorian-health-management-plan-for-pandemic-influenza---October-2014>>.
- 40 Ibid 4; Exhibit HQI0153_RP Witness statement of Prof. Brett Sutton, 10 [46].
- 41 Department of Health and Human Services, Victorian Health Management Plan for Pandemic Influenza (Plan, October 2014) 4–5 <<https://www2.health.vic.gov.au/about/publications/policiesandguidelines/Victorian-health-management-plan-for-pandemic-influenza---October-2014>>.
- 42 Emergency Management Victoria, Victorian Action Plan for Influenza Pandemic (Plan, August 2015) 6 [1.1] <<https://files-em.em.vic.gov.au/public/EMV-web/Victorian-action-plan-for-pandemic-influenza.pdf>>; Exhibit HQI0153_RP Witness statement of Prof. Brett Sutton, 10 [46].
- 43 Emergency Management Victoria, Victorian Action Plan for Influenza Pandemic (Plan, August 2015) 6 [1.1] <<https://files-em.em.vic.gov.au/public/EMV-web/Victorian-action-plan-for-pandemic-influenza.pdf>>.
- 44 Department of Health and Human Services, COVID-19 Pandemic Plan for the Victorian Health Sector (Plan, 10 March 2020) <<https://www2.health.vic.gov.au/about/publications/researchandreports/covid-19-pandemic-plan-for-vic>>; Exhibit HQI0186_RP First witness statement of Kym Peake, 6 [28].
- 45 Department of Health and Human Services, COVID-19 Pandemic Plan for the Victorian Health Sector (Plan, 10 March 2020) 4 <<https://www2.health.vic.gov.au/about/publications/researchandreports/covid-19-pandemic-plan-for-vic>>.
- 46 Ibid 3–4; Department of Health and Human Services, Victorian Health Management Plan for Pandemic Influenza (Plan, October 2014) 6 [2.1] <<https://www2.health.vic.gov.au/about/publications/policiesandguidelines/Victorian-health-management-plan-for-pandemic-influenza---October-2014>>.
- 47 Department of Health and Human Services, Victorian Health Management Plan for Pandemic Influenza (Plan, October 2014) 7 [2.2] <<https://www2.health.vic.gov.au/about/publications/policiesandguidelines/Victorian-health-management-plan-for-pandemic-influenza---October-2014>>.
- 48 Ibid 8 [2.3]; Emergency Management Victoria, Victorian Action Plan for Influenza Pandemic (Plan, August 2015) 7–8 [1.7] <<https://files-em.em.vic.gov.au/public/EMV-web/Victorian-action-plan-for-pandemic-influenza.pdf>>.
- 49 Emergency Management Victoria, Emergency Management Manual Victoria (Manual, 2020) <<https://www.emv.vic.gov.au/policies/emmv>>.
- 50 Emergency Management Victoria, State Health Emergency Response Plan (Plan, 2017) <<https://www2.health.vic.gov.au/-/media/health/files/collections/policies-and-guidelines/s/state-health-emergency-response-plan-edition-4-pdf.pdf?la=en&hash=B2AA0AFAD30854022645E4A9A2F3D>>.
- 51 Department of Health and Human Services, Victorian Health Management Plan for Pandemic Influenza (Plan, October 2014) 51–53 <<https://www2.health.vic.gov.au/about/publications/policiesandguidelines/Victorianhealth-management-plan-for-pandemic-influenza---October-2014>>.
- 52 Ibid.
- 53 Ibid.
- 54 Exhibit HQI0186_RP First witness statement of Kym Peake, 10 [43].
- 55 Department of Health and Human Services, COVID-19 Pandemic Plan for the Victorian Health Sector (Plan, 10 March 2020) 10 <<https://www2.health.vic.gov.au/about/publications/researchandreports/covid-19-pandemic-plan-for-vic>>.
- 56 Exhibit HQI0153_RP Witness statement of Prof. Brett Sutton, 10 [47].
- 57 Department of Health and Ageing, Review of Australia’s Health Sector Response to Pandemic (H1N1) 2009 (Report, September 2011) 41 <[https://www1.health.gov.au/internet/publications/publishing.nsf/Content/review-2011-1/\\$File/lessons%20identified-oct11.pdf](https://www1.health.gov.au/internet/publications/publishing.nsf/Content/review-2011-1/$File/lessons%20identified-oct11.pdf)>.
- 58 Transcript of day 18 hearing 16 September 2020, 1473.
- 59 Ibid 1520.
- 60 Ibid.
- 61 Ibid 1520–1521.
- 62 Transcript of day 22 hearing 22 September 2020, 1886.
- 63 Ibid.
- 64 Ibid.
- 65 Department of Health and Ageing, Review of Australia’s Health Sector Response to Pandemic (H1N1) 2009 (Report, September 2011) 40 <[https://www1.health.gov.au/internet/publications/publishing.nsf/Content/review-2011-1/\\$File/lessons%20identified-oct11.pdf](https://www1.health.gov.au/internet/publications/publishing.nsf/Content/review-2011-1/$File/lessons%20identified-oct11.pdf)>.
- 66 Transcript of day 22 hearing 22 September 2020, 1886.

- 67 Department of Health and Ageing, Review of Australia's Health Sector Response to Pandemic (H1N1) 2009 (Report, September 2011) 41 <[https://www1.health.gov.au/internet/publications/publishing.nsf/Content/review-2011-I/\\$File/lessons%20identified-oct11.pdf](https://www1.health.gov.au/internet/publications/publishing.nsf/Content/review-2011-I/$File/lessons%20identified-oct11.pdf)>.
- 68 Transcript of day 18 hearing 16 September 2020, 1473.
- 69 Ibid.
- 70 Ibid.
- 71 Ibid; Transcript of Day 17 Hearing, 15 September 2020, 1393; Transcript of day 22 hearing 22 September 2020, 1825, 1886, 1892–1894.
- 72 *Emergency Management Act 2013* (Vic) s. 3.
- 73 Exhibit HQI0186_RP First witness statement of Kym Peake, 8 [34].
- 74 Ibid.
- 75 Exhibit HQI0153_RP Witness statement of Prof. Brett Sutton, 11 [50]; Exhibit HQI0186_RP First witness statement of Kym Peake, 8 [34].
- 76 Exhibit HQI0153_RP Witness statement of Prof. Brett Sutton, 12 [56]; Exhibit HQI0186_RP First witness statement of Kym Peake, 9 [39].
- 77 Exhibit HQI0153_RP Witness statement of Prof. Brett Sutton, 11 [51]; Exhibit HQI0186_RP First witness statement of Kym Peake, 8 [35].
- 78 Exhibit HQI0186_RP First witness statement of Kym Peake, 9 [40]–[41].
- 79 Exhibit HQI0153_RP Witness statement of Prof. Brett Sutton, 12 [59].
- 80 Exhibit HQI0186_RP First witness statement of Kym Peake, 10 [42.3].
- 81 Ibid.
- 82 Ibid.
- 83 Exhibit HQI0095_RP Witness statement of Dr Nathan Pinskiar, 1 [7].
- 84 Ibid 1 [1].
- 85 Ibid 5 [47].
- 86 Ibid.
- 87 Exhibit HQI0092_RP Witness statement of Dr Julian Rait.
- 88 Department of Health, Australian Health Management Plan for Pandemic Influenza (Plan, August 2019) 140 <[https://www1.health.gov.au/internet/main/publishing.nsf/Content/519F9392797E2DDCCA257D47001B9948/\\$File/w-AHMPP1-2019.PDF](https://www1.health.gov.au/internet/main/publishing.nsf/Content/519F9392797E2DDCCA257D47001B9948/$File/w-AHMPP1-2019.PDF)>.
- 89 Transcript of day 18 hearing 16 September 2020, 1473.
- 90 Department of Health and Ageing, Review of Australia's Health Sector Response to Pandemic (H1N1) 2009 (Report, September 2011) 41 <[https://www1.health.gov.au/internet/publications/publishing.nsf/Content/review-2011-I/\\$File/lessons%20identified-oct11.pdf](https://www1.health.gov.au/internet/publications/publishing.nsf/Content/review-2011-I/$File/lessons%20identified-oct11.pdf)>.

CHAPTER 4

Understanding Victoria's decision to set up a Hotel Quarantine Program

1. Effective as of 11:59pm Sunday 15 March 2020, the National Cabinet agreed to a 'precautionary self-isolation requirement' on all international arrivals. The rationale for this decision was stated by the Prime Minister as being to reduce community transmission to 'help stay ahead of the curve'.¹
2. The overall intent of the decision was clear. It was 'about reducing the spread of the virus in Australia and saving lives'.²
3. The National Cabinet position was reflected in a Direction from the Chief Health Officer (CHO), issued on 16 March 2020, requiring overseas travellers to '... travel from the airport to a premises that is suitable for the person to reside in for a period of 14 days' (the Self-Quarantine following Overseas Travel Direction).³ A further Direction (the Airport Arrivals Direction), in substantially similar terms, was issued by the Deputy Chief Health Officer (DCHO) on 18 March 2020.⁴ In this Chapter, I refer to these Directions collectively as the 'Self-Isolation Directions'. For most returning Victorian residents, the Self-Isolation Directions would have meant self-isolating at home. The penalty for non-compliance was substantial (\$19,826.40).⁵
4. As noted in the previous chapter of this Report, no plan for a mass quarantine program existed in Victoria⁶ or in Australia more broadly.⁷
5. Yet within 12 days of 16 March 2020, Australian states and territories had transitioned from self-quarantine to mandatory mass quarantine at 'designated premises'.
6. This transition occurred as a result of National Cabinet agreeing to a mass quarantine program for all returned travellers to Australia from 11.59pm on 28 March 2020.⁸
7. Victoria reflected the national decision when the DCHO issued a Direction and Detention Notice to all overseas travellers arriving in Victoria from 11.59pm on 28 March 2020. The penalty for non-compliance remained at \$19,826.40.⁹
8. According to both the Prime Minister and the Premier, the rationale for a mandatory mass quarantine program at designated premises was to reduce community transmission of the COVID-19 virus.¹⁰
9. It is relevant to the Inquiry's Terms of Reference to understand why there was a shift in Victoria from a requirement to self-isolate at suitable premises to a mandatory, mass quarantine program, particularly in the context of there having been no prior planning for a mass quarantine program.

4.1 Events leading to 27 March 2020

10. As outlined in Chapter 1 of this Report, the COVID-19 pandemic was seen to be escalating rapidly in the early months of 2020, from Australia's first case on 25 January 2020 to 112 cases some six weeks later.¹¹
11. The evidence of Victoria's DCHO, Dr Annaliese van Diemen, highlighted how quickly COVID-19 cases were increasing in March 2020. Dr van Diemen stated that:

We were increasing our case numbers by four times every week, week on week, from the first week of March. We had a four-fold increase every week, which put us on track to somewhere in the vicinity of 32,000 cases within a couple of weeks.¹²

12. Dr van Diemen also noted that every introduction of COVID-19 would increase that exponential growth.¹³
13. Given the increase of COVID-19 cases in Victoria, and the growth in cases globally (as outlined in Chapter 1), it is not surprising that the National Cabinet was established on 13 March 2020 with its stated aim to address and ensure consistency in Australia's response to the COVID-19 pandemic.¹⁴
14. By 15 March 2020, when the National Cabinet's 'universal precautionary self-isolation requirement on all international arrivals' was implemented,¹⁵ Australia had a total of 298 confirmed COVID-19 cases, with 57 of these cases in Victoria.¹⁶

The shift from self-isolation to mandatory, mass quarantine

15. What, then, led to the shift from the precautionary self-isolation requirement on 15 March 2020 to a mandatory quarantine program, only 12 days later?
16. It appears that an exponential increase in COVID-19 cases in Australia played a role in this shift. By 27 March 2020, there was a total of 3,162 COVID-19 cases in Australia, with 574 of these cases in Victoria.¹⁷ This represented an approximate eleven-fold increase in COVID-19 cases in Australia and a ten-fold increase in COVID-19 cases in Victoria since 15 March 2020.

Table 4.1: Cumulative COVID-19 cases in Australia and Victoria between 15 March and 27 March 2020

Date	COVID-19 cases in Australia (cumulative total)	COVID-19 cases in Victoria (cumulative total and subset of Australian total)
15 March 2020	298	57
16 March 2020	352	71
17 March 2020	437	94
18 March 2020	559	121
19 March 2020	685	150
20 March 2020	872	178
21 March 2020	1,074	229
22 March 2020	1,368	296
23 March 2020	1,694	355
24 March 2020	2,118	411
25 March 2020	2,415	466
26 March 2020	2,795	520
27 March 2020	3,162	574

Source for Australian COVID-19 figures: Department of Health (Commonwealth) COVID-19 current situation and case numbers: daily reported cases, <https://www.health.gov.au/news/health-alerts/novel-coronavirus-2019-ncov-health-alert/coronavirus-covid-19-current-situation-and-case-numbers#daily-reported-cases>; Source for Victorian COVID-19 figures: <https://www.dhhs.vic.gov.au/media-hub-coronavirus-disease-covid-19> (figures extracted from media releases 15 March – 27 March 2020).

17. Moreover, during this period, there had been an outbreak on the Ruby Princess cruise ship, which had docked in Sydney.
18. Passengers from the Ruby Princess had disembarked into Sydney on the morning of 19 March 2020¹⁸ and had been allowed to disperse, greatly compounding the task of contact tracing and infection control. The outbreak from the Ruby Princess was linked to more than 800 COVID-19 cases.¹⁹

4.2 The basis of the decision to quarantine rather than continue or expand self-isolation for all returning travellers

Increasing COVID-19 cases and community transmission

19. When announcing the National Cabinet decision to enforce quarantine at a designated facility, the Prime Minister noted that 'substantial numbers of returned travellers and small community outbreaks associated with travellers continue to contribute most of the significant further growth in COVID-19 cases in Australia'.²⁰
20. The Premier, similarly, noted that:

While Victoria has seen some community transmission of this virus, most cases have been the result of travellers returning from overseas who then pass it onto their close contacts. To ensure this no longer happens, National Cabinet has agreed that all states and territories will put in place enforced quarantine measures.²¹

21. It is, therefore, reasonable to conclude that the increase in COVID-19 cases, and community transmission linked to returned travellers, influenced the National Cabinet's decision to review the effectiveness of self-quarantine and to elect to enforce a mandatory quarantine program on all returned travellers.²²

Advice from the AHPPC

22. The decision of National Cabinet was announced by the Prime Minister as being based on the advice of medical experts.²³ As outlined in Chapter 1, the Australian Health Protection Principal Committee (AHPPC), led by the Commonwealth's Chief Medical Officer and comprising the chief health and medical officers from each jurisdiction, was the key medical advisory body to the National Cabinet.²⁴
23. Professor Brett Sutton, Victoria's CHO and a member of the AHPPC, gave evidence that the AHPPC had not endorsed a hotel quarantine program for all returned travellers either prior to, or in the wake of, the Prime Minister's announcement on 27 March 2020.²⁵

24. In his evidence, Prof. Sutton stated that 'on 26 March 2020, the AHPPC recommended to governments that the single most important thing that could be done was to stop the capacity for any returning traveller transmitting the virus'.²⁶ However, the AHPPC 'did not endorse the idea of quarantining travellers at hotels (or other designated facilities)'.²⁷
25. The evidence of the Premier was that the AHPPC's advice to National Cabinet recommended that only so-called 'high-risk' cases, where those people would normally reside with others at home, should be placed in an enforced quarantine in facilities such as hotels.²⁸ This evidence is consistent with versions of a draft advice passing from Prof. Sutton to Kym Peake, then Secretary to DHHS, on the evening of 26 March and the early morning of 27 March 2020.²⁹
26. In his witness statement, the Premier said that the 'National Cabinet considered the measure recommended by the AHPPC, but in respect to all returned travellers ... That extended measure was ultimately agreed by National Cabinet'.³⁰

Figure 4.1: Draft AHPPC advice regarding quarantine arrangements for returned travellers noting that high risk cases be placed in a facility such a hotel

Additional Measures recommended:

- In addition to the existing enforced quarantine arrangements for international travellers arriving in Australia, it is recommended that in high risk cases, monitored placement in a facility such as a hotel is enforced for those who would normally reside with others at home.
- Given the epidemiology in Greater Sydney, Greater Melbourne and South East Queensland, it is proposed that these jurisdictions consider immediately instituting additional physical distancing measures through closure of some or all non-essential services for a short-term period.

Additional Consideration of Triggers
The officials were unable to agree on any set numerical triggers for further action given the need for a contextualised assessment of the outbreak in a given area. The previously proposed parameters include an assessment of the following:

- The overall epidemic curve, which demonstrates 'rate of growth' nationally or potentially regionally if a regional lock down is proposed. This needs to be interpreted in the local context.
- Clusters without clear epidemiology links are the strongest indication of outbreaks, which are unlikely to be contained by public health intervention.
- The degree of expected impact of current social distancing on transmission rates.
- Health system impact. An assessment that demand for general or specific health services (particularly critical care services) will likely exceed capacity within 2 to 3 weeks.
- Case positivity rate as an indicator of testing.
- Time to diagnosis and time to complete contact tracing as well as the number of contacts per case as an indicator of public health response capacity.

Deleted: supported

Deleted: Any traveller coming through the international border will have an

Deleted: either in the own home or,

Deleted: in a alternative

Deleted: a two week close down on all non essential services be instituted in these three areas

Deleted: <#>Vulnerable people will be strongly directed and supported to undertake home isolation. These include <#>People age 60 or older with one or more chronic diseases including hypertension, diabetes, heart disease and lung disease¶¶ <#>All people age 70 or older¶¶ <#>Aboriginal and Torres Strait Islanders age 50 or older with one or more chronic disease¶¶

Deleted: ology

Deleted: lack

Source: Exhibit HQ10192_RP, draft advice to National Cabinet.

27. It, therefore, appears that, as at 27 March 2020, while the AHPPC recommended enforced quarantine for 'high-risk' cases, the AHPPC did not recommend or advise on an enforced quarantine program for all returned travellers as a way to minimise the growth or spread of COVID-19 cases.
28. This position changed in the months following the implementation of hotel quarantine programs across Australia. On 26 June 2020, the AHPPC published a statement noting that, on the advice of the Communicable Diseases Network Australia (CDNA), the AHPPC considered two options for addressing what it described as, at that time, an increasing risk of COVID-19 in returning travellers:³¹
- reducing the time of quarantine in a hotel for international travellers. This included most spending part of the time in home quarantine
 - continuing the current model of 14-day quarantine in a hotel.

29. The statement noted that, having considered these options, the AHPPC:
- A. considered that there was not enough data to justify reducing the need for hotel quarantine
 - B. recommended that all international travellers continue to undertake 14 days' quarantine in a supervised hotel.
30. Notwithstanding the AHPPC position as at 27 March 2020, Prof. Sutton confirmed he supported the idea of a hotel quarantine facility for all returned travellers at that time.³² His rationale for supporting this idea is discussed below at paragraph 36.
31. Similarly, Dr van Diemen was of the view that mass quarantining of returning travellers was warranted. This was necessarily so, as it was Dr van Diemen who had to consider whether or not to issue the Direction and Detention Notice that gave effect to the National Cabinet's announcement in Victoria.³³

4.3 Factors that influenced support for an enforced quarantine program for all returned travellers in Victoria

32. The evidence of the Premier, Prof. Sutton and Dr van Diemen was that several key factors drove their support for reducing community transmission of COVID-19 via a program of mandatory, mass quarantine for returning travellers:
- A. the continued increase in COVID-19 cases and the associated rising community concern³⁴
 - B. some evidence of recent arrivals to Victoria who were not complying with requirements to self-isolate at home³⁵
 - C. concern about the rising number of COVID-19 cases internationally and the prospect of our hospitals becoming overwhelmed if returning travellers were permitted to self-quarantine.³⁶
33. The Premier gave evidence regarding the factors that influenced his own agreement with the National Cabinet decision:
- A. Firstly, it would make compliance and enforcement an easier task from a policy perspective.³⁷ The Premier's understanding was that there had been instances of non-compliance with the home quarantine direction for returned travellers in place at that time. The Premier considered that the honesty-based system of home quarantine that had existed to that point was too risky, and he had come to a view that quarantining people in a designated facility would reduce the risk.³⁸
 - B. Secondly, the Premier stated that it was not certain, at that time, how many Victorians who had not been overseas might contract the virus. The Government was trying to buy time to prepare the health system and expecting that the situation would unfold as it had in other parts of the world.³⁹ This evidence accords with remarks made by the Premier at a press conference on 28 March 2020, where he stated that the decision was 'appropriate' and that it was more likely to reduce cases in Victoria and flatten the curve.⁴⁰
 - C. Thirdly, the Premier was aware of a decision of the Expenditure Review Committee (ERC) on 20 March 2020 to allocate \$80 million dollars for procuring hotel rooms. This was for an accommodation package to support key workers and provide emergency accommodation to people in need, including what became known as the Hotels for Heroes program.⁴¹ The Premier agreed, in evidence, that his knowledge of this work was key to his view that it would be feasible for Victoria to implement a mandatory quarantine program.⁴²

Continued increase in COVID-19 cases

34. As noted at paragraph 12, the rapid rate of COVID-19 transmission was concerning.
35. Dr van Diemen's evidence was that she had observed, primarily through international experience, that the disease spread rapidly with very high fatality rates.⁴³ Further, with no vaccine and no treatment to mitigate the effects of COVID-19, the virus was observed as being an 'exceedingly significant risk to public health'.⁴⁴
36. It is clear that the concern over rising COVID-19 case numbers had played a significant role in Victoria supporting the idea of an enforced quarantine program.
37. Indeed, in his evidence, Prof. Sutton stated that he, personally, supported the idea of all returned travellers being quarantined in a hotel.⁴⁵ He discussed this view with Dr van Diemen, where the constraints on individual liberties and individual rights of a mandatory quarantine program were balanced against a 'recognition that countries like Italy were going through thousands of cases and were facing a catastrophic epidemic that ultimately killed tens-of-thousands of people in that country ...'.⁴⁶
38. The Premier, by way of explaining why he considered, by late March, that the Airport Arrival Direction of 18 March 2020 was insufficient to mitigate the risks to Victorians, stated 'it was apparent that, if the virus seeded in a Victorian city, there would be no containing it without the imposition of unprecedented measures'.⁴⁷
39. This was in the context of international borders being closed to non-Australian citizens and residents, and anticipation of a significant number of Australians, returning home in light of the pandemic.⁴⁸ The Premier stated that:

In those circumstances, it was anticipated that a significant proportion of returned travellers would already be infected with the virus. That had been shown to have occurred with at least one group of travellers returning to Melbourne from Aspen, in the United States, and in the large number of infected passengers who had disembarked from the Ruby Princess cruise ship in Sydney, on 19 March 2020, and dispersed from there, with the virus, to other parts of Australia.⁴⁹

Evidence of non-compliance with the Self-Isolation Directions

40. The Inquiry heard evidence from Dr van Diemen, the Premier and former Chief Commissioner of Victoria Police, Graham Ashton, that, prior to 27 March 2020, some recent arrivals to Victoria were not strictly complying with the home quarantine requirements imposed on them.
41. As Dr van Diemen recalled, DHHS had observed, through identified cases and subsequent interviews and outbreaks, that people were not adhering to the home isolation requirements. Dr van Diemen noted that DHHS 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 ...'.⁵⁰
42. Mr Ashton also noted, in his evidence, that there were levels of non-compliance, though he did also note that, on many occasions, people were isolating but not at the place where the Australian Border Force thought they would be. Police accordingly adjusted records and data on peoples' actual location.⁵¹

43. Notwithstanding that some people had incorrect location details, there was a level of concern about people not adhering to self-quarantine requirements. Indeed, the Premier noted, in late March, that he was mindful of reports Victoria Police had 'expressed concerns about instances of non-compliance with the Chief Health Officer's direction, including people continuing to breach self-quarantine requirements'.⁵²
44. In this context, it was the evidence of Dr van Diemen that Victoria had a small window to stop the number of virus importations into the community. It was her view that quick action was needed because for 'every introduction of the virus to the community, there was significant amounts of spread being seen'.⁵³
45. Taking into account the continued increase in COVID-19 cases and the information as to recent arrivals to Victoria not complying with requirements to self-isolate at home, there was support for an enforced quarantine program by the Premier, Prof. Sutton and Dr van Diemen. As stated by the Premier:

I went into the National Cabinet meeting on 27 March 2020 with the firm view that, as a policy for stopping large numbers of returned travellers from spreading the virus, self-quarantine posed an unacceptable risk to the Australian community and to Victoria, and it was therefore insufficient.⁵⁴

46. As set out in Section 2 of the Interim Report, on examination during the Inquiry, the evidence of non-compliance with the existing Self-Isolation Directions was not extensive and was set in the context of poor dissemination of information to those who were subject to the Directions. Mr Ashton's media comments from 23 and 26 March 2020 were played in evidence.⁵⁵ They indicated a degree of non-compliance on 23 March 2020, which was observed by 26 March 2020 to be improving as returned travellers gained a better understanding of the requirements.⁵⁶ In his evidence, Mr Ashton said that some people who were, at first, thought to be breaching their Directions, were later found to be self-isolating at a different address.⁵⁷ However, the Premier's view remained that the risk posed by self-isolation at home was too high.⁵⁸
47. Section 2.8 of the Inquiry's Interim Report discusses the evidence of non-compliance during self-quarantine at home. Noting that the evidence of non-compliance with the existing Self-Isolation Directions was not extensive, concerns about non-compliance remain proper and must be addressed. Recommendations 60–67 of the Interim Report, which are now adopted into this Final Report, provide a pathway for managing non-compliance in an optional home-based quarantine model through a thorough risk assessment, clear communication and understanding of the Home Quarantine Directions and consideration of a range of methods for monitoring compliance with home quarantine requirements.

Concern about the rising number of COVID-19 cases internationally and the prospect of hospitals becoming overwhelmed if returning travellers were permitted to self-quarantine

48. The then Secretary of DHHS, Ms Peake, shared the Premier's concern to 'buy time' to prevent Victoria's health system from being overwhelmed.⁵⁹ Ms Peake focused the concern thus:

Our modelling showed that without intervention, at the peak of the pandemic we would have had 10,304 people in hospital and 5,118 ICU admissions. At the time we had 448 staffed ICU beds and the capacity to surge to 2,000 beds across private and public sectors.⁶⁰

49. The State Controller — Health, Andrea Spiteri, expressed a similar sentiment about the prevailing thinking within DHHS at the start of the Hotel Quarantine Program:

It was also at a time where health services themselves were gearing up for a potential influx of patients that might need intensive care. So at that time it was a very different environment, when the program started, to where we were a couple of months later, with the lifting of restrictions in Victoria, with the easing of the potential pressure on health services, and their ability to be able to potentially support into that environment.⁶¹

50. Given contemporary understanding of the situation facing Victoria as at 27 March 2020, such concerns were doubtless reasonably and sincerely held. The prospect that an influx of people needing hospitalisation could overwhelm the health system was unquestionably a legitimate consideration for health authorities and government at that time. Victoria chose to address those concerns with an appropriate response at that time.
51. That said, it leaves open the question of whether there were and currently are other options available either as an alternative to hotel quarantine, or in conjunction with hotel quarantine in some cases.

4.4 Alternatives to hotel quarantine

52. Addressing the option of a home-based quarantine model, as is contained in Section 2 of the Interim Report, is not to be seen as a criticism of the decision taken on 27 March 2020 to respond to the rapidly rising numbers of cases internationally and the risk of returning travellers spreading the virus into the Victorian community. Rather, the recommendations contained in Section 2 of the Interim Report come after having had the ability to examine the actual evidence as to non-compliance and the context in which that arose.
53. It also comes after consideration, not only of that evidence, but also with time to give consideration to the steps available to minimise the risk that those assessed as suitable to quarantine in residential premises will not comply with Directions to do so. Section 2 of the Interim Report discusses what is necessary to address the issues that arose in the evidence including ensuring that people are properly advised of what is required of them together with the penalties for failing to comply and addressing the need for both support and monitoring for compliance.
54. Further, the recommendations also come set in the evidence that the greatest risk has come from transmission events from returned travellers in hotel quarantine to those working at the hotels. This appears to have happened in other states, too.
55. As stated at the outset to this Chapter, this was done in the Interim Report not to criticise the decision that was made **at the time** to abandon the Self-Isolation Directions for quarantining at home but rather to more closely examine, now, what actually happened and to re-assess what can now be considered as a more nuanced and potentially safer approach to quarantining as recommended in the Interim Report.
56. Section 2.7 of the Interim Report contains a summary of the evidence as to the forms of communication that were being used to advise international arrivals by air of their obligations to self-quarantine at that time. As I concluded at paragraph 49 of Section 2.7, this fell 'well short' of what was needed to effectively communicate what each person's legal obligations were as they entered the country. The consequences of non-compliance (particularly in terms of the spread of infection, but also of penalty) required far more direct, personal and reliable communication than such a system provided.
57. Section 2 of the Interim Report and the attached recommendations as to a home quarantine model set out what I have concluded and recommended in this regard.

4.5 Conclusions

58. As at 15 March 2020, Victoria adopted the agreement reached at National Cabinet to make precautionary self-isolation directions to all international arrivals to reduce the risk of community transmission from those potentially carrying the virus in from international locations.
59. At that time, numbers of cases were starting to rise in Australia and in Victoria. By 15 March 2020, Australia had a total of 298 confirmed COVID-19 cases and Victoria had 57 of those cases.
60. The DCHO and other experts were noting that, without effective intervention, those numbers would continue to rise exponentially.
61. By 27 March 2020, there was a total of 3,162 cases in Australia and 574 of those cases were in Victoria. This represented a ten-fold increase in cases in Victoria. Moreover, during this period, there had been an outbreak on the Ruby Princess cruise ship, which had docked in Sydney, with infected passengers allowed to disperse across the nation. This event was linked to 800 cases in Australia.
62. The view of National Cabinet, echoed by the Victorian Premier, was that the majority of cases in the community at that time were linked to the virus coming in via international arrivals.
63. Together with the considerable concern raised in the wake of the Ruby Princess, there was evidence that some returned travellers were not adhering to the requirement to self-isolate at home.
64. Notwithstanding that, as at 27 March 2020, the AHPPC had only recommended enforced quarantine to the National Cabinet for 'high-risk' cases, both the National Cabinet and the Victorian Premier took the decision to direct the mandatory detention of all international arrivals into designated facilities which, in Victoria, were hotels. Both the CHO and the DCHO supported the decision based on the following:
 - A. an exponential increase in COVID-19 cases
 - B. a link between returned travellers and community transmission rates
 - C. perceived rates of non-compliance with Self-Isolation Directions
 - D. perceived inadequacy of the Self-Isolation Directions.
65. As at 27 March 2020, there was a proper and grave concern being expressed about the extent to which Victoria's health system might be overrun by COVID-19. The situation in many countries was already very grave, with substantial rates of infection and serious illness that had caused demand for hospital care to exceed existing medical services.
66. Recommendation 58 of the Interim Report states that, in conjunction with a facility-based model for international arrivals, the Victorian Government should develop the necessary functionality to implement a supported home-based model for those international arrivals assessed as suitable for such an option.
67. Given the physical limitations of hotels as quarantine facilities (as in, they are not designed as such), a major risk of the hotel model is the daily movement of personnel in and out of the facility and then into the communities in which they live. Even in a best practice model, which has dedicated personnel not moving between facilities, clinical and non-clinical personnel are, of necessity, coming in and out of a facility which, by definition, contains potentially infected people.
68. Minimising the number of people working in such environments, by only having those unable to quarantine safely at home, in the facility, reduces this risk of transmission to the broader community.

Endnotes

- 1 Prime Minister, 'Coronavirus Measures Endorsed by National Cabinet' (Media Release 16 March 2020), <<https://www.pm.gov.au/media/coronavirus-measures-endorsed-national-cabinet>>.
- 2 Exhibit HQI0142_RP Voluntary Submission from the Commonwealth of Australia, HQI.0001.0002.0050.
- 3 Exhibit HQI0155_RP Annexures to witness statement of Prof. Brett Sutton, DHS.6000.0066.3880-3882.
- 4 Ibid DHS.6000.0084.0648-0649.
- 5 From 1 July 2019 to 30 June 2020 a penalty unit in Victoria was \$165.22, 120 penalty units were attached to this fine, <<http://www.gazette.vic.gov.au/gazette/Gazettes2019/GG2019G014.pdf>>.
- 6 Exhibit HQI00211_P First witness statement of the Hon. Jenny Mikakos, former MP, 9 [47]; Exhibit HQI0218_P Witness statement of the Hon. Daniel Andrews MP, 8 [39].
- 7 Transcript of day 18 hearing 16 September 2020, 1471-1472.
- 8 Exhibit HQI0157_P Transcript of Prime Minister's Press Conference 27 March 2020, 3.
- 9 Dr Annaliese van Diemen, 'Revocation of Airport Arrivals Direction and Cruise Ship Docking Direction' in Victoria, *Victoria Government Gazette*, No S 167, 30 March 2020, 1 <<http://www.gazette.vic.gov.au/gazette/Gazettes2020/GG2020S167.pdf>>.
- 10 Exhibit HQI0157_P Transcript of Prime Minister's Press Conference 27 March 2020, 5; Premier of Victoria, 'Enforced Quarantine for Returned Travellers to Combat Coronavirus', (Media Statement 27 March 2020) <<https://www.premier.vic.gov.au/sites/default/files/2020-04/200327-Enforced-Quarantine-For-Returned-Travellers-To-Combat-Coronavirus-1.pdf>>.
- 11 World Health Organization, 'Coronavirus disease 2019 (COVID-19) Situation Report 51' (Situation Report, 11 March 2020) 1 <https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200311-sitrep-51-covid-19.pdf?sfvrsn=1ba62e57_10>; Department of Health, 'COVID-19 current situation and case numbers: daily reported cases' (Web page), <<https://www.health.gov.au/news/health-alerts/novel-coronavirus-2019-ncov-health-alert/coronavirus-covid-19-current-situation-and-case-numbers#daily-reported-cases>>.
- 12 Transcript of day 18 hearing 16 September 2020, 1536-1537.
- 13 Ibid 1537.
- 14 Prime Minister, Minister for Health, Chief Medical Officer, 'Advice on Coronavirus' (Media Release, 13 March 2020) <<https://www.pm.gov.au/media/advice-coronavirus>>.
- 15 Prime Minister, 'Coronavirus Measures Endorsed by National Cabinet' (Media Release, 16 March 2020) <<https://www.pm.gov.au/media/coronavirus-measures-endorsed-national-cabinet>>.
- 16 Department of Health 'COVID-19 current situation and case numbers: daily reported cases' (Web page) <<https://www.health.gov.au/news/health-alerts/novel-coronavirus-2019-ncov-health-alert/coronavirus-covid-19-current-situation-and-case-numbers#daily-reported-cases>>; Department of Health and Human Services 'More COVID-19 cases confirmed in Victoria' (Media Release 15 March 2020) <<https://www2.health.vic.gov.au/about/media-centre/MediaReleases/more-covid19-cases-confirmed-victoria-15-march>>.
- 17 Department of Health 'COVID-19 current situation and case numbers: daily reported cases' (Web page) <<https://www.health.gov.au/news/health-alerts/novel-coronavirus-2019-ncov-health-alert/coronavirus-covid-19-current-situation-and-case-numbers#daily-reported-cases>>; Department of Health and Human Services 'Coronavirus update for Victoria' (Media Release 27 March 2020) <<https://www.dhhs.vic.gov.au/coronavirus-update-victoria-27-march-2020>>.
- 18 Special Commission of Inquiry into the Ruby Princess, 'Report of the Special Commission of Inquiry into the Ruby Princess' (Report, 14 August 2020) 265 [14.1] <<https://www.dpc.nsw.gov.au/assets/dpc-nsw-gov-au/publications/The-Special-Commission-of-Inquiry-into-the-Ruby-Princess-Listing-1628/Report-of-the-Special-Commission-of-Inquiry-into-the-Ruby-Princess.pdf>>.
- 19 Ibid 252-256 [13.21]-[13.43], 263 [13.64]-[13.65], 265 [14.2], 265 [14.4], 267 [14.10] <<https://www.dpc.nsw.gov.au/assets/dpc-nsw-gov-au/publications/The-Special-Commission-of-Inquiry-into-the-Ruby-Princess-Listing-1628/Report-of-the-Special-Commission-of-Inquiry-into-the-Ruby-Princess.pdf>>. The Ruby Princess Report notes that, of the 1,682 Australian passengers, there were 663 cases, and an additional 62 reported secondary and tertiary cases in Australia. Further, the Report notes of the Tasmanian outbreak, at the North West Regional Hospital, that the original source of the 138 cases (as at August 2020) was due to one or both of two inpatients who had acquired COVID-19 on the Ruby Princess.
- 20 Prime Minister, 'Update on Coronavirus measures' (Media Release 27 March 2020) <<https://www.pm.gov.au/media/update-coronavirus-measures-270320>>.
- 21 Premier of Victoria, 'Enforced Quarantine for Returned Travellers to Combat Coronavirus', (Media Statement 27 March 2020), <<https://www.premier.vic.gov.au/sites/default/files/2020-04/200327-Enforced-Quarantine-For-Returned-Travellers-To-Combat-Coronavirus-1.pdf>>.

- 22 Exhibit HQI0218_P Witness statement of the Hon. Daniel Andrews MP, [18]-[24] and [29].
- 23 Exhibit HQI0157_P Transcript of Prime Minister's Press Conference 27 March 2020, 12.
- 24 Prime Minister, 'Advice on Coronavirus' (Media Release 13 March 2020) <<https://www.pm.gov.au/media/advice-coronavirus>>.
- 25 Transcript of day 18 hearing 16 September 2020, 1476-1477; Exhibit HQI0153_RP Witness statement Prof. Brett Sutton, 32 [176]-[177].
- 26 Exhibit HQI0153_RP Witness statement Prof. Brett Sutton, 32 [178].
- 27 Ibid [176].
- 28 Exhibit HQI0218_P Witness statement of the Hon. Daniel Andrews MP, 3 [13].
- 29 Exhibit HQI0192_RP DHHS draft advice to National Cabinet; Transcript of day 22 hearings 22 September 2020, 1891.
- 30 Exhibit HQI0218_P Witness statement of the Hon. Daniel Andrews MP, 3 [13].
- 31 AHPPC, Australian Health Protection Principal Committee (AHPPC) statement on hotel quarantine (News Release, 26 June 2020) <<https://www.health.gov.au/news/australian-health-protection-principal-committee-ahppc-statement-on-hotel-quarantine>>.
- 32 Transcript of day 18 hearing 16 September 2020, 1477-1478.
- 33 Exhibit HQI0160_P Witness Statement of Dr Annaliese van Diemen, 7-8 [34]-[37].
- 34 Transcript of day 18 hearing 16 September 2020, 1481, 1536; Exhibit HQI0160_P Witness statement of Dr Annaliese van Diemen, 8 [36]-[37].
- 35 Transcript of day 18 hearing 16 September 2020, 1537; Exhibit HQI0218_P Witness statement of the Hon. Daniel Andrews MP, 5 [24].
- 36 Transcript of day 18 hearing 16 September 2020, 1536-1537; Exhibit HQI0218_P Witness statement of the Hon. Daniel Andrews MP, 4 [17] [20].
- 37 Transcript of day 25 hearing 25 September 2020, 2133.
- 38 Ibid 2188; 2133.
- 39 Ibid 2133.
- 40 Premier of Victoria, 'Victorian Premier Daniel Andrews Update on Cases' (Press Conference, 28 March 2020) <<https://www.theage.com.au/national/victoria/victoria-records-biggest-jump-in-virus-cases-as-on-the-spot-fines-introduced-20200328-p54erz.html>>.
- 41 Transcript of day 25 hearing 25 September 2020, 2122.
- 42 Ibid 2127.
- 43 Transcript of day 18 hearing 16 September 2020, 1536.
- 44 Ibid.
- 45 Ibid 1478.
- 46 Ibid.
- 47 Exhibit HQI0218_P Witness statement of the Hon. Daniel Andrews MP, 5 [21].
- 48 Ibid 4 [19].
- 49 Ibid [20].
- 50 Transcript of day 18 hearing 16 September 2020, 1537.
- 51 Transcript of day 19 hearing 17 September 2020, 1681.
- 52 Exhibit HQI0218_P Witness statement of the Hon. Daniel Andrews MP, 5 [23].
- 53 Transcript of day 18 hearing 16 September 2020, 1537.
- 54 Exhibit HQI0218_P Witness statement of the Hon. Daniel Andrews MP, 5 [24].
- 55 Transcript of day 25 hearing 25 September 2020, 2118-2120.
- 56 Exhibit HQI0220_P Transcript of press conference by the Hon. Daniel Andrews MP, HQI.0001.0033.0028; Exhibit HQI0221_P Transcript of press conference by former Chief Commissioner Graham Ashton, HQI.0001.0033.0067.
- 57 Transcript of day 19 hearing 17 September 2020, 1681.
- 58 Transcript of day 25 hearing 25 September 2020, 2133.
- 59 Exhibit HQI0218_P Witness statement of the Hon. Daniel Andrews MP, 5 [22].
- 60 Exhibit HQI0188_RP Second witness statement of Ms Kym Peake, 11 [30].
- 61 Transcript of day 19 hearing 17 September 2020, 1602.

CHAPTER 5

'The day was measured in minutes'

5.1 The first 72 hours of the Hotel Quarantine Program from 27–29 March 2020

1. As a consequence of there being no plan for the large-scale detention of international arrivals into a mandatory quarantine program when the National Cabinet decision was announced, those who would have to implement the program in Victoria had to do so without warning and without any available blueprint for what was required. The situation was further complicated by the fact that the decision would come into effect just 36 hours later, at 11.59pm on 28 March 2020.
2. At the Prime Minister's press conference on 27 March 2020, it was made clear that the arrangements were to be implemented by the state and territory governments, with the cost to be borne by them. It was announced that there would be support from the Australian Border Force (ABF) and the Australian Defence Force (ADF), but that was said to be a matter being worked on between those agencies and the Department of Prime Minister and Cabinet (DPC) with the state and territory jurisdictions 'to ensure they can get the measures in place'.¹
3. When asked about the scale and number of people who would require quarantine, the Prime Minister said there had been 7,120 arrivals at airports around the country the day before, and that '(t)he number of arrivals now are at a level which the states and territories believe means they are able to practically implement these types of arrangements'.²
4. In response to a question about the level of restrictions more generally, the Prime Minister said:

The decisions that I communicate from this podium are the decisions of all Premiers, Chief Ministers and myself. This is not some personal view of mine; these are the decisions of the National Cabinet based on the medical expert advice that we receive in terms of the restrictions that are necessary to deal with the management of the outbreak of the virus in Australia.³
5. As a member of the National Cabinet, the Premier of Victoria, the Hon. Daniel Andrews MP, was a party to the decision and committed Victoria to its implementation. He agreed, in evidence, that he did so, on the basis of very limited information or pre-planning for such a program.⁴ He was aware that there was no pre-existing plan for large-scale quarantine in Victoria.⁵ There had been no discussion in the Victorian Cabinet about the prospect of such a wide-scale quarantine program being put in place.⁶
6. The Premier, had only had a short period of notice of the possibility a quarantine program would be established. Prior to the National Cabinet meeting, he had received a briefing from DPC.⁷ It outlined the possibility of a recommendation that all travellers self-isolate in hotels, rather than at home, if the household had more than one person.⁸

7. The Premier had also been provided with a written advice from the Australian Health Protection Principal Committee (AHPPC),⁹ which included a recommendation that consideration be given by National Cabinet to requiring people to quarantine away from home in high-risk cases where those people would normally reside with others at home.¹⁰ This was the recommendation to which then Commonwealth Chief Medical Officer, Professor Brendan Murphy, referred in his press conference with the Prime Minister. The Premier stated, in evidence, that while he did not know what the AHPPC regarded as 'high-risk' cases, his own view was that high-risk cases would mean travellers returning from countries with little or no public health response.¹¹
8. There was clear evidence that returned travellers posed a serious risk of carrying the virus into this State. It was proper for the Premier to have regard for the need to take all actions necessary to minimise the risk of community transmission as identified in Chapter 4.
9. On the question of the power to enforce quarantine, the Premier said in his evidence that he made an assumption at that time that the powers to be used were those in the *Public Health and Wellbeing Act 2008 (Vic)* (PHW Act), which were already being used to issue directions to returned travellers to isolate at home. He did not consider who was going to monitor compliance with the directions. It was his evidence that this was not a matter to which he would ordinarily turn his mind.¹²
10. With nothing more known to him beyond the availability of hotel rooms and a sense of what the detention power would be, the Premier was of the view that it was feasible to set up the program in the time allowed.¹³

... it seemed to me that a dedicated team of people at that very much operational level ... would be able to do as they had done many times before, they could rise to a challenge like this and that they would be able to stand the system up within the timeframe.¹⁴

Assumption of risk

11. In committing Victoria to the implementation of the National Cabinet decision, the Premier had committed the Victorian Government to assuming responsibility for managing the COVID-19 risk posed by returned travellers and ensuring compliance with the mandatory detention orders. What had, until that time, been a system in which returned travellers were directed to self-isolate at home was now to be a system in which the government assumed responsibility for the quarantine of, and the prevention of transmission by, returned travellers.
12. The Department of Health and Human Services (DHHS) submitted that it was returning travellers potentially carrying the virus that created the risk and the Government had to make a decision about how best to manage that risk. DHHS submitted that the Chief Health Officer (CHO) and Deputy Chief Health Officer (DCHO) considered the competing risks of the continuing Self-Isolation Directions for returning travellers versus those involved in the hotel quarantine option and agreed on the latter.¹⁵ As noted in Chapter 4, no criticism is made of that decision. However, by directing the mandatory detention of returning travellers into the Hotel Quarantine Program, the government became responsible for the proper functioning of the Program. That is, in deciding to compel people into facilities it had selected for that purpose, the government took on the management of the risk inherent in doing so. The Premier agreed in evidence that the government was responsible for such risk.¹⁶ (This issue of risk is discussed further in chapters 6 and 7.)

13. This included an assumption of responsibility for identifying and planning for the following:
 - A. ensuring that quarantine would be enforced by requiring people to stay in a particular place¹⁷
 - B. managing the risk posed by infection in the quarantine setting¹⁸
 - C. ensuring that people were at least as safe in the hotels as they would have been at home¹⁹
 - D. ensuring that the community was at least as protected from infection risk as it would have been were returning travellers quarantining at home²⁰
 - E. the risk that the workers in the quarantine program might be exposed to infection.²¹
14. The Premier said that he thought he was aware of how large a task it would be to set up the Program when he agreed to it at National Cabinet and formed a view that it was an appropriate process for Victoria. However, while the Premier had a sense of how many travellers may return and that there was sufficient stock of hotel rooms, he could not say, in his evidence, whether he would have turned his mind to these risks that were, as a consequence, assumed by his government. The effect of his evidence was that he would have left the risk mitigations to those at an operational level.²²
15. I accept this evidence. The decision to embark on the Hotel Quarantine Program in Victoria was made by the Premier without any detailed consideration of the risks that such a program would entail. The risk from the spread of COVID-19 to the community from returned travellers was the only risk considered, and the assessment that that risk was too high to be managed with home-based self-isolation was the only analysis done before the decision was made. No consideration was given to the risks that such a program would, itself, create. The evidence was that those risks were considerable.

Complex logistical arrangements made within 36 hours

16. The Premier agreed, in evidence, that it was a very substantial logistical undertaking to stand up such a complicated program within that timeframe. He rightly described it as 'an unprecedented set of circumstances'.²³
17. No one who was subsequently involved in the initial decision-making or planning that took place during the first 36 hours questioned whether it could be done. Yet, throughout the course of the public hearings, various witnesses spoke about the challenges that arose from the fact that there was no 'off-the-shelf' plan or blueprint of any sort for mass quarantine, let alone in a hotel setting.²⁴
18. The Program was a complex logistical operation. It was known from the beginning that it would have to cater for thousands of returned travellers. To do so, it would require a workforce of thousands of people because the Program needed to run 24 hours per day, seven days per week for an indeterminate amount of time and accommodate an indeterminate number of people.
19. This unprecedented and complex logistical operation was being designed to serve a primary purpose — preventing the further spread of a deadly virus into the Victorian community. It was, therefore, an operation designed to protect public health.
20. There was no question that many people worked extraordinarily hard to give effect to the National Cabinet decision by the deadline given to them. Their planning and design for the Program was necessarily developed in haste and from 'scratch'. Significant decisions were made between the time of the National Cabinet resolution and the first arrivals into the Program on 29 March 2020. They were made under pressure and with limited information. They were often made on the basis of assumptions about how the Program would work as there was no model or plan. In many cases, those early decisions set the course for the Program and, ultimately, its failure to prevent the spread of the virus from returned travellers to the community.

21. Understanding the reasons for those decisions and the ones made subsequently has been the core work of the Inquiry. If lessons are to be learned for the future, those decisions need to be understood and evaluated, and that process must commence with trying to account for what occurred in those 36 hours from the Premier's commitment to the National Cabinet decision up to midnight on 28 March 2020. Ultimately, it can be observed that the extraordinary pressure placed on individuals and the unprecedented nature of what they were trying to achieve explains some, but not all, of what occurred.

5.2 The initial set-up of the Hotel Quarantine Program

A dual purpose

22. Following the press conference by the Prime Minister on 27 March 2020, the Premier held his own press conference at 3.00pm that same day to address the National Cabinet decision.²⁵
23. The remarks made by the Premier, and the corresponding media release, provide a contemporaneous account of the public position of the Victorian Government regarding the development of the Hotel Quarantine Program at that time, as well as its intended purpose. The media release was in the following terms:

Following agreement by the National Cabinet, all travellers returning from overseas to Victoria will be placed in enforced quarantine for a self-isolation period of 14 days to slow the spread of coronavirus.

While Victoria has seen some community transmission of this virus, most cases have been the result of travellers returning from overseas who then pass it onto their close contacts.

To ensure this no longer happens, National Cabinet has agreed that all states and territories will put in place enforced quarantine measures.

This will see returned travellers housed in hotels, motels, caravan parks, and student accommodation for their 14-day self-isolation period.

These measures will not only help slow the spread of coronavirus, they will also support hospitality workers who are facing significant challenges during this time.

The new measures will be operational from 11.59pm on Saturday 28 March, with the Victorian Government already securing 5000 hotel rooms.

We will try to accommodate returned travellers close to their homes, but in some instances that may not be possible. Each person will also receive self-isolation care packages of food and other essentials.

The costs of accommodation, public health and security will be covered by each individual jurisdiction, and there will be reciprocal arrangements in place to house the residents of other states and territories.

It has also been agreed that the Australian Defence Force will be engaged to support the implementation of these arrangements.

The Victorian Government is working closely with the Australian Hotels Association and other organisations so all returned travellers can be housed safely and securely.

As we take this extra step to slow the spread of coronavirus, our message to every other Victorian remains the same: Stay at home, protect our health system, save lives.

If you can stay home, you must stay home.

If you don't, people will die.²⁶

24. The Hotel Quarantine Program was regarded by the Victorian Government as a necessary and justified risk mitigation strategy in order to prevent spread in the transmission of COVID-19. The message of the Premier echoed the sentiments expressed by the Prime Minister — the purpose of the Program was to save lives.
25. However, the Hotel Quarantine Program also served a dual purpose. This was remarked upon by the Premier during his press conference when he stated that it was 'not just about an appropriate health response. It's also ... about working for Victoria and re-purposing people who have perhaps had their hours cut ...'²⁷ The dual purpose was again reiterated by the Premier at his press conference the following day, 28 March 2020.²⁸
26. Contemporaneous submissions later made to the Crisis Council of Cabinet (CCC) also refer to these dual objectives of the Program, being the protection of public health and the need to support the viability of the tourism and accommodation industry.²⁹ I note the CCC was established on 3 April 2020 and tasked with determining 'all significant matters of policy, administration, budget and legislation required to respond to the COVID-19 pandemic crisis'.³⁰ The CCC is discussed further in Chapter 8.
27. The Premier agreed in his evidence that there was a perceived economic benefit from the Program that was in addition to the stated public health objective. Hotels were largely empty and this was a chance to use them. However, his evidence was that this was a secondary consideration to the public health objective,³¹ which was the principal objective.³²
28. I accept that the Hotel Quarantine Program was created in response to the perceived risk posed by returning travellers and not, in the first instance, as an economic stimulus package. I note that the Victorian Government had been intending to support the accommodation industry even before 27 March 2020, through the \$80 million allocation to the Department of Jobs, Precincts and Regions (DJPR) for use in securing hotel rooms. The opportunity to support sectors that were profoundly affected by COVID-19-related restrictions was seen by government as a substantial benefit of a hotel-based model. As the Premier agreed in evidence, a home-based quarantine model would not have had those economic benefits.³³

5.3 DJPR becomes the lead department

29. Chris Eccles AO, the then Secretary of DPC, was present with the Premier at the National Cabinet meeting on 27 March 2020. Just before 12.20pm, having become aware of the impending decision regarding mandatory quarantine, Mr Eccles stepped out to make a telephone call to Simon Phemister, the Secretary of DJPR.³⁴
30. Mr Eccles told Mr Phemister about the National Cabinet decision. It was during this call that Mr Phemister first became aware of the plan to quarantine returning travellers. Mr Phemister had no prior warning that there was going to be a Hotel Quarantine Program or that his Department would be called upon to implement it.³⁵

31. According to Mr Eccles, the purpose of the call was to discuss with Mr Phemister the need for hotels, and for people with deep logistical experience, for the Program.³⁶ According to Mr Eccles, he called Mr Phemister before anyone else because his most urgent concern was to ensure that accommodation arrangements were put in place.³⁷
32. Mr Eccles gave evidence that he had no awareness, prior to 27 March 2020, of any plans for enforced quarantine measures but, like the Premier, he was aware that funding had been approved on 20 March 2020 for the COVID-19 Emergency Accommodation Assistance Program (CEA) Program, which included what became known as the Hotels for Heroes program.³⁸ The CEA Program was being designed, as part of the Victorian COVID-19 pandemic response, to provide support for the self-isolation of certain groups of individuals who could not self-isolate at home.³⁹ This was part of the \$80 million program referred to at paragraph 28. Mr Eccles had no immediate recollection that, at the time, he knew of the services that had been procured for the CEA Program, but he did know that DJPR had been sourcing hotel rooms as part of it.⁴⁰
33. Mr Eccles gave evidence that, at the time of this phone call, his focus was fixed on the imperative to source hotel rooms and he did not give any greater consideration to the architecture of the Program or how it would be implemented.⁴¹ The message from him to Mr Phemister at this time was to 'get on with it',⁴² but he also gave evidence that the purpose of the call to Mr Phemister was not to commission the whole Hotel Quarantine Program.⁴³
34. Mr Phemister described the call as short.⁴⁴ Telephone records reveal it lasted for six minutes and one second.⁴⁵ Mr Phemister viewed its purpose as giving him a head start to check the number of hotel rooms available and whether it was 'doable' to have hotel stock available 36 hours later.⁴⁶ Mr Phemister told Mr Eccles that he was confident that around 5,000 rooms would be available. Mr Phemister knew this from the work of DJPR sourcing hotel rooms for the CEA Program.⁴⁷
35. At odds with the evidence of Mr Eccles, by the end of that call Mr Phemister understood that he and his Department were in charge of the Program 'from end-to-end', meaning that DJPR was to lead the Hotel Quarantine Program.⁴⁸ Even if it was not intended by Mr Eccles, the effect of his phone call was that DJPR understood it was commissioned to plan and implement the Hotel Quarantine Program. The evidence demonstrates that Mr Phemister set to work in the immediate wake of that call, consistent with his understanding that he was responsible for the set-up of a significant governmental program.
36. After the discussion with Mr Eccles, Mr Phemister understood it was his role to immediately start planning for all contingencies. He planned to put together an end-to-end program of work to support the operation but said, in evidence, that he immediately acknowledged in his own mind that he would be deferring to experts on many matters.⁴⁹ As Secretary of DJPR, he was aware that, in many respects, his Department did not have the requisite expertise to plan and implement the Hotel Quarantine Program beyond some necessary logistical capability.⁵⁰
37. The conversation between Mr Eccles and Mr Phemister was the beginning of a quarantine program in which only hotels were ever seriously considered as locations for the detainment of returned travellers.
38. When the National Cabinet decision was announced, the Prime Minister stated that it was a matter for each state and territory to decide the nature of the 'designated facilities' that were to be used to house returned travellers.⁵¹ He did, however, use the specific example of a hotel at the press conference.⁵² The option to use hotels had also formed part of the AHPPC advice to National Cabinet regarding the potential quarantine of 'high-risk' people.⁵³ Beyond that evidence, I can make no findings about what, if any, discussions took place at National Cabinet about the use of hotels specifically.
39. Suffice to say, hotels were certainly the option to which the Premier immediately turned his mind when deciding if it was feasible to implement quarantine for returned travellers by the deadline. This was not surprising in light of the Premier's awareness that there was a CEA Program being funded to source hotel rooms from 20 March 2020.⁵⁴ He agreed in his evidence that he made that assumption.⁵⁵

40. The work done by DJPR was known to Mr Eccles and was one of the main reasons for his call to Mr Phemister.⁵⁶ By contacting Mr Phemister regarding the available hotel stock that had been sourced by DJPR and indicating to Mr Phemister that he should [or that DJPR should] get on with making the arrangements to engage hotels, the decision regarding the appropriate 'detention facilities' in Victoria was effectively made at the time of the phone call.
41. By the time of the Premier's press conference at around 3.00pm, only hotels were mentioned in association with the National Cabinet decision.⁵⁷ While the associated media release still mentioned the possibility of more varied accommodation being used⁵⁸ and the Premier gave evidence that, to his mind, the use of hotels was not finally settled until the time of his press conference the following day,⁵⁹ there was no evidence from the moment Mr Eccles spoke to Mr Phemister that any other option was considered for the 'designated facilities'.
42. It was logical, at the time, that the initial work that had been done by DJPR for the CEA Program would be used to implement the National Cabinet decision. However, the Hotel Quarantine Program was, in fact, a substantially different undertaking to the CEA Program. Most importantly, the enforced quarantine of travellers required the mandatory detention of returned travellers who would number in the thousands. This aspect of the Program, and the implications arising from it, was plainly not something that had formed part of the previous planning by DJPR. In fact, other than the bare sourcing of numbers of available hotel stock, DJPR had done little preparation that was of relevance to an enforced quarantine program. The capability and capacity of the hotels, in terms of the provision of security, cleaning and catering, had not been a factor at that time,⁶⁰ nor had the capacity of the hotels to accommodate large numbers of people in a manner that would prevent transmission of COVID-19 to the community.
43. From the time of that phone call between Mr Eccles and Mr Phemister, there was no indication in the evidence that the decision to use hotels as designated facilities was subsequently revisited by anyone during the initial planning stages or that any assessment was made to determine if the purpose of the Program could actually be met using a hotel setting, and on such a large scale.
44. The suitability of hotels and their contracting and set-up arrangements is dealt with at length in Chapter 7.

The early context of decisions made by DJPR and DHHS

45. At 12.35pm, immediately after the phone call with Mr Eccles, Mr Phemister held a meeting with team members from DJPR to draft the 'end-to-end' plan of the operation.⁶¹ Mr Phemister envisaged the operation as encompassing a chain of custody of the passengers through the quarantine program from the time they returned to Australia to the time they left quarantine.⁶²
46. Claire Febey, Executive Director, Priority Projects Unit, DJPR, was allocated to lead the end-to-end response and this was Ms Febey's understanding of her role from the outset.⁶³ Mr Phemister selected Ms Febey because he considered her to be a highly trusted leader with experience managing large operations through previous roles in the not-for-profit sector.⁶⁴ He described Ms Febey as an 'excellent systems thinker' and someone who could put together different phases of large-scale operations and solve large-scale problems.⁶⁵
47. Ms Febey and her team started work immediately. The record of messages they exchanged throughout the day on 27 March 2020 demonstrates the range of tasks they identified and the connections they were making with other relevant departments in the first few hours of planning.⁶⁶
48. Mr Phemister allocated the task of procuring hotels to Unni Menon, Executive Director, Aviation Strategy and Services, DJPR.⁶⁷ Mr Menon had already been working on the CEA Program, sourcing available hotel stock in consultation with the hotel accommodation sector.⁶⁸ Mr Menon set about adapting that work to the new DJPR hotel quarantine operation. The Crown Promenade and Crown Metropal were the initial hotels used on 29 March 2020 when the first returned travellers arrived.⁶⁹

49. Later that night, and in circumstances that will be reviewed later in this Report in Chapter 6, the function of sourcing private security firms was tasked to Alex Kamenev, Deputy Secretary, DJPR, who delegated it to Mr Menon and other DJPR executives, who then further delegated the task to Katrina Currie, Executive Director, Employment Outcomes, DJPR.⁷⁰ Ms Currie was on secondment to Working for Victoria, a program that was established to support people who had been impacted by COVID-19 and who had lost their employment.⁷¹ Ms Currie made contact by Saturday morning with two security companies and one of them, Unified Security Group (Australia) Pty Ltd (Unified), provided guards on the Sunday morning at the Crown hotels.⁷²
50. Mr Phemister said, in evidence, that from the moment he understood his department to be leading the operation, 'the day was measured in minutes, not hours'.⁷³ Staffing appointments were made quickly and the various staff members gave evidence regarding the detail of their actions and decision-making, which will largely be dealt with in subsequent chapters (particularly chapters 6 and 7).
51. By midnight on 27 March 2020, Mr Phemister and his DJPR team had produced a *Journey Map and Action Plan* for the entirety of the Hotel Quarantine Program.⁷⁴ The plan designated who was responsible for anticipated actions within the Program.⁷⁵ There were many gaps, but the document richly demonstrates the complexity of the Program and the breadth of expertise required at different phases. It was more detailed than the first iteration of what became the Operation Soteria plan, produced the same day by the State Control Centre (SCC).⁷⁶
52. At some stage during the afternoon, Mr Phemister informed the Minister for Jobs, Innovation and Trade, the Hon. Martin Pakula MP, about the decision and the role assumed by DJPR to lead the Program.⁷⁷
53. Prior to 27 March 2020, Minister Pakula was not aware of any plan to quarantine international arrivals.⁷⁸ He said, in evidence, that he first became aware of the Hotel Quarantine Program during a phone call with Mr Phemister on the afternoon of 27 March 2020.⁷⁹ He did not believe he received any notification about the Program from the Premier or the Premier's office on that day.⁸⁰
54. According to Minister Pakula, Mr Phemister told him that DJPR would be 'in charge' of the Program.⁸¹ From the Minister's perspective, he thought the allocation was the logical consequence of DJPR already working to acquire hotel rooms.⁸² He did not believe that it was unusual that he was receiving this information from his Secretary rather than from the Premier's office.⁸³
55. The Minister for Police and Emergency Services, the Hon. Lisa Neville MP, had learned of the proposed program from the Premier's Chief of Staff in a telephone call at 1.39pm on 27 March 2020.⁸⁴ She was told that DJPR would be responsible for standing up the Program.⁸⁵
56. Soon after learning of the Program and of what he understood to be his role in it, Mr Phemister spoke to Kym Peake, the then Secretary of DHHS.⁸⁶
57. Mr Phemister said that he knew that DHHS would be relied upon across all phases of the operation for advice, if not direct control, because he regarded the quarantine operation as primarily a health operation. He stated it was for that reason he made early contact with Ms Peake. He said that, at the beginning of his involvement, he had not contemplated exactly what all the phases would look like.⁸⁷
58. When Mr Phemister spoke to Ms Peake, she was already aware of the National Cabinet decision. Ms Peake was first told about the decision by Kate Houghton, a Deputy Secretary at DPC, after the National Cabinet meeting.⁸⁸ Ms Peake had no prior knowledge that there was going to be a Hotel Quarantine Program implemented in Victoria.⁸⁹
59. Ms Peake's evidence was that she believed that Mr Phemister understood that DJPR had been commissioned to be the lead agency for the stand-up of hotel quarantine.⁹⁰ She said that she believed that Mr Phemister initially envisaged that the Program would be run by DJPR.⁹¹ Ms Peake, as the head of DHHS, did not question that DJPR, a department with no medical or public health expertise, was leading a program of large-scale mandatory quarantine with the primary purpose of preventing transmission of COVID-19. At this stage, there is no evidence that Ms Peake raised any concern or view that her own department, DHHS, ought to be in charge.

60. According to the evidence of Mr Phemister, in all early planning by DJPR, DHHS was regarded as responsible for health and wellbeing, and for crafting the legal framework within which the mandatory quarantine of returned travellers would occur.⁹² As a result, legal advice was being sought from within DHHS and from external counsel to facilitate the detention arrangements.⁹³ DHHS still played no role in the logistical planning and contracting efforts being undertaken by DJPR at that point, but it did commence making its own arrangements with private medical contractors, including General Practitioners (GPs) and nursing agency staff.⁹⁴

Victorian Secretaries Board meeting — 27 March 2020

61. The Inquiry was told that formal debriefs by all department secretaries about National Cabinet decisions have occurred on occasion at meetings of the Victorian Secretaries Board (VSB).⁹⁵ The VSB is a forum of all department secretaries, the Police Commissioner and the Victorian Public Sector Commissioner. It is a meeting convened about the 'stewardship' of the public service.⁹⁶ Decisions of the VSB are limited to that stewardship function and not matters that are either operational or policy orientated.⁹⁷
62. A VSB meeting occurred at 4.00pm on 27 March 2020.⁹⁸ There was discussion during the meeting about the Hotel Quarantine Program, with all the departmental secretaries present, relevantly including Mr Eccles, Mr Phemister, Ms Peake, Secretary of the Department of Justice and Community Safety (DJCS) Rebecca Falkingham, and then Chief Commissioner of Police (CCP) Graham Ashton.
63. Mr Eccles gave evidence that the VSB made no decision at this meeting about where accountability or responsibility should sit as between departments for the Hotel Quarantine Program.⁹⁹ Mr Eccles also said that it was here that it was first conceptualised that the SCC would play the dominant role in the Program using the legislated Victorian emergency management framework.¹⁰⁰ It was also, he said, when he first turned his own mind to what the Program would be.
64. Notes from the VSB meeting on 27 March 2020 were tendered into evidence.¹⁰¹ Indeed, as this meeting was occurring, a planning meeting was already taking place inside the SCC, convened by Emergency Management Commissioner (Commissioner) Andrew Crisp and attended by representatives of multiple departments.¹⁰²

State Control Centre

65. The SCC is the Victorian operations centre for emergencies. It does not belong to a particular agency; it is a facility. The SCC may be used at the discretion of the control agency for 'Class 2 emergencies' to bring various agencies together.¹⁰³ The classification of, and response to, emergencies are matters that are dealt with in detail in Chapter 8.
66. The COVID-19 pandemic was a 'health emergency' and therefore a Class 2 emergency under the legislated Victorian emergency management framework.¹⁰⁴ Under that same framework, DHHS was the control agency for the health emergency.¹⁰⁵
67. The SCC had been stood up in early March 2020 at the request of DHHS in relation to the pandemic.¹⁰⁶ It was through that framework that the Victorian Government's response to the COVID-19 pandemic more generally had been occurring. The emergency management framework, and the understanding of it by the various decision-makers involved in the Program, is also considered in detail in Chapter 8.

68. Ms Peake gave evidence that it was at the VSB meeting that it was agreed the SCC would be the architecture through which the detailed planning for the Hotel Quarantine Program would occur.¹⁰⁷ As noted, in fact, a planning meeting at the SCC was taking place even as the VSB discussed the Program. However, it does not seem that anyone at the VSB meeting thought that DHHS should be running the Program as part of its responsibility as the control agency for the COVID-19 health emergency.
69. Throughout the afternoon and evening of 27 March 2020, Mr Phemister remained of the understanding that DJPR was running the Program announced by the Premier.¹⁰⁸ He came to the VSB with that belief in place and that remained his understanding at the end of the meeting.¹⁰⁹ The content and tenor of the notes of the VSB meeting suggest that this would have been apparent to others who were at the meeting. Mr Eccles, although he had no memory of the meeting, agreed the notes suggested Mr Phemister understood or was speaking about being in charge of developing the Program at the time.¹¹⁰ There was no suggestion that anyone challenged Mr Phemister's understanding or that Ms Peake or anyone else suggested that DHHS should take the lead under the emergency management framework or otherwise.
70. Ms Peake understood that, under the emergency management arrangements, DHHS was the control agency for any health emergency.¹¹¹ The VSB meeting confirmed that DHHS had the lead responsibility for developing legal directions in order to enforce mandatory quarantine of returned travellers.¹¹² At that point in time, Mr Phemister did not know what the source of power was going to be to detain people.¹¹³ In his evidence, he stated that this caused some difficulties setting up the Program due to having to plan for a number of contingencies regarding an enforcement model.¹¹⁴ I note that the Premier had assumed that the PHW Act would be used, but the details of how the powers in that Act would be used were not finalised until late the following day.¹¹⁵
71. Ms Peake said that the reason for the decision to use the SCC for the overarching structure of the Program was because it was a really critical intervention to deal with the threat of COVID-19; it had the characteristic of requiring a multiagency response and it needed to be stood up incredibly quickly because of the threat.¹¹⁶ This was uncontroversial. The SCC was a resource that was available to the control agency that was responding to an emergency and, indeed, DHHS was already using the facility for its more general response to the pandemic.
72. When Mr Eccles first spoke to Mr Phemister and asked him to 'get on with' planning for mandatory quarantine using hotels, he had not turned his mind to the emergency management architecture or the nature of the Class 2 emergency.¹¹⁷ Nor did he turn his mind to calling Ms Peake from DHHS. In his evidence, he stated that this was because his:
- ... immediate interest was in activating an extensive external facing logistics process as opposed to activating a process internal to Government — which was the activation of the EM [emergency management] arrangements under which DHHS was the control agency.¹¹⁸
73. The meeting at the SCC was attended by representatives from DJPR, including Ms Febey. DHHS was also represented among the various department and agency representatives. A recording of the meeting was tendered in evidence.¹¹⁹
74. It was at this SCC meeting, on 27 March 2020, that Jason Helps, State Controller — Health (also referred to as a Class 2 Controller), first became aware that DJPR had been tasked by its Secretary to put together the 'end-to-end' Hotel Quarantine Program and considered itself the lead agency.¹²⁰ From his perspective, this had occurred despite discussion throughout the afternoon and leading up to the SCC meeting that was moving towards locating the Program under the auspices of the emergency management framework. Meanwhile, by 4.30pm, DJPR staff had already been working for several hours to establish the necessary logistical components for the Program and understood themselves to be in charge. They had no sense that the Program was anything other than their responsibility.

5.4 The emergency management framework: Operation Soteria

75. According to Commissioner Crisp, the Hotel Quarantine Program was conducted within the emergency management framework, partly for role clarity:

It was important to put a control structure around this particular operation and, again, based on our experience of our running operations about having a control agency and then support agency, being really clear as to their role, it is really important and useful in terms of achieving a good outcome.¹²¹

76. Commissioner Crisp went on to say '[i]t is always very important to know who is in control, who is running a particular operation, and the distinction is which other agencies are providing support to the control agency'.¹²²
77. The role played by the Emergency Management Commissioner did not involve direct operational control. In this emergency, Commissioner Crisp did not have a 'hands on' role. Rather, as will be discussed in Chapter 8, the Emergency Management Commissioner is responsible for ensuring the State's response to an emergency is coordinated and that effective control arrangements are in place. The actual operational response is led through the State Controller for any particular emergency.¹²³
78. Commissioner Crisp gave evidence that it was upon being advised of the decision to quarantine returning travellers at the meeting at 2.00pm on 27 March 2020 with Minister Neville and other relevant stakeholders that he commenced planning for what became Operation Soteria.¹²⁴ In doing so, Commissioner Crisp spoke with Mr Helps and the State Consequence Manager to put together an operational plan.¹²⁵ This was then discussed at the first SCC inter-agency meeting on the afternoon of 27 March 2020 at 4.30pm.¹²⁶
79. Mr Helps stated that he first learned of the Program on the afternoon of 27 March 2020.¹²⁷ His evidence was that he spoke with Commissioner Crisp and they arranged the SCC meeting on 27 March 2020 to bring together all the agencies to plan the Program. At that stage, Mr Helps believed that the coordination of the Program would fall under the purview of the DHHS State Controller — Health in accordance with the State emergency management arrangements.¹²⁸
80. As part of those arrangements, due to the complexity and span of control that the State Controller — Health had in the overall COVID-19 response, it was ultimately agreed that a dedicated Deputy State Controller — Health would be appointed to coordinate Operation Soteria.¹²⁹ Chris Eagle and Scott Falconer were appointed to share that role by 29 March 2020.¹³⁰ Both had extensive experience in emergency management in their substantive roles with the Department of Environment, Land, Water and Planning (DELWP), the department from which they were seconded.¹³¹
81. Following the SCC meeting on 27 March 2020, the first draft Operational Plan (V 0.1) was released for review to DHHS, DJPR, DPC, the Department of Transport, the ADF and Victoria Police.¹³² This first plan did not have DHHS as the control agency. This suggests that, whatever was in the minds of some DHHS officials, there was no formal decision yet that the Program would be under DHHS control. It was still unclear to Commissioner Crisp whether the operation would be run under the emergency management framework. However, it was his view that it should come into line with the emergency management structures already in place in order to provide clear control and command structures.¹³³ Commissioner Crisp stated this was a view shared with him by telephone on 27 March 2020 by the Secretary of the DJCS.¹³⁴ At this point, Mr Phemister and DJPR staff still regarded themselves as leading the operation.

82. At around 9.00am on 28 March 2020, Mr Phemister received a telephone call from Mr Eccles informing him that Commissioner Crisp had responsibility for coordinating the Program and that DHHS was the control agency.¹³⁵ From that point, Mr Phemister regarded his Department's new role as that of a support agency within the emergency management framework.¹³⁶
83. At some stage on the same day, Commissioner Crisp had a telephone meeting with the secretaries of DHHS, DJPR, DPC and DJCS, at which Commissioner Crisp repeated his view that the Program should sit within the State emergency management arrangements with DHHS as the control agency. Commissioner Crisp understood the secretaries present agreed with that view.¹³⁷
84. There were two further SCC meetings that day: at around 10.00am and 6.15pm respectively.¹³⁸ At the second meeting, following a request by Mr Helps to clarify control arrangements, Commissioner Crisp confirmed DHHS would be fulfilling that role, stating:¹³⁹

So everyone, well, most people will be well aware that we have a State Controller ... Health, Department of Health and Human Services is the control agency. So, we want to fit this as a discrete operation into the overall state operation. So as of tomorrow morning, we will have a Deputy State Controller — Health; not a person from DHHS. So, Chris Eagle from DELWP is on the line at the moment. So, Chris will be the first of those to take on that Deputy State Controller role who will sit over this particular operation.

And Jason touched on it before in terms of who's in charge. It is the Department of Health and Human Services for this operation because, as I said, it fits in with the State's structure and under the State Controller Health. However, as we've discussed, and it is evident by the number of people in the room and on the phones, there are various departments and agencies and organisations that will be playing a support role, as we used (sic) to under our emergency management arrangements, to the Department of Health and Human Services and supporting the Deputy State Controller.

So, does anyone have any questions around that? I just wanted to be absolutely clear in relation to who is in charge of this operation.¹⁴⁰

85. In accordance with these arrangements, on 29 March 2020, Mr Helps telephoned Ms Febey emphasising that DHHS was the control agency and needed to be in charge as it was accountable for the Program.¹⁴¹ Ms Febey and Mr Helps agreed that DJPR would transition various roles and functions over to DHHS.¹⁴²
86. Later in the day, Mr Helps sent an email to Ms Febey with the subject line *DJPR-DHHS role clarity*.¹⁴³ As was clear from that email, there was, understandably, still work to do in clarifying where responsibilities now lay under the control structure. This was confirmed by Mr Helps who gave evidence that, although Commissioner Crisp had made it clear that DHHS had taken responsibility as the control agency, Mr Helps 'would not say that practically it was resolved' so he needed to 'clarify some aspects of that and how we would work through it'.¹⁴⁴ The email relevantly provided:

As you are aware the Department of Health and Human Services (DHHS) is the Control Agency for the COVID-19 Pandemic, and at this time I am the State Controller — Health appointed by the Control Agency under the Emergency Management Act. Prof Brett Sutton is the Chief Health Officer leading the Public Health response under the Public Health and Wellbeing Act. As the Control Agency, DHHS has overall responsibility for all activities undertaken in response to this emergency. The response to the direction for all passengers returning to Victoria after 11.59 p.m. 28/03/20 requiring to be quarantined in approved accommodation is being led by Dep State Controller Chris Eagle as 'Operation Soteria'.

... I don't underestimate the complexity of this task in the current environment. It will be vital that DHHS make the operational decisions in regards to which hotels we utilise and when, along with other decisions which require a risk assessment by the Chief Health Officer or delegated Authorised Officer.¹⁴⁵

87. Ms Febey understood this email to confirm what had been discussed in the SCC meeting on the evening of 28 March 2020 — that DHHS was in control and that DJPR would be playing a support agency role.¹⁴⁶
88. The first returned travellers arrived on the morning of 29 March 2020. By this time, the Program was being run as Operation Soteria out of the SCC and apparently overseen by DHHS in its capacity as the control agency. Operational responsibility at the SCC was managed at this stage by the Emergency Management Commissioner, State Controller — Health, Deputy State Controller — Health, the DHHS Agency Commander and a team of DHHS emergency management staff.¹⁴⁷

5.5 Change of lead agency

89. From the time of his 9.00am call with Mr Eccles on 28 March 2020 (see paragraph 82 above), Mr Phemister regarded his Department's new role as that of a support agency within the emergency management framework.¹⁴⁸
90. While, as discussed in Chapter 8, this substantially changed the governance arrangements then in place, it appears to have made little practical difference to the work DJPR already had in train at that early stage. DJPR remained responsible for contracting and organising many of the key logistical aspects of the Program — selecting the hotels, organising private security, cleaning and catering services where necessary and coordinating the transfer of returned travellers from the airport to hotels.
91. To assist in the logistical role that DJPR took on, Mr Phemister called on the CEO of Global Victoria, Gönül Serbest. Global Victoria was an agency that sat within DJPR. Ordinarily, its function was to organise logistics for events such as trade fairs.¹⁴⁹ Mr Phemister requested its involvement for its logistical expertise with 'advancing' of large events.¹⁵⁰ It was intended that its main role would be to assist with the initial 'dry runs' of the Program that occurred on 28 March 2020. Its role quickly expanded when it became obvious that the Program would require substantially more resources.¹⁵¹ Having regard to its ordinary business model, it was unsurprising that none of the staff of Global Victoria had any public health expertise or any experience that could sensibly be said to equate with managing a large-scale disaster with public health implications.¹⁵²
92. From the perspective of Mr Phemister and Ms Peake, the logistical tasks undertaken by DJPR did not change with the shift to a model where DHHS was the control agency. What did change, and where dispute remains, was the division of responsibility for the operation and oversight of the entire Program. According to Mr Phemister, this was, by 28 March 2020, a DHHS-led activity in which DJPR participated as a support agency.¹⁵³ Ms Peake, on the other hand, was of the view that DHHS had 'overall responsibility for ensuring any operation through the State Control Centre was appropriately scoped, involved the right people and had appropriate operational governance within it'¹⁵⁴ but that the DHHS role within that operation was limited by what she understood to be a model of 'joint accountability' for the Program with DJPR.¹⁵⁵ From this early point, that lack of role clarity became symptomatic of some aspects of the Hotel Quarantine Program and caused some of the gaps, fault lines and problems that emerged.
93. The issue of who was in charge of the overall Program, whether there was shared or joint accountability and what that meant for the day-to-day operation of the Hotel Quarantine Program and the contracts that were put in place with private security companies, hotels and cleaning contractors is dealt with in detail in chapters 6, 7 and 8.

5.6 Legal enforcement powers to direct people into quarantine

94. There was no controversy over the source of the legal powers to direct returning travellers into the Hotel Quarantine Program. It was the powers exercised under the PHW Act that were used to legally enforce the detention of returned travellers in quarantine at the hotels, including whether or not there would be any exemption from quarantine. As the fundamental legal basis of the Program, they were crucial to the Program's existence, enforceability and legality.
95. Over the course of the weekend, DHHS received legal advice from in-house lawyers¹⁵⁶ and external counsel¹⁵⁷ regarding the nature of the powers necessary to detain returned travellers. The Detention Notices that compelled returned travellers into the Hotel Quarantine Program were drafted and approved that weekend, relying on the powers in the PHW Act to detain individuals in hotels for the purpose of a 14-day quarantine period.¹⁵⁸

Enforcement of quarantine

96. Implicit in the decision to require all returned travellers to quarantine in designated facilities was the need for an enforcement mechanism — a means to keep travellers in their places of quarantine in accordance with the directions issued by the Deputy Chief Health Officer under the PHW Act.
97. As of 27 March 2020, the range of enforcement options that were potentially available included one or more of the following:
 - A. Victoria Police
 - B. ADF
 - C. private security.

5.7 The use of private security companies

98. That three private security companies, MSS Security Pty Ltd (MSS), Wilson Security Pty Ltd (Wilson) and Unified were engaged to provide the services of security guards as part of the enforcement regime in the Hotel Quarantine Program was an uncontroversial fact.¹⁵⁹
99. The contracts with these three companies, initially verbal and, later, confirmed in writing, were authorised by the Secretary of DJPR and entered into by the Secretary of DJPR as the contracting agency. Invoices rendered under those contracts were authorised for payment by DJPR.¹⁶⁰
100. Private security guards engaged through the three lead contractors were present at all of the quarantine hotels until their removal in early July 2020 and replacement by staff engaged by DJCS.¹⁶¹ I deal with the changes to the DJCS model in more detail in Chapter 11.
101. These were settled, uncontroversial facts. The process by which the firms were identified and contracted, the terms of those contracts and the ultimate suitability of private security guards for the roles they were asked to perform are all considered in Chapter 6.

Who decided to use private security as the 'first tier' of enforcement?

102. What proved to be controversial was how the decision was reached to use private security companies as the first tier of enforcement, rather than some other enforcement model using police or the ADF or a combination of any of the three options.
103. The first public mention made of private security guards being used in the Program was made by the Premier during his press conference at around 3.00pm on 27 March 2020:

Police, private security, all of our health team will be able to monitor compliance ... I'm very grateful to the Prime Minister for his agreeing to let this be a true partnership between Victoria Police, our health officials, as well as the Australian Defence Force, I think that will work very well. (The ADF) won't be exercising any statutory power. They will be working to assist those who beyond any doubt have the powers necessary to get this job done.¹⁶²

104. This suggests that use of private security in the Program — in some form — was in contemplation by that time.
105. By 6.00pm on the same day, Mr Phemister and others understood that DJPR's role as the lead agency included the obligation to engage private security and, over the weekend, that was done by Ms Currie who, having sent emails late on 27 March 2020, verbally engaged Unified to be present on 28 and 29 March 2020 to prepare for, and then receive, the initial cohort of returned travellers.¹⁶³
106. Subsequent formal contracts with Unified and with Wilson and MSS resulted in the use of thousands of guards and the expenditure of some \$60 million on private security.
107. But no one was able to say who it was who committed Victoria to the enforcement model that placed such heavy reliance on private security; a commitment that was understood by all concerned to have been made by the evening of 27 March 2020.
108. Despite examination and cross-examination, evidence, submissions and counter-submissions, no person, agency, Minister or department has been willing or able to identify that the engagement of private security commenced as a result of some action, instruction, agreement or understanding on their own part.
109. No one denied that a decision was made but, equally, no one admitted being the one to have made the decision or knowing who did. The Inquiry has been offered accounts of what was said to be a, shared governance, and 'shared accountability' model for the Hotel Quarantine Program. I accept that, in this context, the decision was most likely contributed to by a number of people. But none of those people have accepted accountability or responsibility for, or acknowledged their role in, the decision-making process. Shared accountability in this context has amounted to no accountability in that no person has accepted they were involved in the decision making and this represents a failure in the very first stages of the governance model for this Program.
110. The Premier, when asked whether we should know who made the decision, was firm in his reply:¹⁶⁴

Ms Ellyard: Because we really should know, shouldn't we? We should be able to say who made the decision to not only spend that much money but to give such an important function in this infection control program?

Premier: Yes, it's one of a number of very important questions, yes.

Ms Ellyard: Mr Eccles in his evidence, when I asked him a similar question, suggested that this might be ... I'm sure I'm not doing justice to his answer, but I understood him to say this might be an example of what he called collective governance or collective decision-making.

Do you have a view about whether that's what happened here in relation to private security?

Premier: Well, I would only be offering an opinion, if that would be useful to the Board.

Ms Ellyard: Yes, if you think that what happened here was collective decision-making, we would be pleased –

Premier: I think it's ... Ms Ellyard, I want good and the best decision-making, and I think it's very difficult to make judgements about that unless you can point to who made it. I don't know that this ... I don't ... my understanding of collective decision-making does not remove accountability, it does not remove ... for instance, as the Chair of the Cabinet, the Cabinet makes a collective decision, but I have made that decision because I am the Chair of that Cabinet. If a group of people meet and a decision is made, then a similar formality ought [to] be borne to those process ... come to those processes as well. That's, at least, my practical experience from the many, many meetings and different forums that I'm the chair of. I don't think collective decision-making makes it harder to determine what body and which people made a judgement, made a decision. That's why those forums have a record of decisions and minutes and a degree ... they are an authorising environment.

Ms Ellyard: So, to pick up on your point, Premier, Cabinet is an obvious example of group decision-making but everyone who is there understands that that's what they are doing, they are participating in a group decision-making process. Is that fair?

Premier: That is correct, yes. That's correct.

Ms Ellyard: They are all able to say afterwards, 'Yes, I was part of that, I was part of that decision-making'.

Premier: Yes and, furthermore, at a subsequent meeting, if the decisions were not recorded accurately, if you had a different view, if your participation was not recorded accurately, then you have opportunities to correct the record. There's a formality to that, even though it's collective.

Ms Ellyard: So here, assuming that Mr Eccles's analysis is correct, and this was an instance of collective decision-making, one would expect those who were part of the collective to know that they were and to be able to identify themselves as part of that collective decision-making. Is that fair?

Premier: I would certainly hope so.

Ms Ellyard: Given that would be your hope, it's alarming here, isn't it, that, to the extent it was a collective decision, no one seems to have understood that they were part of it?

Premier: Yes, it is very disappointing.

111. Many said they participated in discussions or meetings that were information gathering or sharing exercises and not decision-making forums. In some cases, however, it was clear that discussions and meetings presented opportunities for influence, particularly where one or more party to a conversation or meeting held a position of power and influence.
112. To come to a view about this question I have examined all of the relevant evidence and submissions to the Inquiry. After the close of the evidence, in the context of consideration of the submissions in reply, I sought more information, followed by further statements and submissions in light of that additional information.
113. Set out below is the detailed evidentiary trail upon which I have come to a conclusion by inferential reasoning as to how the 'decision' was made to use private security.

As of 27 March 2020, the use of private security was not considered problematic

114. In reviewing the discussions about private security on 27 March 2020, I bear in mind what those involved or potentially involved in any decision or approval of the use of private security would have understood the role private security was going to play. The significance of the decision to use private security turns very much on what, precisely, that workforce would be doing.
115. That private security guards would have some role in the Hotel Quarantine Program was not itself an unreasonable operational decision as of 27 March 2020. Private security had been used in hotel quarantine in other jurisdictions.¹⁶⁵ As the private security representatives said in their evidence and submissions, private security is a flexible and easily scalable resource that can be responsive to fluctuating demands. Indeed, a document entitled *Process Summary for Mandatory Quarantine*, apparently prepared by the ABF and circulated to Victoria Police on the evening of 27 March 2020, refers to the use of private security to enforce social distancing at hotels, suggesting that it was in the contemplation of Commonwealth agencies that private security would have some role in each State's mandatory quarantine program.¹⁶⁶ Accepting the limitations upon the Inquiry's access to evidence that was National Cabinet in Confidence, I infer that there was broad discussion of enforcement options that might be used by states and territories as part of the deliberations leading to the National Cabinet resolution.
116. From the evidence of those who made initial contact with security companies and from the evidence of those security companies, I am satisfied that the initial conception of the role private security contractors were to perform was the role of static guards or sentinels, in which they would have very limited contact with returned travellers.
117. The current Chief Commissioner of Police (CCP), Shane Patton, stated he had no grounds to form any reservations or concerns about the use of private security in the Hotel Quarantine Program.¹⁶⁷ He stated that, in the past, Victoria Police had worked successfully with private security in the context of major events and sporting events.¹⁶⁸ CCP Patton did not consider that the involvement of private security in the Program would be inappropriate, subject to adequate skills, training, advice and supervision being in place.¹⁶⁹ However, he did recognise the Program was outside the normal work of private security as it had the added overlay with respect to infection control.¹⁷⁰
118. Similarly, former CCP Ashton's view was that the role of private security, as proposed, was appropriate. The guarding duties — that is, being present to ensure guests remained in their rooms — were suited to private security, with police as a backup if any person attempted to leave quarantine. Mr Ashton did not envisage that the guards would be used for other purposes and, in that context, he viewed the arrangement as appropriate. He noted that this type of arrangement was consistent with how Victoria Police had worked with private security at events.¹⁷¹ At the time of his evidence, Mr Ashton's view had not changed in relation to the use of private security, provided they were well-trained.¹⁷² He had since learned that security was being used to escort travellers, which was not what he envisaged when the plan was first put forward.¹⁷³
119. Commissioner Crisp believed at the time that security would be a suitable workforce for use in the Program based on previous experience working with them. When well-trained and well-supervised, Commissioner Crisp believed private security would be effective in this type of role.¹⁷⁴
120. Minister Neville said she did not turn her mind to the appropriateness of using private security when she was told about the proposal on 27 March 2020. Her evidence was that the use of private security alongside Victoria Police was not inconsistent with her experience of how arrangements for major events operated; for her, it did not 'jump out' as a major concern¹⁷⁵ as private security contractors are used widely in Victoria for security purposes, including at Parliament House, hospitals and police headquarters.¹⁷⁶

121. I accept that it has become common practice for private security to work alongside police and Protective Services Officers in a range of situations, including in many government buildings such as courts and detention settings. There were important differences between those situations and the Hotel Quarantine Program with all of its complexities, including:
- A. those being detained were potentially carrying a highly infectious virus, meaning they posed a risk to each other and those working in the Program
 - B. those being detained included a percentage with additional health or welfare needs that made them vulnerable and requiring additional assistance
 - C. the nature of this environment required a workforce that was able to absorb changing written and verbal information and instructions in a complex health environment
 - D. the need for specific and ongoing training not being well-suited to a highly casualised workforce.
122. In making these comments, I note that CCP Patton, Mr Ashton, Commissioner Crisp and Minister Neville are not public health experts. I also note the evidence given by Professor Brett Sutton, Chief Health Officer, who *is* a public health expert, about what his position would likely have been if consulted on the decision to engage private security in the Hotel Quarantine Program. Putting to one side the question of what he knew about the decision at the time, which is dealt with below at Paragraph 130, when asked whether he would have raised the same concerns he raised in June 2020 after the outbreaks occurred, Prof. Sutton said:
- I don't think so. I think the wisdom we have in hindsight is a key element here. I'm not sure anyone at the point in time of decision-making around hotel quarantine commencement might have been able to foreshadow some of the complexities of that workforce. I certainly wouldn't have had sufficient familiarity with it to have made some of the conclusions that I can make now by virtue of having seen some of those complexities play out. I would have obviously brought a public health view, but I certainly couldn't say that I would have had the same level of concerns or understood what those concerns to be back at that point in time, in late March.¹⁷⁷
123. Having regard to this, I accept that it would not be reasonable to expect that CCP Patton, Mr Ashton, Commissioner Crisp or Minister Neville would have turned their minds to the specific public health issues that were ultimately generated by the use of private security guards in the Program.
124. I note the evidence of Professor Lindsay Grayson, Director of the Infectious Diseases Department at Austin Health, that security guards are used at Austin Health's COVID and SCOVID wards. His evidence was that security guards working in the hospital undergo specific additional training in terms of PPE, the same as nursing staff or doctors would do.¹⁷⁸
125. In this regard, I note that CCP Patton, Mr Ashton and Commissioner Crisp — each of whom gave evidence that private security was appropriate for the Hotel Quarantine Program — qualified their answers about suitability with the proviso that they would be appropriately trained, with Mr Ashton adding the further qualification that their role would be limited to static guarding.¹⁷⁹ Given her experience, it was reasonable to infer that Minister Neville would have expected the same limitation in role.
126. As will be discussed in Chapter 6, the evidence established that the initial role of private security on hotel sites grew.¹⁸⁰ That is, the role of private security expanded beyond the pure static guarding role that may have been anticipated on 27 March 2020 when it was expected guests would not leave their hotel rooms. Security guards taking guests for smoking and fresh air breaks, and transporting luggage to guests' rooms, meant that they moved through potentially contaminated areas or had the potential to interact with COVID-positive guests.
127. Finally, I note that the 'small-scale security force' originally contemplated by DJPR on 27 and 28 March 2020¹⁸¹ became hundreds of guards by the time of the first arrivals on 29 and 30 March 2020.¹⁸²

128. I am satisfied these matters must also be taken into account when assessing the role played by others, including Mr Eccles and those present at the SCC meetings on 27 and 28 March 2020, in the decision to engage private security. Neither Mr Eccles nor those present at the SCC meeting professed to be public health experts. It was not reasonable to expect that they should have turned their minds to the full extent of the supervision and training issues, the role changes and the increase in private security numbers that occurred over time.
129. These issues arose and evolved without any proper revisiting of whether the private security workforce remained the appropriate cohort for the first-tier security role.
130. This was compounded by the lack of clarity over who was 'in control' or 'in charge' or had 'oversight' of the detention program as a whole. The compartmentalisation of roles and failure of leadership (discussed in Chapter 8) added to the failure to address the dangers associated with the matters listed in paragraphs 121–128. This was perhaps best exemplified by evidence showing that, in the days following the engagement of private security, Ms Febey continued to advocate for a 24/7 police presence at hotels.¹⁸³ By that time, DJPR had ceased being lead agency and the matter was appropriately raised with DHHS for actioning. Despite Ms Febey's efforts, clearly, nothing came of it.
131. It was further compounded by the limited engagement of public health experts in the Program. One of the issues that arose in this regard was the level of knowledge held by Prof. Sutton about the use of private security in the Program.¹⁸⁴ There was a chain of emails dated 27 March which emerged after the close of public hearings which, on its face, was contrary to the evidence Prof. Sutton had given as to his knowledge about the engagement of private security until after the outbreak at Rydges.¹⁸⁵ Prof Sutton was required to provide further evidence on oath answering questions about his state of knowledge in light of that series of emails. Prof Sutton responded with an affidavit on 4 November 2020. I accept the explanation provided by Prof. Sutton in his affidavit,¹⁸⁶ and the submissions made by Counsel Assisting in respect of that evidence.¹⁸⁷ That is, while the evidence revealed there were opportunities by way of email traffic for Prof. Sutton to become aware that private security had been engaged in the Hotel Quarantine Program prior to the outbreaks occurring in late May 2020, I am satisfied that Prof. Sutton did not 'register' this detail or have a practical awareness of security arrangements on-site consistent with his lack of operational awareness more generally within the Hotel Quarantine Program. I am also satisfied that Prof. Sutton and the Public Health Team at DHHS had no role in the decision to engage private security, that Prof. Sutton had no role in their management and oversight, and that the Public Health Team had little or no role in this regard.
132. I approach this issue conscious of the immense public interest in the process that sat behind the decision to engage private security contractors. That public interest was no doubt heightened in circumstances where key witnesses were unable to recall key events and those who might be expected to know who decided to engage private security denied having this information. It was no doubt heightened by the nature of the outbreaks and numbers of security guards across the two 'outbreak' hotels who contracted the virus. It was further heightened by the provision of relevant information after the close of evidence that would have assisted the Inquiry during hearings.
133. The Inquiry has heard that the day was measured in minutes, and this was how I forensically approached this question. In doing so, on the evidence to the Inquiry and the investigations conducted, I have concluded:
- A. the decision was not one made by an 'individual' but, rather, there were those with influence who contributed to an understanding being reached that private security would be used and this understanding then became the decision that was adopted and acted upon at the SCC meeting chaired by the Emergency Management Commissioner
 - B. that understanding was reached by the conclusion of the SCC meeting on 27 March 2020
 - C. there were several main factors that appeared to have led to the understanding that became a 'decision' that was acted upon by DJPR in the wake of the SCC meeting
 - D. the timeline was not completely linear and there were overlapping and independent influences on the 'decision'

- E. the use of private security was in contemplation from the earliest time after National Cabinet concluded and likely during the course of discussions in National Cabinet given the widespread use of private security in other jurisdictions (National Cabinet discussions were not available to the Inquiry due to Cabinet in Confidence restrictions)
- F. the use of private security was not considered controversial at the time.

Before 1.00pm

134. At 12.17pm, Alex Kamenev, a Deputy Secretary who had been working exclusively on COVID-19 responses within DJPR,¹⁸⁸ sent an email to several DJPR officers including Ms Currie, with Mr Menon copied in. In her evidence, Ms Currie identified this email as the first time she learned of the Hotel Quarantine Program.¹⁸⁹ The email was titled *Cleaning workforce for isolation rooms in hotels* and was in the following terms:

Unni is going to write to us shortly with potential requirements for a cleaning and security workforce to manage people who might be quarantined in hotel rooms.

We might need to act quickly depending on govt policy choices in this space so would be good to think through options. It would be in metro and regions

I need a point person who can work with Unni¹⁹⁰

135. At 'around midday', in Mr Menon's recollection, he received a telephone call from Mr Phemister informing him that a hotel quarantine program was likely to be implemented and asking him to ascertain which hotels would be available to provide accommodation as part of the program (including their capacity to provide meals, security and cleaning services).¹⁹¹
136. At 12.20pm, Mr Eccles spoke to Mr Phemister.¹⁹² Mr Phemister said the conversation was about contracting hotel rooms and 'a few other obvious phases of the operation, particularly transport from the airport to the hotels'.¹⁹³ Neither recalled the question of private security being discussed.¹⁹⁴
137. At 12.35pm, Mr Phemister met with Ms Febey and others¹⁹⁵ to begin planning.¹⁹⁶ Ms Febey's notes include:

I will be responsible for the whole process

Everything

Sanitation, food services, health care, security

They need to be safe, but we need them to stay where they are

Simon will call Graeme Ashton, need a regime that makes sure they adhere to their quarantine

...

Police and security¹⁹⁷

138. The notes taken by Charles Rankin, Director, Office of the Secretary of DJPR, in respect of the same meeting include:

Claire will be responsible for DJPR process. hotels to provide sanitation, health, security, catering. Medical support, concierge support. They need to provide a full suite of service. They cannot go out and wander. SP to call Graham Ashton. Need to ensure they abide by quarantine.¹⁹⁸

139. In its Further Written Submissions, Victoria Police submitted that this evidence supported a finding that a decision was made to engage private security in the Hotel Quarantine Program before the SCC meeting commenced at 4.30pm or that there was a settled consensus in favour of private security (unaided by Victoria Police's view) prior to that meeting. In so doing, Victoria Police also referred to text messages exchanged by DJPR staff between 4.12pm and 4.30pm on 27 March 2020.¹⁹⁹
140. I do not accept this submission for the following reasons.
141. First, the 12.17pm email from Mr Kamenov was preceded by an email sent at 12.06pm from Michael Lemieszek, Assistant Director, International Engagement, DPC, to DJPR staff, including Mr Menon. The 12.06pm email stated:

We are seeking your assistance to respond to an urgent request from the Premier on the number of hotel rooms and other commercial accommodation available in Victoria. This is part of the broader work on COVID19 preparedness. Unni Menon, who is working on another element of this issue, is aware of the request and suggested we speak directly with you.

Could you please provide any data you have on the number of:

- Hotel/motel rooms
- AirBNB listings
- Other accommodation such as caravan parks, cabins, holiday camps (with buildings, not tents (sic) sites), guest houses, B&Bs.
- Unused student accommodation.
- Anything else you can think of.

If possible, we'd like the data by region. We are primarily seeking the total number, but welcome any data on current availability if it was on hand.

We need to get this to the Premier's Office by the end of the day. Please send through the best data you have available by the end of the day, earlier if you can.

I'll give you a call shortly to discuss.²⁰⁰

142. Although not expressly stated, it was evident from the content and timing of the 12.06pm email that:
- A. work was being done to ascertain what accommodation would be available for the quarantining of returned travellers (for example, a matter that was being considered by National Cabinet at that time)
 - B. work that had already done by DJPR in relation to the separate CEA Program was being leveraged as part of that work.
143. There was no mention of security in the 12.06pm email. However, as part of the separate CEA plan then in place,²⁰¹ there was a plan for hotels to provide 'general additional services' including 'general security'. It appeared far more likely that it was these matters, rather than some decision that had been made at this early stage of the day within DJPR to engage private security for the Hotel Quarantine Program, that gave rise to the 12.17pm email from Mr Kamenov.²⁰²

144. Second, Mr Menon's evidence was that he first learned of the Hotel Quarantine Program from Mr Phemister.²⁰³ I accept this evidence and Mr Phemister's evidence that he first heard about the Hotel Quarantine Program from Mr Eccles at 12.20pm.²⁰⁴ I therefore infer that Mr Menon did not speak with Mr Phemister about the Program until after receiving the 12.06pm and 12.17pm emails.
145. Third, even putting aside these matters, the language used in the emails at 12.06pm and 12.17pm did not support a finding that a decision was made to engage private security in the Program before the SCC meeting commenced at 4.30pm or that there was a settled consensus in favour of private security (unaided by Victoria Police's view) prior to that SCC meeting, including for the following reasons:
- A. In the 12.17pm email, Mr Kamenev refers to 'potential requirements for a ... security workforce'.²⁰⁵ The reference to 'potential' represents clear and contemporaneous evidence that a decision was yet to be made.
 - B. In her notes, Ms Febey refers to 'security' but says that 'Simon will call Graeme [sic] Ashton, need a regime that makes sure they adhere to their quarantine'.²⁰⁶ This reference to Simon (whom I take to be Simon Phemister) contacting, Graeme Ashton, (clearly a reference to the then CCP Graham Ashton) strongly indicates that a decision was not only yet to be made about the security regime, but that it would not be made until Mr Ashton's views had been sought. This finds further support in the evidence of Ms Febey, who stated that the decision to engage private security was communicated to her at the SCC meeting and that she understood this to be a directive to engage private security.²⁰⁷
 - C. Mr Rankin's notes also stated 'SP to contact Graham Ashton'.²⁰⁸ This provides support for the accuracy of the notes and recollection of Ms Febey that DJPR was waiting for the opportunity to consult with Mr Ashton before a decision was made about the security option. Both sets of notes represent contemporaneous evidence that a decision was yet to be made and would not be made until Mr Ashton had been contacted by Mr Phemister.
 - D. Mr Menon's statement²⁰⁹ and Mr Rankin's notes²¹⁰ referred to hotels providing security. These references were consistent with the arrangement contemplated as part of the CEA Program at that time, not the arrangement that was ultimately reached in the Hotel Quarantine Program, where private security companies were directly engaged by the State of Victoria (State). These references therefore provided further support for the conclusion, drawn above, that these early communications between DJPR staff were made in the context of initial plans leveraging off work already done in the CEA Program, rather than a decision that had already been made to engage private security in the Program at that time.
 - E. The text messages exchanged by DJPR staff between 4.12pm and 4.30pm were sent following several important developments, discussed in more detail below, including the 1.17pm telephone call between Mr Ashton and Mr Eccles, the 2.00pm meeting between Minister Neville, Mr Ashton and Commissioner Crisp, the debriefing by DPC that appeared to have occurred before 2.48pm, the Premier's press conference at around 3.00pm and the commencement of the VSB meeting at 4.00pm. I accept Ms Febey's evidence that these text messages reflected a 'working assumption' held by DJPR at that time, rather than a decision that had been made.²¹¹
 - F. The submission made by Victoria Police was also at odds with evidence establishing that DJPR did not begin contacting private security companies to ascertain their availability for work in the Program until well after the SCC meeting.²¹²
146. Having regard to this evidence, I find that, while the *potential* engagement of private security in the Program may have been in the minds of DJPR staff prior to the SCC meeting, no decision had been made and no decision was being actioned by DJPR staff in the hours prior to that SCC meeting.

1.00–2.30pm

147. Sometime before 1.16pm, Mr Ashton received what he described as a 'heads up' from his Australian Federal Police (AFP) colleagues that the Hotel Quarantine Program would be announced later that day.²¹³ In his affidavit, dated 19 October 2020, Mr Ashton identified a call made to him at 1.03pm from AFP Commissioner, Mr Reece Kershaw, as the most likely source of this 'heads up' and his understanding about the potential use of police as the enforcement mechanism in the Program.²¹⁴

148. 13 minutes later, at 1.16pm, Mr Ashton sent the following text message to Mr Eccles:

Chris I am getting word from Canberra for a plan whereby arrivals from overseas are to be subjected to enforced isolation from tomorrow. The suggestion is Victorian arrivals are conveyed to a hotel somewhere where they are guarded by police for 14 days. Are you aware of anything in this regard?? Graham.²¹⁵

149. During his evidence before the Inquiry, Mr Eccles was shown this text message.²¹⁶ Mr Eccles stated that, at the time of the text message, he was not aware of any plan for police to be guards in the Program, as stated by Mr Ashton in the text to be his understanding of the plan from Canberra.²¹⁷

Ms Ellyard: ... So you may feel I've asked you these questions already but are you aware of any involvement by the DPC as at about 1.30pm in setting up what were going to be the details of the enforcement arrangements in Victoria?

Mr Eccles: I'm not aware.

Ms Ellyard: Is it possible that it could have been happening without you being aware?

Mr Eccles: It's possible. But I would have thought extremely unlikely.

Ms Ellyard: Likely that if it had been happening at the time without you being aware, you would since have become aware, I take it, if arrangements of that ... if work of that kind had been being done?

Mr Eccles: Both that and the simple fact that if National Cabinet was finishing at 1 o'clock and there was no ... the relevant matter being considered by National Cabinet originated within National Cabinet itself and not in material going into National Cabinet, then to have developed a plan between the end of National Cabinet and this time seems ... I'm unaware of how a plan could be developed within that timeframe.²¹⁸

150. Mr Ashton did not receive any text message from Mr Eccles in response and could not recall if he spoke to Mr Eccles, or anyone else, on the phone at that time.²¹⁹ Mr Eccles said, in evidence, that he did not recall speaking with Mr Ashton, though it would be his usual practice to do so.²²⁰ Mr Eccles's phone records, which were obtained by the Inquiry after evidence had closed, reveal that there was a call made by Mr Eccles to Mr Ashton at 1.17pm that lasted two minutes and 15 seconds.²²¹ Both Mr Ashton and Mr Eccles gave evidence that they could not recall the contents of any conversation.²²²

151. However, five minutes after that phone call, at 1.22pm, Mr Ashton sent a text message back to Commissioner Kershaw stating, 'Mate my advise [sic] is that ADF will do Passenger transfer and private security will be used'.²²³

152. At 1.32pm, Mr Ashton sent another message to Commissioner Kershaw, which stated: 'I think that's the deal set up by our DPC. I understand NSW will be a different arrangement. I spoke to Mick F',²²⁴ Michael Fuller, who is the Commissioner of the NSW Police Force.

153. Mr Eccles was asked about Mr Ashton's texts to Commissioner Kershaw. Mr Eccles stated that he was not aware, as at about 1.30pm, of any involvement by DPC with regard to setting up the details of the enforcement arrangements in Victoria. As noted above, he thought it was extremely unlikely it was happening without him being aware.²²⁵
154. In his affidavit, made after his phone records were produced, Mr Eccles rejected any inference that Mr Ashton had learned of the proposed use of the ADF and private security from him, stating that he 'had no knowledge of these matters'.²²⁶ He stated that it was not his role to have made operational decisions about the use of private security, nor would he have had the expertise to do so. He stated:

[I]f I did call him [CCP Ashton] back [at 1.17pm], I would not have conveyed (and would not have been able to convey) any decision about the use of private security.²²⁷

155. Mr Eccles stated that he did not recall the content of the conversation with Mr Ashton,²²⁸ and strenuously rejected any claim that he had misled the Inquiry, as his evidence under oath spoke to the fact that his normal practice made it likely that he would have called the then Chief Commissioner back.²²⁹ Mr Ashton had no recollection of the contents of the conversation with Mr Eccles either.
156. The Premier was also taken to the message sent by Mr Ashton, which referred to the arrangement for private security as 'the deal set up by ... DPC'. The Premier's evidence was that he was not personally aware of any such proposal made by his department.²³⁰
157. Based on the content of the text message sent to Mr Eccles from Mr Ashton, the call made by Mr Eccles one minute later to Mr Ashton lasting for two minutes and 15 seconds and then the text message to Commissioner Kershaw sent approximately 12 minutes after that call ended saying 'I think that is the deal set up by our DPC', I draw the inference that a discussion took place between Mr Ashton and Mr Eccles that caused Mr Ashton to 'think' there was a 'deal' set up by DPC whereby private security would be used for the Program.
158. This inference was further supported by the evidence given by Mr Ashton during cross-examination by Mr Attiwill QC for DPC:

Mr Attiwill: And prior to that meeting [at 2.00pm], you were not aware of any request for Victoria Police to play any role in that quarantine program, were you?

Mr Ashton: Ah ... not that I have a recollection of, no.

Mr Attiwill: Relating to private security, you had a belief that private security were to be used?

Mr Ashton: An understanding, yes.²³¹

159. In closing submissions, DPC submitted that neither Mr Eccles nor DPC were involved in the decision to use private security in the Program.²³²
160. While neither Mr Ashton nor Mr Eccles had any recollection of what was said in the 1.17pm telephone call, it would be fanciful to think that Mr Ashton sent the 1:22pm and 1.32pm text messages to Commissioner Kershaw based on no more than some inner speculation of his own when at 1.16pm he had been asking Mr Eccles for information about a proposal that police be used as security for the Program.

161. At 1.34pm, Mr Ashton received a text message from Commissioner Crisp, who forwarded a text received regarding the ADF:

I just received this from [redacted] from ADF. I assume you would have it but just letting you know.

Thanks Andrew, federal announcement very shortly regarding ADF support to state police for COVID19.²³³

162. Mr Ashton's telephone records reveal that he then rang Commissioner Crisp and that they spoke for nearly three minutes. Mr Ashton could not recall the details of that conversation.²³⁴
163. At 1.39pm, Minister Neville received a call from the Premier's Chief of Staff and spoke to her for just over five minutes.²³⁵ In her evidence at the Inquiry's public hearings, Minister Neville could not recall who the call was from, but said she was told that there would be a Hotel Quarantine Program and that DJPR would be running it.²³⁶ In her later affidavit evidence, Minister Neville said there was no discussion regarding enforcement options, including security at hotels, during that call.²³⁷
164. At 2.00pm, about 26 minutes after the text from Commissioner Crisp to Mr Ashton, both men attended an online meeting with Minister Neville²³⁸ and other DJCS representatives. Such meetings had been taking place regularly since the pandemic started.²³⁹ The evidence was that there was a discussion about the use of private security in that meeting but a divergence on the evidence about who said what to whom.
165. A few minutes after 2.00pm, and while in the meeting, Commissioner Crisp sent the following text message to Ms Houghton of DPC, who had texted Commissioner Crisp to update him on National Cabinet discussions about the use of the ADF:

Think my Minister has some idea of ADF role and that's what we're discussing with Graham Ashton at the moment.²⁴⁰

166. The text message from Commissioner Crisp was contemporaneous evidence that the issue was being discussed in that meeting. Whatever was discussed, there did not appear to have been a settled position reached on the use of ADF or private security, as Mr Ashton contemplated in the VSB meeting later that afternoon that the ADF might be used at some point to assist with static presence over time.²⁴¹
167. Minister Neville said that it was clear Commissioner Crisp and Mr Ashton already knew more than she did about the Program when they met. Her 'best recollection' was that Commissioner Crisp raised the issue of private security being used to guard those in mandatory quarantine and Mr Ashton discussed ADF involvement, however, she could not be sure.²⁴² Minister Neville said that the decision to use private security was provided at the meeting as a piece of 'factual information' and she did not know who made the decision.²⁴³
168. When asked whether she had had a view about the use of the ADF, Minister Neville said that her concern at the time would have been about the absence of any enforcement powers on the part of the ADF and whether Victoria Police would have been better suited for a role at the airport — a role she noted was ultimately filled by the AFP.²⁴⁴
169. Mr Ashton said that Commissioner Crisp was the one who said that private security would be used to guard hotels, that the Program would be coordinated by DJPR and that police would be used to help transfer travellers and provide back up to security.²⁴⁵ His notes of the meeting refer to private security and hotels, but do not say by whom these matters were raised.²⁴⁶
170. Commissioner Crisp said that he first heard about the Program during that meeting with Minister Neville, prior to the Prime Minister's announcement.²⁴⁷ He understood that, as Emergency Management Commissioner, his role in the Program would be overseeing coordination and ensuring effective control arrangements were in place.²⁴⁸

171. Commissioner Crisp said that he had no independent recollection of the meeting, apart from what was in his notes, which included the words 'ADF' and 'private security'.²⁴⁹ He said that he had no recollection of making the comments ascribed to him by Mr Ashton and no recollection of having pre-existing knowledge at the time of the meeting that DJPR would be running the Program.²⁵⁰
172. Having regard to the contemporaneous notes made by Commissioner Crisp and Mr Ashton, it was clear that the ADF and private security were mentioned at the meeting. Each of Commissioner Crisp,²⁵¹ Mr Ashton²⁵² and Minister Neville²⁵³ gave evidence that they were not aware who made the 'decision' to use private security in the hotels.
173. It was possible that Commissioner Crisp heard about the Program from Mr Ashton during their conversation prior to the online meeting, rather than at the meeting itself. Mr Ashton already knew about the National Cabinet decision and had been party to a discussion about potential private security involvement.
174. I am satisfied that, at the 2.00pm meeting between Minister Neville, Mr Ashton and Commissioner Crisp, the issue of the use of private security and ADF was discussed. There was no evidence that a settled position or decision was made at that meeting. Equally, neither was there evidence of objection, concern or disagreement among this group. Had Minister Neville, Commissioner Crisp or Mr Ashton disagreed with the proposal to use private security in any capacity, they would have said so, and it was reasonable to expect that their opposition would have carried substantial weight given their leadership positions and expertise in policing, security and emergency management. However, in saying this, I reiterate the matters discussed in paragraphs 121–129 above. While these senior justice-portfolio office holders are experts in policing and emergency management, they do not profess to be experts in public health or public health emergencies. Further, I do not consider that, on 27 March 2020, they should have reasonably foreseen the extent of the training and supervision issues that would arise, the changing role of security over time, the substantial increase in numbers of security engaged in the Program, the fragmentation of departmental responsibility and oversight or the limited involvement public health experts would have in the management of the Program. Without that foresight and, on the assumption that the role of security would be static or sentinel guarding, there was no reason for them to oppose the idea.
175. In addition to these matters, Minister Neville submitted that it was 'simply not her role' to disagree with the engagement of private security under the emergency management structures then in place, including because it would have been contrary to that framework and the legislation underpinning it.²⁵⁴ While there was some force to this argument, and while I accept that any view expressed by Minister Neville would not have had legal force, it would naturally have been open to Minister Neville to express any view she may have had, as evidenced by Commissioner Crisp's text message referred to at paragraph 165 above, where Commissioner Crisp said he thought Minister Neville had 'some idea' about the role of the ADF and that this was being discussed at the time. In saying this, I again reiterate the matters discussed in paragraphs 121–129 above.
176. It is important to note that there was no evidence that any formal request was made to Victoria Police to provide personnel for the Hotel Quarantine Program. As Minister Neville explained, she, as Minister, cannot direct the CCP as to how to deploy his personnel.²⁵⁵ She did note that she would ordinarily be consulted if a request was to be made to deploy Victoria Police to perform a role and she was not so consulted.²⁵⁶ There is no evidence that a formal request was so made to Victoria Police.

Other information disseminated by DPC

177. Around the same time as the 2.00pm meeting of DJCS officials, there appears to have been a debrief from DPC staff who had attended the National Cabinet meeting.
178. As a result of that debrief, an email sent by Nicole Lynch, Director, National Cabinet (Health and Public Health), DHHS, at 2.48pm stated 'keen for police not to babysit, but called in as needed (e.g. use private security)'.²⁵⁷

179. A subsequent email from Ms Lynch, on 31 March 2020, says the 2.48pm email reflected National Cabinet outcomes (based on verbal debrief from DPC) and further clarifications 'from Kym [Peake] via Chris Eccles'.
180. The Premier and Mr Eccles each gave affidavit evidence about the extract from Ms Lynch's 2.48pm email.
181. The Premier said that:
- A. it did not reflect the view he then held about the potential use of police and private security
 - B. he did not understand this to be one of the outcomes of the National Cabinet meeting
 - C. he was not aware of this view being held within his private office or within DPC.²⁵⁸
182. Mr Eccles also said that the extract did not reflect the view he held about the potential use of police and private security. He said that he had no view about such matters and that he was not aware that anyone else held the view expressed in the extract at that time.²⁵⁹
183. As discussed in paragraph 157 above, I have drawn the inference that the telephone call between Mr Eccles and Mr Ashton at 1.17pm caused Mr Ashton to have the impression that private security would be used and that there was a 'deal' set up by DPC whereby private security would be used for the Program. By extension, I draw the inference that Mr Eccles had some concept or idea of the potential for the use of private security at the time of that conversation and, therefore, at the time of Ms Lynch's 2.47pm email, but am unable to conclude on the evidence that that rose to the level of a 'view' held by either him or others in DPC at that time. I also note the possibility for the reference to 'keen for police not to babysit' to reflect Mr Eccles having discussed the issue of police versus private security with Mr Ashton and one or other of them having expressed that view, but the evidence did not provide the capacity to make a positive finding on the point.

1.00–4.00pm

184. There was evidence of those working in the Premier's office trying to gather information about what the enforcement model would be. This includes texts and telephone calls between the Premier's office and DPC.²⁶⁰ The timing and content of these communications indicated that they were made for the purposes of the Premier's press conference.
185. At around 3.00pm, the Premier gave the press conference, during the course of which he said:

Police, private security, all of our health team will be able to monitor compliance in a much easier way, in a static location, one hotel or a series of hotels, as the case may be. That'll mean, and this is the really important message, that will mean that more of those police that we have, those 500 police that are doing that work in terms of Coronavirus enforcement, they'll be able to get to even more homes where people are supposed to be quarantining. Those who've arrived prior to midnight tomorrow night. So, if you're doing the wrong thing, you will be caught (emphasis added).²⁶¹

186. The Premier was asked during his evidence whether this announcement suggested that he had an assumption or understanding of what the enforcement model would be. He responded that, despite having given the matter 'quite some thought', he was not certain why he mentioned the above three groups of people during his press conference. He could not recall what was in his mind at the time about the enforcement model.²⁶² The Premier further stated that a matter such as security, which was a 'deeply operational matter', would not be determined by his office or his department, and that was what emergency management structures and agencies were for.²⁶³

187. In his further evidence by affidavit, the Premier stated that the press conference was given on short notice and in urgent circumstances. He stated that he always receives an oral briefing from a small number of advisers immediately before a press conference, and that he is usually provided with a written press release and sometimes a policy document to which he can have regard when answering questions. He produced two such documents — a press release and a document titled *Policy Q&A's* — and said that, while he had no present recollection of the briefing he received before the press conference, he had been informed that, before the press conference, he was very likely handed a copy of the press release but not the *Policy Q&A's*. Both documents refer to 'security', but neither contained the phrase 'private security' used by the Premier in his press conference. It may be that this additional detail was conveyed in the oral briefing he received before the press conference. The Premier's evidence was that, in preparing for an oral briefing of this kind, his staff would, as relevant, contact officers of DPC or one or more other line departments, to obtain operational and policy details concerning the subject of his announcement.²⁶⁴
188. The Premier said he did not know who made the decision to use private security as the first tier of enforcement.²⁶⁵ He was not able to say when he became aware that private security would be used as frontline security, and did not remember having a specific view on the appropriateness of the decision to use private security at the time.²⁶⁶
189. Mr Eccles said that he was not aware that private security would be used when the Premier stated it during the press conference.²⁶⁷ He was not aware of any information provided by him or DPC to the Premier to that effect.²⁶⁸ Mr Eccles was unable to say who briefed the Premier regarding police, private security and the health team working together, or the use of private security freeing up police to do more community checks.²⁶⁹ In his further evidence by affidavit, Mr Eccles maintained that he 'did not play any role in briefing or assisting the Premier with the remarks he made in his press conference'.²⁷⁰
190. Mr Phemister also gave evidence that he did not brief the Premier or his office at any time on 27 March 2020.²⁷¹ Phone records produced to the Inquiry reveal that members of the Premier's office did have contact with staff from DPC, who, in turn, were in contact with DJPR officers.²⁷²
191. Ms Febey was watching the Premier's press conference. At 3.26pm, she sent a message to members of her team that quoted the Premier's reference to police and security monitoring compliance.²⁷³
192. At 3.30pm, Mr Phemister sent a text message to Mr Ashton:

Graeme, [sic] we're running the inbound passenger isolation system with Transport (just announced by Premier). Can I get a point person from your crew to liaise with pls. If anyone else sees a role for their crew pls let me know. Claire Febey DJPR is running this with support of Paul's team.²⁷⁴

193. At 3.34pm, Mr Ashton responded to Mr Phemister:

Mate ask Claire to call dep commissioner Rick Nugent in the first instance. I will send you his number.²⁷⁵

194. Mr Phemister said that the reason for his making contact with Mr Ashton (which had been contemplated at about 12.30pm in his initial meeting with his staff)²⁷⁶ was that, having segmented the end-to-end operation, the three most important partners for the delivery of the operation would be Health (primarily), Transport and Victoria Police. Victoria Police was one of the three because he knew, given the nature of the operation, there would be a security element and they held this expertise.²⁷⁷

195. At 4.12pm, in the context of continued messaging about different aspects of the Program she and her team were developing, Ms Febey sent the following message to her team:

We need a security stream in our plan²⁷⁸

196. A few minutes later, at 4.18pm, she messaged her team:

We will likely need:

Private security on buses (TBC)

Additional security at hotels (please raise with Unni that we require this as part of full service)

Police on call to enforce where there is non compliance

Authorized officers (health system) to direct security

We will get more information on the scc call²⁷⁹

4.00–4.30pm: VSB meeting

197. As noted above, at the VSB meeting Mr Phemister remained of the view that DJPR would be running the Program.²⁸⁰ Mr Ashton did not recall any discussion regarding the use of security at this meeting.²⁸¹ Mr Phemister did not recall having an understanding of Victoria Police's views about the enforcement arrangements as a result of the meeting either.²⁸²

198. However, the notes of the meeting suggest, and Mr Ashton and Mr Eccles agreed, that the question of the potential role for security and police and matters of that kind were, in fact, discussed.²⁸³

199. In the notes taken from the meeting, under a heading 'questions', Mr Ashton was recorded as posing the question:

People coming in from OS ... police wont [sic] guard but will be doing the checks?²⁸⁴

200. Later in the notes was the following exchange:

GA [Graham Ashton] 'Challenge will be static presence over a long period of time - will end up with some private contractor or else the ADF ideally'. CE [Christopher Eccles] 'I assume a private contractor'.²⁸⁵

201. It might be thought that Mr Ashton had no need to pose this question if he knew from either Mr Eccles or Commissioner Crisp that a decision had been made to use private security. When asked about this in evidence, Mr Ashton said he asked this question to clarify that the arrangements he already understood to be in place were, in fact, now agreed. He had made notes for himself about the matters he intended to raise, including this question.²⁸⁶

202. Mr Eccles had no recollection of the remarks and would not speculate about what he understood at the time of the meeting.²⁸⁷ When taken to the notes of the meeting, Mr Eccles did not agree it was an inevitable conclusion that he assumed, at the time, there was a role for private security in the enforcement arrangements for the Hotel Quarantine Program.²⁸⁸ He said that, prior to this meeting, he had not turned his mind to how people would be kept in their rooms, and was not aware of anyone from DPC formulating plans or views about enforcement.²⁸⁹ While I accept Mr Eccles was doing his best to recollect his state of knowledge and thought processes on this very busy day, as I set out above, I have drawn an inference that the issue of private security was discussed in the conversation he had with Mr Ashton at 1.17pm earlier that day.

4.30pm: SCC meeting

203. By the conclusion of the SCC meeting, following the numerous exchanges and discussions throughout the afternoon set out above and at the meeting set out below, there was a decision of that meeting that private security would play the first-tier role. That meeting was recorded and the recording was produced to the Inquiry.²⁹⁰
204. During the first phase of the meeting, while Commissioner Crisp was absent, the following exchange occurred:

ADF Officer: Thanks. Just a question on, given that the security element probably overarches all of this, anybody got anything to say whether they can — on maintenance of security or the process?

Ms Febey: Is anyone from Victoria Police on the call?

AC Michael Grainger: Yeah, so you've got Mick Grainger monitoring, and [redacted] from our planning area. But, you know, just thinking through security, it is multi-layered, yeah, so we've got receipt of people at the airport, and someone who is working out a process flow will work their way through this, but then you've got the potential for people not to want to get on a bus, for example. My preference would be that if we were going to house these people anywhere, CBD makes sense, to keep it simple. I support, I think it was Claire's, comments on that. But then in terms of security, there would be private security, and then the police would have a role perhaps around that as well, but we'd have to work through what that looks like.

Ms Febey: I'd be really keen to take this up with you. And I'm so sorry, I missed your name. Did you say, was it Rick?

AC Grainger: No, Michael. Mick Grainger.

Ms Febey: Michael Grainger. Sorry about that, Michael. I'd be really keen to work this through with you because, as you say, there are different steps in security and some of it should be, for example, increasing the provision of private security at hotels. Some of it will be around security either at the point of arrival or during transport. And then we'd like to understand from you where you see VicPol's role being predominantly, which I would have thought was around where things are not going as they should, and you need to be called in to assist with enforcement. So, could you and I take that up separately, and perhaps with you I could understand who else I need to bring to the table in that conversation?

AC Grainger: Yep, so we'll have a planning and an operation cell in our State Police Operations Centre. I'll take the call from you —

Ms Febey: Yep.

AC Grainger: — and then we'll connect in with that group who are working afternoon and night.

Ms Febey: Great, thank you.

ADF Officer: And I'll talk with you on that, on the next steps, Mick, as well.

205. Later, Commissioner Crisp returned to the meeting after speaking with Mr Ashton. He gave evidence that, as he returned, he sent a text message to Assistant Commissioner (AC) Grainger at 5.20pm whom he knew to be on the SCC meeting call:

I stepped out to speak to Graham and I let him know you're in this meeting as he's only just come out of VSB. He made it clear in VSB that private security is the first security option at hotels/motels and not police.²⁹¹

206. On returning to the meeting Commissioner Crisp said:

Commissioner Crisp: Sorry, [redacted] can we get ... again, apology, I missed, I had to step out again ... but in terms of security at accommodation, have we covered that? Is it private security, Victoria Police? I understand that the preference of Victoria Police or the Chief Commissioner is that private security be the first line of security and police to respond as required. Is that your understanding, Mick?

AC Grainger: Yes. It's Mick Grainger here. Absolutely that's our preference.

207. At the end of the meeting, in response to a question from a DPC representative about the potential use of the ADF, Commissioner Crisp said:

Commissioner Crisp here. Again, that's why we went through this particular process, to identify where there was a lack of capability or capacity to undertake any of the phases of this operation. I suggest that at this stage we can manage this. The ADF will be doing just exactly what they're doing at the moment, helping us to plan for this particular operation. So, at this stage, we don't see a need for boots on the ground, so to speak.

5.30pm onwards

208. From the time the SCC meeting concluded, the die was cast. Private security would be the first tier. Police would play a support role.

Evidence on the question

209. As I have noted, no one who gave evidence to the Inquiry thought they were the person who decided to engage private security in the Program or knew, with precision, who the 'decision-maker' was or even the point at which the decision was made. Indeed, there was heated resistance from almost every witness related to the issue that they were the decision-maker or involved in the decision.
210. Mr Phemister stated that DJPR did not execute any planning for the engagement of private security until such time as they felt they were either directed by an expert agency or commissioned to do so by a source of authority.²⁹² This only occurred, from the perspective of DJPR, at the 4.30pm SCC meeting.²⁹³
211. Mr Phemister understood from Ms Febey that it was during the SCC meeting on 27 March 2020 that DJPR was asked to commission private security to support the operation.²⁹⁴ Not unreasonably, he regarded the Emergency Management Commissioner, ADF and Victoria Police as experts at the meeting with relevant authority to make judgements and decisions about enforcement.²⁹⁵ The process to engage private security was only commenced by DJPR after Mr Phemister received a debrief of that meeting.²⁹⁶ He made the observation that DJPR defers to the SCC for all engagement with 'uniforms' as standard practice and process.²⁹⁷

212. Mr Phemister explained, by way of example of the role played by Victoria Police and the deference given to its views, that Victoria Police was involved in the initial walk through on 28 March 2020 in order to identify how many guards were required, because it was the expert in security operation.²⁹⁸
213. Mr Phemister agreed in evidence that, from the time of the SCC meeting on 27 March 2020, it was the view of DJPR that there would be private security in hotels, and that police would assist with enforcement when things were not going well.²⁹⁹ He did not agree that that was a model put forward by DJPR.³⁰⁰
214. Given the position of DJPR as the lead agency at 27 March 2020, it was understandable, and I accept Ms Peake's evidence, that she was not consulted about the suitability of using private security firms.³⁰¹
215. Former Minister for Health, the Hon. Jenny Mikakos MP, stated that she did not know who made the decision to engage private security and that, to the best of her recollection, she only became aware of private security being used after the Rydges Hotel (Rydges) outbreak:

I would have had no reason to turn my mind to issues around security guards until we had that first case and the first outbreak at the Rydges Hotel.

... it was in fact DJPR that was the Department that had all the contracts with security contractors.³⁰²

216. Following public revelations that former Minister Mikakos had been present with Minister Pakula at a press conference on 29 March 2020, where the use of private security in the Program was discussed, former Minister Mikakos provided a second statement to the Inquiry.
217. Former Minister Mikakos stated that, since giving evidence to the Inquiry, media reports had suggested that there may have been opportunities for her to become aware of the use of security guards in the Program prior to the Rydges outbreak.³⁰³ In particular, she referred to Minister Pakula's media conference on 29 March 2020 and a briefing note that she may have also received, which was sent to caucus by the Premier's office on or about 8 April 2020. Former Minister Mikakos maintained that she had no independent recollection of these matters. She further stated that she had no recollection of becoming aware of (and had no reason to turn her mind to) the use of security guards in the Program on these or any other occasions prior to the Rydges outbreak in late May 2020.³⁰⁴
218. I accept from former Minister Mikakos that, when giving evidence, she gave answers consistent with her best recollection of events. Former Minister Mikakos accepted that the legal powers to detain people in quarantine came from the PHW Act, which was within her portfolio. Despite that, she maintained that she had not turned her mind to how those legal powers were being enforced at the hotels for the first few months of the Program.³⁰⁵ Former Minister Mikakos added that the decision to use private security, knowing what she now knows, was not a decision she would have supported.³⁰⁶ Issues about the way in which DHHS and former Minister Mikakos saw their role operationally in the oversight of the Hotel Quarantine Program are dealt with in detail in Chapter 8.
219. Minister Pakula's evidence was that he had no recollection of how he became aware that private security was being used in the Program.³⁰⁷
220. The effect of this evidence was that each of the relevant secretaries, agency heads, Ministers, the former CCP and the Premier not only disavowed being the source of any decision to engage private security, but each could not or did not say how the decision came into being.

221. During the 4.30pm SCC meeting he chaired on 27 March 2020, Commissioner Crisp said that he understood it was the preference of Victoria Police or the CCP that private security be the first line and that police respond as required. I am satisfied that he said this having been informed by his telephone discussion with Mr Ashton at 5.15pm,³⁰⁸ when he stepped out of the 4.30pm SCC meeting, as reflected in his text to AC Grainger at 5.20pm³⁰⁹ and AC Grainger's subsequent statement in the SCC meeting, that private security was 'absolutely' Victoria Police's 'preference'.³¹⁰
222. Commissioner Crisp said, in evidence, that he understood the decision to use security had already been made prior to the SCC meeting³¹¹ (although he did not know by whom) and that, when he raised the issue at the SCC meeting, he was trying to confirm the arrangements were in place and confirm the position of Victoria Police, which was expressed by AC Grainger.³¹² Of course, this must be seen in light of Commissioner Crisp having been the conveyer of the information from Mr Ashton to AC Grainger himself. The sequence of the phone conversation and text message followed by the invitation to AC Grainger to confirm Victoria Police's view in the meeting suggests that, in Commissioner Crisp's mind, the issue was not yet clearly settled and that he sought Mr Ashton's view and then ensured that that view was articulated to the meeting.
223. On the evening of 27 March 2020, the witness 'Police Superintendent', who had been in the SCC meeting, sent an email to various parties, which said 'CCP recommendation that private security is to be the first line of security'.³¹³ In her statement to the Board, the Police Superintendent said she was unable to recall why she described the use of private security as the 'recommendation' of the CCP, that she had not communicated directly with Mr Ashton in relation to Program and that the content of the email was based on her understanding of what had been discussed at the SCC meeting that afternoon.³¹⁴
224. In his evidence, Mr Ashton denied making any 'recommendation' that private security be used and said he was unsure why this language was used by his colleagues.³¹⁵ Moreover, his evidence was he did not make any 'recommendation' regarding the enforcement model to be used in the Program. Mr Ashton's evidence was that he was not consulted about the use of private security by anyone and he made no comment or recommendation regarding its use.³¹⁶ I do not accept that he was not 'consulted' or made no comment during the multiple discussions to which he was party, including with Minister Neville and at the VSB meeting. In the context of Mr Ashton's imperfect memory of various exchanges during the afternoon of 27 March 2020, the far more reliable evidence was contained in the content of the text messages, notes (such as they were), recordings and emails taken and exchanged that day. The reference in the Police Superintendent's email to the CCP's 'recommendation', while conveying a stronger position than 'preference', was evidence of a position being taken that was consistent with the text message of Commissioner Crisp to AC Grainger and then the electronic recording of what was said between Commissioner Crisp and AC Grainger in the wake of AC Grainger receiving the text message from Commissioner Crisp.
225. As discussed above, in paragraphs 134–146, Victoria Police submitted that the decision to engage private security was made prior to the 4.30pm SCC meeting, and indeed before the 2.00pm meeting between Minister Neville, Commissioner Crisp and Mr Ashton. Alternatively, if no decision was made, Victoria Police submitted that an assumption or default consensus was reached prior to the SCC meeting without the input of any view expressed by Victoria Police.³¹⁷ This finding was said to be supported by the evidence before the Inquiry, including that there was no proposal or request made to Victoria Police, prior to or at the 4.30pm SCC meeting, for Victoria Police to guard returned travellers in the Program.³¹⁸ Having regard to the notes of, and evidence given about, the VSB meeting on 27 March 2020, Victoria Police submitted that the preferable finding was that Mr Ashton communicated his understanding arising from the VSB meeting that a decision had been made to engage private security as 'tier 1' enforcement, not that he told Commissioner Crisp of a preference that he had made clear in the VSB meeting.³¹⁹

226. Notwithstanding these submissions, on all of the evidence, I find that Mr Ashton expressed a 'preference' in the VSB meeting and in conversation with Commissioner Crisp that Victoria Police not be the first tier of enforcement in the Program, consistent with Commissioner Crisp's text to AC Grainger at 5.20pm.³²⁰ In circumstances where Victoria Police was present at the SCC meeting as the law enforcement agency for Victoria and where, under the *Victoria Police Act 2013* (Vic), only the CCP can make operational decisions about how police are deployed, I find that this 'preference' carried considerable weight at the SCC meeting. The weight attributed to this preference must be qualified by reference to the fact, as already stated, that there was no evidence of a formal request being made to Mr Ashton or the Minister for Police and Emergency Services for Victoria Police members to be deployed as the frontline of security in the Program. Victoria Police was not formally asked and, therefore, did not formally refuse, but its view was clearly articulated, and the likely outcome of any potential request clearly foreshadowed.
227. The Premier was asked to comment on the evidence from Minister Neville and Mr Ashton that they had not been consulted in relation to the decision to use private security or the enforcement model in general. The Premier said it would be very unusual or even unprecedented for a decision of this type to have been made without consulting the Minister and/or the CCP. He said that, ordinarily, he would expect the views of the CCP to be sought in relation to a decision about enforcement, and that he would expect the CCP's view to carry some weight.³²¹ His expectation accords with the conclusions I have reached based on the evidence set out above.
228. The effect on others at the SCC meeting when hearing of Victoria Police's view was significant. As soon as AC Grainger expressed the view and Commissioner Crisp asked who then would organise private security, Ms Febey said she understood it was for DJPR to take it up. The meeting moved on to other topics, with the decision now made, though those at the meeting do not appear to have been aware that such a significant decision had been taken.

5.8 The use of the ADF

229. The question of the availability of ADF personnel was also examined at length during the Inquiry. Whereas the examination of the private security workforce concerned the decision made to use that workforce, the issue regarding ADF personnel was whether they were, and should have been requested, to fill frontline enforcement roles in the Program.

Was the ADF available to fill frontline enforcement roles in the Program?

230. It was uncontroversial that ADF personnel were generally available to assist in respect of Victoria's COVID-19 response.
231. As of 27 March 2020, Victoria Police was already using ADF resources. ADF personnel were embedded in the SCC prior to the Hotel Quarantine Program, where they had been assisting the State response to the 2019–2020 summer bushfires.³²² The evidence also established that ADF personnel were present and involved in the initial planning meetings at the SCC for Operation Soteria on 27 and 28 March 2020.³²³
232. The question, in this context, was whether ADF personnel would have been available to perform the frontline enforcement role in hotels as part of the Program, if requested, from 27 March 2020 onwards.

233. On all the evidence, it was not possible to say that ADF personnel would have been available to fill that role from 27 March 2020 onwards.
234. While much has been said about media statements made by Commonwealth and Victorian leaders around this time,³²⁴ the best available evidence comes from the terms of the National Cabinet decision reached on 27 March 2020. On that best available evidence, noting the Inquiry's limited ability to obtain evidence that was National Cabinet in Confidence, the terms of that decision included that:
- A. the requirement to quarantine in a designated facility such as a hotel will be implemented under state and territory legislation and will be enforced by state and territory governments, with the **support of** the ABF and the ADF **where necessary and according to need across Australia**
 - B. ADF will begin assisting state and territory governments to undertake quarantine compliance checks of those who are required to be in mandatory isolation after returning from overseas, with enforcement remaining the responsibility of states and territories.³²⁵
235. These terms were open to multiple interpretations, including because:
- A. It was not certain whether the phrase 'with the support of' extended to front of house enforcement roles in hotels, as well as back of house support roles, such as the logistical support the ADF ultimately provided.
 - B. It was not certain how the phrase 'where necessary and according to need across Australia' would have been applied. In this regard, I note that the Australian Government Disaster Response Plan (COMDISPLAN), which applied to requests for ADF assistance, and which was no doubt in contemplation by Commissioner Crisp and others at the time,³²⁶ provides that before a request for ADF assistance was made under the COMDISPLAN 'a jurisdiction must have exhausted all government, community and commercial options to provide that effect'.³²⁷
 - C. It was not certain whether the agreement that the ADF would 'begin assisting state and territory governments to undertake compliance checks ...' extended beyond the 'door-knock' campaign known as Operation Sentinel, which focused on monitoring compliance with Directions in place before the Program commenced requiring returned travellers to self-quarantine at home. In this regard, there was no evidence of an express offer of assistance being made by the Commonwealth prior to 7 April 2020.³²⁸
 - D. While ADF personnel were provided to fill frontline enforcement roles in NSW, this was done while NSW was responding to the Ruby Princess outbreak, meaning that such assistance was logically more likely to be deemed 'necessary and according to need' in that state.
 - E. While a request for ADF personnel to fill frontline enforcement roles in Victorian hotels was granted by the ADF in June 2020,³²⁹ this was amidst a very significant outbreak in this state that, again, meant that such assistance was logically more likely to be deemed 'necessary and according to need'.
 - F. The Commonwealth Government declined the Inquiry's request to provide sworn evidence on these matters³³⁰ and, to that extent, in the absence of powers enabling the Inquiry to compel the Commonwealth to provide such sworn evidence, the unsworn evidence of the Commonwealth remains untested.
236. Having considered this, on all the evidence, it was possible to say with sufficient certainty, and I find, that:
- A. had a request for ADF personnel to be present in the quarantine hotels been made on or around 27 March 2020, it would have been considered by the Commonwealth

- B. ADF personnel were most likely available to assist in frontline enforcement roles at the quarantine hotels in Victoria from 8 April 2020, at the latest, although I am not able to say whether that would have removed the need for private security guards, given the number of guards involved. It seems most likely, having regard to the models adopted in NSW and Queensland, that if the ADF was available it would have only been available in numbers to supplement, rather than replace, the existing security workforce. This was further supported by recent media reports indicating that, while the ADF has made personnel available to assist in Victoria's revised hotel quarantine program, the ADF has not been willing to provide personnel for the purposes of patrolling the floors of 'hot hotels'.³³¹
237. I have arrived at this conclusion on the basis that:
- A. ADF personnel appear to have been provided to fill frontline enforcement roles in hotels in Queensland from 31 March 2020 following a request made on 27 March 2020.³³²
- B. In evidence, Commissioner Crisp stated that, had a request for ADF personnel to fill frontline roles in hotels in Victoria been made, he would have expected it to be given proper consideration by the ADF.³³³
- C. In the diary notes of CCP Patton, taken in respect of a conference call he attended with Mr Ashton and Deputy Commissioner (DC) Rick Nugent on the evening of 27 March 2020, reference was made to the ADF being 'available re static guarding of those sites'.³³⁴ From the surrounding context of those notes, I infer that by 'sites', CCP Patton meant 'hotels'.
- D. By email on 8 April 2020, the Secretary of the Commonwealth Department of Prime Minister and Cabinet, Phil Gaetjens, sent an email to Mr Eccles in response to an enquiry by Mr Eccles about the availability of financial assistance from the Commonwealth, stating:
- On the question of assistance with security, I am advised the only deal with NSW was in-kind provision of ADF personnel. I am sure the Commonwealth would be willing to assist Victoria if you wanted to reconsider your operating model.³³⁵
- E. In evidence, Mr Eccles accepted it would be reasonable to infer from this email that, had Victoria wanted ADF personnel in hotels, the Commonwealth would have considered it. From the terms of the email, and Mr Gaetjens's senior position within the Commonwealth public service, I infer that the Commonwealth would have not only considered such a request, but would have considered it favourably.
238. When Mr Eccles was asked whether he had passed on Mr Gaetjens's email to those responsible for operational responsibility, he could not recall whether he did or did not.³³⁶
239. In his evidence, the Premier stated that he was not aware of the proposition that ADF personnel might have been available if Victoria elected to adopt a model that that required them in hotels and that he, in fact, had 'quite the opposite view'.³³⁷
240. There was nothing in Mr Eccles's response to Mr Gaetjens,³³⁸ or anywhere else on the evidence, indicating that Mr Eccles communicated the terms of Mr Gaetjens's email to the Premier or anyone else with operational responsibility for the Hotel Quarantine Program. The Premier's evidence was that he would, ordinarily, have expected that the availability of a resource, such as the ADF, would be drawn to his attention and the attention of those who were making policy and operational decisions for the structure of the Hotel Quarantine Program.³³⁹ The Premier said the proposition would have been 'very significant' to him and that he 'certainly would have wanted to know, because it would have presented us with options we otherwise didn't have ...' in terms of the Premier's interpretation of what had been decided at National Cabinet.³⁴⁰
241. It was surprising and inexplicable that Mr Eccles did not communicate Mr Gaetjens's proposal when there was a possibility that the significant costs of private security might have been reduced through the introduction of an alternative workforce.

Why was a request for ADF personnel to fill frontline enforcement roles in the Program not made?

242. The evidence on this question follows a similar trajectory to the evidence on the question, discussed above, of who decided to engage private security in the frontline enforcement role in the Program.
243. The answers to these questions were clearly interlinked. The evidence demonstrated that there was no request for ADF personnel to fill frontline enforcement roles in the Program as of 27 March 2020 because it was not seen as necessary. The reason it was not seen as necessary was that the decision had been made to engage private security as the first tier of enforcement with Victoria Police to be called in as needed, so there was no 'need' that could then be identified for ADF to supplement that enforcement model.
244. The timeline of evidence that led to these related decisions being reached was largely the same and leads me to a similar conclusion. While there were, throughout the day of 27 March 2020, key events and players who influenced what became a decision not to request ADF assistance in frontline enforcement roles, that decision did not crystallise and was not made until the SCC meeting held at 4.30pm that day.
245. Rather than repeat matters already discussed in full, the evidence that has led me to this conclusion may be summarised as follows.
246. On the evidence, the first mention of the role that would be played by the ADF was the National Cabinet decision.
247. The next mention of the ADF's role appears in the text messages sent from Mr Ashton to Commissioner Kershaw at 1.22pm and 1.32pm, where Mr Ashton stated that the ADF would be doing 'passenger transfer'.³⁴¹ For the reasons discussed above, I infer from these text messages, and the communications between Mr Ashton and Mr Eccles immediately prior,³⁴² that Mr Ashton and Mr Eccles discussed the potential role that would be played by the ADF in the Program during their 1.17pm telephone call. It was not possible to say which of the two men raised this matter or that the conversation could be characterised as a 'decision' at that stage of the day. It was also not possible to say with certainty that the reference to the ADF doing 'passenger transfer' meant, by implication, that they would not be engaged to fill frontline enforcement roles, although I accept from the subsequent reference that 'private security will be used', and from Mr Eccles's comments at the 4.00pm VSB meeting, that this conclusion is open.
248. At 1.34pm, Commissioner Crisp sent a text message to Mr Ashton forwarding a message from the ADF stating that there would be a 'federal announcement very shortly regarding ADF support to state police for COVID19'.³⁴³
249. Commissioner Crisp's notes of the subsequent meeting at 2.00pm with Minister Neville, Mr Ashton and others included the words 'ADF' and 'private security'.³⁴⁴ I am satisfied on the evidence that both matters were raised. During the meeting, Commissioner Crisp sent a text message to Ms Houghton of DPC advising 'I think my Minister has some idea of ADF role and that's what we're discussing with Graham Ashton at the moment'.³⁴⁵ In her evidence, Minister Neville agreed that there was a discussion in which she participated about suitable roles for the ADF, but only in relation to the role they may play in escorting people at airports, and whether that role was appropriate noting the limits on the enforcement powers that could be exercised by ADF personnel.³⁴⁶ It was not possible to say on the evidence that there was discussion of the ADF's role beyond that transport role. Further, whatever was discussed, there did not appear to have been a settled position reached at the meeting, since Mr Ashton appears to have contemplated at the VSB meeting later that afternoon that the ADF might be used at some point to assist by way of a static presence over time.³⁴⁷

250. At around 3.00pm, the Premier gave a press conference and spoke about ADF involvement in the Program, but gave no specific description of the role that it would play. In evidence, the Premier said he understood that ADF assistance was available where it was necessary, meaning where it was needed in the relevant state. He agreed that, when he spoke about the ADF being available according to need, that meant that it was a finite resource such that it would be apportioned according to who needed it most if there were multiple demands,³⁴⁸ stating further:

... leaving the National Cabinet meeting I had absolutely no expectation whatsoever that in the establishment and the running of hotel quarantine there would be significant, extensive ADF support. That was ... that was not the case for every state. A case, I think, had been well made in relation to New South Wales. But I had no expectation at all that we would receive that type of support.³⁴⁹

251. At 4.00pm, the VSB met and discussed the Program. During that discussion, Mr Ashton was quoted as saying 'challenge will be static presence over a long period of time — will end up with some private contractor or else the ADF ideally'. Mr Eccles was then quoted as saying 'I assume a private contractor'.³⁵⁰ While these comments from Mr Eccles cannot be characterised as a decision, they do reflect the ultimate outcome — private security was selected over Victoria Police and the ADF.
252. As the meeting at the SCC reached its conclusion, a DPC representative asked a direct question about the role the ADF would play in the Hotel Quarantine Program. Commissioner Crisp responded:

Again, that's why we went through this particular process, to identify where there was a lack of capability or capacity to undertake any of the phases of this operation. I suggest at this stage we can manage this. The ADF will be doing just exactly what they're doing at the moment, helping us to plan for this particular operation. So, at this stage we don't see a need for boots on the ground, so to speak.³⁵¹

253. The reference to a lack of capability or capacity was a reference to the criteria for requesting ADF assistance. It was for Commissioner Crisp to make the assessment that there was any relevant lack of capability or capacity that required ADF resources. He agreed in evidence that he was aware, on 27 March 2020, that he could request ADF assistance, if necessary, and that his assessment was that there was not a lack of capacity.
254. No one present at the SCC meeting spoke against that assessment. This view was reached by Commissioner Crisp after consideration of the requirements of each of the phases of the operation and in discussion with DHHS, the State Controller — Health and Victoria Police.³⁵² Mr Helps gave evidence consistent with Mr Crisp on this topic.³⁵³
255. This was Commissioner Crisp's assessment. Minister Neville said, in evidence, that she was not consulted by Commissioner Crisp prior to his statement at the SCC meeting that Victoria had sufficient capacity to meet all the requirements of the Program and, consequently, did not require 'boots on the ground' from the ADF.³⁵⁴
256. Mr Ashton initially provided a statement that he had no recollection of any discussion about the possible use of ADF as part of the Program.³⁵⁵ He stated that he was aware of the suggestion that it would be used to help transfer passengers. Such assistance never eventuated because, on the afternoon of 27 March 2020, DJPR indicated that Skybus would be doing that job.³⁵⁶
257. The evidence of Mr Ashton was at odds with CCP Patton's diary note, detailed at paragraph 237.C above, which referred to the ADF assisting with 'back of house' checks and the ADF being available 're static guarding of those sites'.³⁵⁷ CCP Patton did not have an independent memory of the conversation to which this note relates, and cannot add to what was in the diary note.³⁵⁸ It clearly came to nothing.

258. CCP Patton, in his evidence to the Inquiry, stated that the ADF did not have any enforcement powers and ADF personnel were not trained in dealing with civilians.³⁵⁹ He was clear that, while the ADF was assisting Victoria Police's enforcement response to the pandemic, it was not involved in enforcement *per se*. This corresponded with public statements made by the Prime Minister and the Premier that, to the extent the ADF was involved, or was to be involved, it would be in a role that assisted compliance and did not involve the exercise of any legal powers. Of course, private security guards have no enforcement powers either.
259. Victoria Police had a senior representative at the SCC meeting on 27 March 2020 and no concern was raised about the view provided by Commissioner Crisp regarding the ADF. This was unsurprising in light of the preference expressed at that meeting by Victoria Police that private security be used, and confirmation in the SCC meeting that DJPR was attending to those arrangements.³⁶⁰ Frontline security was being addressed³⁶¹ and the assessment was that there was no gap.
260. Commissioner Crisp reiterated his position at another SCC meeting the following day, on 28 March 2020, stating that 'at this particular point in time, we certainly don't see the need for ADF boots on the ground in support of this operation'.³⁶² Once again, no one present, including Victoria Police, spoke against that assessment.
261. If there was any doubt about the decision announced on 27 March 2020 by Commissioner Crisp that the ADF would not have a frontline enforcement role in the Program, there could not have been any by the time of his remarks at the SCC meeting on 28 March 2020. Those remarks were accompanied by comments made by an ADF representative who, when asked if they wished to raise anything, responded 'no ... just noting that the news tonight mentioned that ADF would be patrolling the corridors of hotels, ah, not in Victoria'.³⁶³ It was a clear indication to all those at the meeting that ADF personnel would not be used inside the hotels in Victoria, albeit they were being used in other jurisdictions.
262. Mr Eccles could not recall the point in time that he became aware of the role that the ADF was to play. He was not aware why a DPC representative at the SCC meeting on 27 March 2020 sought clarification about what role was to be played by the ADF. He accepted that it was possible that DPC had a role to play in furnishing information to the Premier on that point, as it was a role played by DPC when requested, but he had no reason to conclude one way or the other. Mr Eccles was also shown an email sent shortly before 4.00pm from the Premier's office to someone at DPC regarding information the Premier required.³⁶⁴ It asked *What role will the ADF play?* Mr Eccles agreed that DPC representatives at the SCC were likely asking about ADF at the SCC meeting because there had been a request from the Premier's office for information.³⁶⁵ Mr Eccles, otherwise, had no recollection of being aware, on 27 March 2020, of any particular view or decision within government generally about the appropriateness or otherwise of using the ADF.³⁶⁶
263. As I have considered earlier in this Chapter, the use of private security as the first tier of enforcement was never the subject of analysis. At no time on 27 March 2020 did it appear there was any consideration of the respective merits of private security versus police versus ADF personnel in that first-tier role. Instead, an early mention of private security rather than police grew into a settled position, adopted by acquiescence at the SCC meeting. This means that there was no actual consideration of whether ADF personnel would have been a better option. That question never seems to have arisen in anyone's mind. The assessment that the ADF was not needed on the ground at the hotels was an assessment made without any proper consideration of the anterior question of what would be the best enforcement option.

264. Minds may differ about the benefits the ADF could have provided to the Program at that time. It is, in fact, a resource that could have been requested of the Commonwealth, at least in theory, and assuming a case could be made for its use.³⁶⁷ I am satisfied that, as of 27 March 2020, the decision not to request the assistance of the ADF for a role in the quarantine hotels was made by Commissioner Crisp, on the basis of his assessment that the various agencies represented at the SCC meeting were appropriately resourced and did not require that form of ADF assistance. I am satisfied that no person or agency raised a concern about this assessment. It was an assessment that was open in the sense that, once it was agreed private security would be used at the hotels, there was no longer a 'need' for ADF.

5.9 Conclusions on initial decision-making

265. As a consequence of there being no pre-planning for the large-scale detention of international arrivals into a mandatory quarantine program, when the Premier committed Victoria to hotel quarantine, those who would have to implement the program in Victoria were required to do so with very little warning and without any available blueprint for what was required. The situation was further complicated by the fact that the decision would come into effect just 36 hours later, at 11.59pm on 28 March 2020.
266. To put the scale in context using information provided by the Prime Minister on 27 March 2020, 7,120 people had arrived at airports around the country on 26 March 2020, the day before the announcement of hotel quarantine.
267. The Premier was aware there was no pre-existing plan for large scale quarantine in Victoria and there had been no discussion in the State Cabinet about the National Cabinet decision. He considered it feasible to achieve, however, based on his knowledge of the availability of hotel rooms and the dedicated team of 'operational people' able to rise to this challenge.
268. The initial responsibility for setting up the Program was given to DJPR.
269. Other than the sourcing of numbers of available hotel stock, DJPR had no preparation for, or relevant expertise to operate, an enforced quarantine program. The capability and capacity of the hotels in terms of the provision of security, cleaning and catering had not been a factor at the time of allocating the lead to DJPR, nor had the capacity of the hotels to accommodate large numbers of people in a manner that would prevent transmission of COVID-19 to the community.
270. It was not appropriate to conceive of the Hotel Quarantine Program as an extension of, or substantially similar to, existing accommodation programs, such as the CEA Program. The logic of tasking DJPR to source hotels for quarantine purposes on the basis that it had previous awareness of hotels for the CEA Program, did not extend to DJPR sourcing hotels for quarantine purposes; the nature and purposes of the two programs were significantly different and involved different levels of risk.
271. DJPR understood from the outset that it would need the assistance of DHHS for crafting the legal framework for the Program and arrangements for the health and wellbeing of the people in quarantine.
272. Within a few hours of that call to the Secretary of DJPR, the Emergency Management Commissioner and the State Controller — Health at DHHS were setting up a meeting at the SCC on the understanding that this Program would be operated using the emergency management framework and would be named Operation Soteria.

273. By the afternoon of 28 March 2020, from a meeting at the SCC, the Emergency Management Commissioner, in conjunction with the DHHS State Controller — Health, made clear that DHHS was in charge of the operation as the control agency and that DJPR was a support agency, as were a number of other agencies attending the meeting.
274. DJPR continued to provide the contracting and organising of many logistical aspects of the program including hotels, security, cleaning contractors and general logistics, including transport and aspects of catering.
275. This appears to have been the genesis of the ongoing dispute as between DHHS and DJPR as to who was in charge of the overall operation of the Program. DJPR was clear that it was DHHS. DHHS was adamant that it was only responsible for parts of the Program and that DJPR was jointly responsible and accountable for the delivery of the Hotel Quarantine Program. This was the source of considerable and significant problems with the way in which the Program was operated.
276. I am satisfied that the decision to embark on a Hotel Quarantine Program in Victoria involved the State Government assuming the responsibility for managing the risk of COVID-19 transmission. But even though that risk was assumed by the Government, and as critical 'decisions' were made with respect to enforcement measures, there was no detailed consideration of the risks that would be involved in such a program. This was a failure in the establishment of the Program.
277. In committing Victoria to the mandatory quarantine of returned travellers, the Premier had committed the Victorian Government to responsibility for managing the COVID-19 risk posed by returned travellers and ensuring compliance with the mandatory detention orders. In so doing, the Government assumed responsibility for the safe quarantine of, and the prevention of transmission by, returned travellers and the maintenance of a safe system of work for those it brought onto quarantine sites.
278. This included an assumption of responsibility for identifying and planning for the following:
- A. ensuring that quarantine would be enforced, directing that people isolate in a particular place and monitoring compliance
 - B. managing the infection risk posed by the quarantine setting
 - C. ensuring that people were at least as safe in hotel quarantine as they would have been quarantining at home
 - D. ensuring that the community was at least as protected from infection risk as it would have been were returning travellers quarantining at home
 - E. managing the increased exposure risk for workers in the quarantine program.
279. It is beyond doubt that many people worked incredibly hard, in extraordinary timeframes, to deal with an unprecedented set of circumstances. But that is not a total justification for the deficiencies in some of the actions taken and decisions made in that first 36 hours, and it does not excuse the deficiencies I have found in the Program.

5.10 Conclusions on the enforcement model

280. I am satisfied that, while the evidence did not identify a single person who decided to engage private security in the Program, there were clearly people who influenced that outcome, which was the position adopted at the SCC meeting at 4.30pm on the afternoon of 27 March 2020.
281. I am satisfied that the first of those was Mr Eccles. The second was Mr Ashton.
282. Mr Eccles's oral and written evidence was that he did not make a decision or express any opinion.³⁶⁸ I accept that Mr Eccles did not make the 'decision' within the strict meaning of that word as it relates to formalised government processes that would require documents to be produced and signed off. I also accept that Mr Eccles did not have the power to make any such decision on his own.
283. With the benefit of Mr Eccles's telephone records, I am satisfied that Mr Ashton first heard of the possibility of private security being used during the two minute and 15 second call they had at 1.17pm on 27 March 2020.³⁶⁹ I cannot reach any firm conclusion about what was discussed but am satisfied that it was during that call that Mr Ashton gained the impression that private security could be used instead of police. Given that Mr Eccles had been present during National Cabinet discussions,³⁷⁰ and given that all jurisdictions made some use of private security, I conclude that he was the one to mention private security as (at least) an option.
284. However, the mention of private security as an option did not equate to Mr Eccles having determined the precise role it would play. There was no evidence that the conversation between Mr Eccles and Mr Ashton was conveyed to anyone who was present in the SCC during the discussions about enforcement options. Further, there was no evidence that Mr Ashton, himself, referred to his conversation with Mr Eccles to anyone other than, by inference, Commissioner Kershaw in his text message outlining that DPC had made a 'deal' or established the private security role.
285. By the time Mr Ashton referred to 'a deal set up by our DPC, he had also spoken to his NSW counterpart, Commissioner Fuller.³⁷¹ Mr Ashton and Commissioner Crisp then spoke to each other before they met with Minister Neville at 2.00pm. I am not able to make any finding about what they discussed or about who first raised the question of private security in the 2.00pm meeting, but the evidence before me supports the view that Mr Ashton was the person who entered those discussions with some existing knowledge that private security would have a role to play, although he was not yet clear what that would be. He then raised the question at the VSB meeting and spoke to Commissioner Crisp while the SCC meeting was in progress.³⁷² Commissioner Crisp's text to AC Grainger about Mr Ashton's views appears to have prompted AC Grainger's comments about Victoria Police's preference,³⁷³ which Ms Febey and others understood as having determinative force.³⁷⁴
286. It would be highly unusual if a final decision on an enforcement model was taken without consulting the CCP or taking into account their view. I am satisfied that Mr Ashton did have a view that the mention of private security by Mr Eccles was consistent with Mr Ashton's view, and that he promoted that view in subsequent meetings directly and by means of his conversation with Commissioner Crisp. As I have noted, it was after the view of Victoria Police was articulated in the meeting that DJPR's representatives understood that private security needed to be engaged.³⁷⁵
287. It was telling that it was not until after the SCC meeting that private security was engaged. Mr Phemister made the point in his evidence that, on 27 March 2020, it was DJPR that was responsible for the Program.³⁷⁶ DJPR had no knowledge of any decision before the SCC meeting.³⁷⁷ Had a decision already been made, one would expect DJPR to have begun the process of contacting security contractors much earlier in the day, noting the extreme urgency with which everything was being organised. In this regard, I am satisfied that Mr Eccles did not mention private security to Mr Phemister in their telephone conversations throughout the day.

288. The comments by AC Grainger in the SCC meeting clearly carried significant weight for Ms Febey from DJPR, who reasonably understood it to be a 'direction' that private security would be used.³⁷⁸ Indeed, upon AC Grainger expressing that view, the discussion on security options ended because it was perceived that an agreement had been reached. DJPR then commenced its efforts that resulted in the informal engagement of Unified, Wilson and MSS to provide private security at the hotels.
289. I acknowledge the haste with which these decisions were being made. I note, too, the separate controversy that emerges with respect to the appropriateness of engaging private security for the various roles it ultimately performed, a matter I consider in Chapter 6. However, the fact remains that not one document was produced to the Inquiry that demonstrated a contemporaneous rationale for the decision to use private security as the first tier of enforcement, or an approval of that rationale in the upper levels of government. Such a finding is likely to shock the public. Unlike the formal application through the ERC process for the funding for the CEA Program, no such process has been uncovered for the use of private security in the Hotel Quarantine Program. It was a decision made in haste, without regard to its financial implications, and with no person made responsible for reviewing the decision as those financial implications became apparent.
290. The people of Victoria should understand, with clarity, how it was that millions of dollars of public money was ultimately spent, and we should be able to be satisfied that the action to proceed in this way was a considered one that addressed the benefits, risks and options available in arriving at such a decision. There was no evidence that any such considered process occurred on 27 March 2020 or in the days and weeks that followed.
291. The decision to engage private security was not a decision made at the Ministerial level. The Premier and former Minister Mikakos said they played no part in the decision. Similarly, Minister Neville and Minister Pakula stated they were not involved in the decision. Minister Neville was aware of the proposal but not responsible for it and Minister Pakula appears not to have been told until after private security had been engaged. Enforcement of quarantine was a crucial element of the Program that the Premier had committed Victoria to adopting, but neither he nor his Ministers had any active role in, or oversight of, the decision about how that enforcement would be achieved.
292. On its face, this was at odds with any normal application of the principles of the Westminster system of responsible government in that individual Ministers of the Crown are ultimately responsible to the Parliament (and thereby the people) for the actions of their departments. That a decision of such significance for a government program, which ultimately involved the expenditure of tens of millions of dollars and the employment of thousands of people, had neither an owner nor a transparent rationale for why that course was adopted, plainly did not accord with those principles. I have addressed this issue further in Chapter 8.
293. I issued Notices to Produce for documents relevant to the Inquiry's Terms of Reference to all government departments involved in the Program. The Inquiry received more than 70,000 documents in response, including Cabinet documents. No document was produced to the Inquiry that definitively revealed who made the decision to engage private security or how the initial decision-making process occurred. Likewise, no document produced to the Inquiry revealed that there was any consideration given to the ongoing expenditure associated with private security, the appropriateness of that expenditure or whether an alternative enforcement model should have been adopted, until late June 2020 following two significant outbreaks of infections among security guards.
294. This itself bespeaks of a failure of governance. This decision was a substantial part of an important public health initiative and it cost the Victorian community many millions of dollars. But it remained, as multiple submissions to the Inquiry noted, an orphan, with no person or department claiming responsibility.

295. In his evidence, the Premier agreed that the question of how this occurred should be capable of being answered.³⁷⁹ As the head of the Victorian Public Service at the time, Mr Eccles acknowledged it was a fair point that, if no one knew who made the decision, there was an obvious risk that no one would understand that they have the responsibility for revisiting the decision if time and experience showed that it was not the correct one.³⁸⁰ This was what occurred here. The decision was made without proper analysis or even a clear articulation that it was being made at all.
296. No one involved took issue with the use of private security at the time the arrangements were being made. This was despite an ongoing government-commissioned review that raised serious issues about the reliability and professionalism of some sectors of that industry.³⁸¹

Endnotes

- 1 Exhibit HQI0142_RP Voluntary Submission from the Commonwealth of Australia, HQI.0001.0002.0059.
- 2 Ibid.
- 3 Ibid HQI.0001.0002.0065.
- 4 Transcript of day 25 hearing 25 September 2020, 2121.
- 5 Ibid.
- 6 Exhibit HQI0218_P Witness statement of the Hon. Daniel Andrews MP, 3 [11]; Transcript of day 25 hearing 25 September 2020, 2121.
- 7 Exhibit HQI0219_RP Annexures to witness statement of the Hon. Daniel Andrews MP, DPC.0001.0001.0230-0234.
- 8 Ibid DPC.0001.0001.0231; Transcript of day 25 hearing 25 September 2020, 2123–2124.
- 9 Exhibit HQI0219_RP Annexures to witness statement of the Hon. Daniel Andrews MP, DPC.0023.0001.0002; Exhibit HQI0218_P Witness statement of the Hon. Daniel Andrews MP, 3 [12]; Transcript of day 25 hearing 25 September 2020, 2124.
- 10 Exhibit HQI0218_P Witness statement of the Hon. Daniel Andrews MP, 3 [13].
- 11 Transcript of day 25 hearing 25 September 2020, 2124.
- 12 Ibid 2126.
- 13 Ibid 2127.
- 14 Ibid.
- 15 Submission 03 Department of Health and Human Services, 17 [91].
- 16 Transcript of day 25 hearing 25 September 2020, 2134.
- 17 Ibid 2133-2134.
- 18 Ibid 2134.
- 19 Ibid.
- 20 Ibid.
- 21 Ibid.
- 22 Ibid 2135.
- 23 Ibid 2127.
- 24 Transcript of day 22 hearing 22 September 2020, 1895; Transcript of day 18 hearing 16 September 2020, 1473.
- 25 Exhibit HQI0210_P Transcript of Press Conference of the Hon. Daniel Andrews MP on 27 March 2020.
- 26 Premier of Victoria, 'Enforced Quarantine for Returned Travellers to Combat Coronavirus' (Media Release, 27 March 2020) <<https://www.premier.vic.gov.au/enforced-quarantine-returned-travellers-combat-coronavirus>>.
- 27 Exhibit HQI0210_P Transcript of Press Conference of the Hon. Daniel Andrews MP on 27 March 2020, VPOL.0006.0002.0013-0020.
- 28 Premier of Victoria, 'Victorian Premier Daniel Andrews Update on Cases' (Press Conference, 28 March 2020) <<https://www.theage.com.au/national/victoria/victoria-records-biggest-jump-in-virus-cases-as-on-the-spot-fines-introduced-20200328-p54erz.html>>.
- 29 Exhibit HQI0178_RP Annexures to first witness statement of Mr Christopher Eccles, DPC.0012.0001.0734; DPC.0001.0001.6565.
- 30 Exhibit HQI0193_P Letter from the Hon. Daniel Andrews MP to Ms Kym Peake, DHS.0001.0031.0004.
- 31 Transcript of day 25 hearing 25 September 2020, 2137.
- 32 Ibid.
- 33 Ibid.
- 34 Exhibit HQI0237_P Affidavit of Mr Christopher Eccles, 3-4 [14]-[16].
- 35 Transcript of day 22 hearing 22 September 2020, 1816; Exhibit HQI0184_RP Witness statement of Mr Simon Phemister, 6 [25]; Exhibit HQI0243_P Affidavit of Simon Phemister, 3 [11].
- 36 Exhibit HQI0177_RP First witness statement of Mr Christopher Eccles, 19-20 [77]-[78]; Transcript of day 21 hearing 21 September 2020, 1757.
- 37 Transcript of day 21 hearing 21 September 2020, 1757; Exhibit HQI0177_RP First witness statement of Mr Christopher Eccles, 20 [79].
- 38 Transcript of day 21 hearing 21 September 2020, 1755; Exhibit HQI0177_RP First witness statement of Mr Christopher Eccles, 20 [79].
- 39 Exhibit HQI0211_P Witness statement of the Hon. Jenny Mikakos, 3 [16].
- 40 Transcript of day 21 hearing 21 September 2020, 1755-1756; Exhibit HQI077_RP First witness statement of Mr Christopher Eccles, 20 [79].
- 41 Transcript of day 21 hearing 21 September 2020, 1758.
- 42 Ibid.

- 43 Ibid.
- 44 Transcript of day 22 hearing 22 September 2020, 1816.
- 45 Exhibit HQI0238_RP Further DPC documents, HQI.0001.0060.0001.
- 46 Transcript of day 22 hearing 22 September 2020, 1816.
- 47 Ibid 1813-1814.
- 48 Ibid 1816.
- 49 Ibid.
- 50 Exhibit HQI0184_RP Witness statement of Mr Simon Phemister, 7 [27], 8 [42].
- 51 Prime Minister, 'Update on Coronavirus Measures' (Media Release, 27 March 2020) <<https://www.pm.gov.au/media/update-coronavirus-measures-270320>>.
- 52 Exhibit HQI0158_P Transcript of Prime Minister's press conference 27 March 2020, HQI.0001.0002.0003,
- 53 Exhibit HQI00218_P Witness statement of the Hon. Daniel Andrews MP, 3 [13].
- 54 Ibid 1-2 [4].
- 55 Transcript of day 25 hearing 25 September 2020, 2125.
- 56 Exhibit HQI0177_RP First witness statement of Mr Christopher Eccles, 20 [79]; Transcript of day 21 hearing 21 September 2020, 1757.
- 57 Exhibit HQI0210_P Transcript of Premier's press conference on 27 March 2020, 1.
- 58 Premier of Victoria, 'Enforced Quarantine for Returned Travellers to Combat Coronavirus' (Press Release, 27 March 2020) <<https://www.premier.vic.gov.au/enforced-quarantine-returned-travellers-combat-coronavirus>>.
- 59 Transcript of day 25 hearing 25 September 2020, 2125.
- 60 Transcript of day 10 hearing 31 August 2020, 634.
- 61 Exhibit HQI0185(1)_RP Annexures to witness statement of Mr Simon Phemister, DJP.202.002.0001; Transcript of day 22 hearing 22 September 2020, 1818.
- 62 Transcript of day 22 hearing 22 September 2020, 1818.
- 63 Transcript of day 22 hearing 22 September 2020, 1823-1824; Exhibit HQI0032_P Witness statement of Ms Claire Febey, 3 [11].
- 64 Transcript of day 22 hearing 22 September 2020, 1824.
- 65 Ibid.
- 66 Exhibit HQI1033_RP Annexures to witness statement of Ms Claire Febey, DJP.500.001.0001-DJP.500.001.0020.
- 67 Exhibit HQI0184_RP Witness statement of Mr Simon Phemister, 10 [48].
- 68 Exhibit HQI0184_RP Witness statement of Mr Simon Phemister, 7 [28]; Exhibit HQI0049_RP Witness statement of Mr Unni Menon, 6 [19].
- 69 Exhibit HQI0184_RP Witness statement of Mr Simon Phemister, 15 [77]; Exhibit HQI0185_RP Annexures to witness statement of Mr Simon Phemister, DJP.105.007.4370-DJP.105.007.4372.
- 70 Transcript of day 22 hearing 22 September 2020, 1829; Exhibit HQI0036_RP Witness statement of Ms Katrina Currie, 4 [14].
- 71 Exhibit HQI0036_RP Witness statement of Ms Katrina Currie, 4 [12].
- 72 Ibid 10 [34]-[35]; Exhibit HQI0037_RP Annexures to witness statement of Ms Katrina Currie, DJP.108.005.5135; Exhibit HQI0069_RP Witness statement of Mr David Millward adopted by Nigel Coppick, 7 [47], 8 [51]-[53].
- 73 Transcript of day 22 hearing 22 September 2020, 1825
- 74 Exhibit HQI0185_RP Annexures to witness statement of Mr Simon Phemister, DJP.101.002.6347, DJP.101.002.6348.
- 75 Exhibit HQI0184_RP Witness statement of Mr Simon Phemister, 8-9 [43]; Transcript of day 22 hearing 22 September 2020, 1827.
- 76 Exhibit HQI0185_RP Annexures to witness statement of Mr Simon Phemister, DJP.113.008.5598; Exhibit HQI0184_RP Witness statement of Mr Simon Phemister, 17 [85(b)].
- 77 Exhibit HQI0195_RP Witness statement of the Hon. Martin Pakula MP, 1 [1], 2 [6].
- 78 Ibid [2].
- 79 Transcript of day 23 hearing 23 September 2020, 1924.
- 80 Ibid 1925.
- 81 Exhibit HQI0195_RP Witness statement of the Hon. Martin Pakula MP, 2 [6]; Transcript of day 23 hearing 23 September 2020, 1925.
- 82 Transcript of day 23 hearing 23 September 2020, 1925.
- 83 Ibid 1926.
- 84 Exhibit HQI0246_P Affidavit of the Hon. Lisa Neville MP, 1 [5]. Exhibit HQI0242_RP Premier's Private Office Documents, HQI.0001.0063.0001.
- 85 Exhibit HQI0246_P Affidavit of the Hon. Lisa Neville MP, 1 [20].
- 86 Exhibit HQI0184_RP Witness statement of Mr Simon Phemister, 7 [28].
- 87 Transcript of day 22 hearing 22 September 2020, 1817.
- 88 Ibid 1902.

- 89 Exhibit HQI0186_RP First witness statement of Ms Kym Peake, 22 [105].
- 90 Transcript of day 22 hearing 22 September 2020, 1898.
- 91 Ibid 1907.
- 92 Exhibit HQI0184_RP Witness statement of Mr Simon Phemister, 9 [43(f)]; Exhibit HQI0185(1)_RP Annexures to witness statement of Mr Simon Phemister, DJP:101.002.6353; Transcript of day 22 hearing 22 September 2020, 1827-1828; Exhibit HQI0186_RP First witness statement of Ms Kym Peake, 15 [65].
- 93 Exhibit HQI0266_RP Bundle of notices and advices tendered by DHHS, DHS.0001.0004.1872, DHS.0001.0011.0658, DHS.0001.0103.0007.
- 94 Exhibit HQI0085_RP Witness statement of Ms Janette Curtain, 18 [118]; Exhibit HQI0095_RP Witness statement of Dr Nathan Pinski, 2 [10]; Exhibit HQI0090_RP Witness statement of Mr Eric Smith, 2 [6.1].
- 95 Transcript of day 21 hearing 21 September 2020, 1761.
- 96 Ibid, 1761; Exhibit HQI0177_RP Witness statement of Mr Christopher Eccles, 14 [54].
- 97 Transcript of day 21 hearing 21 September 2020, 1761.
- 98 Exhibit HQI0178_RP Annexures to first witness statement of Mr Christopher Eccles, DPC.0016.0001.0095, DPC.0013.0001.0001.
- 99 Transcript of day 21 hearing 21 September 2020, 1762.
- 100 Ibid 1763.
- 101 Exhibit HQI0178_RP Annexures to first witness statement of Mr Christopher Eccles, DPC.0016.0001.0095, DPC.0013.0001.0001.
- 102 Exhibit HQI0033_RP Transcript of audio recording of SCC Operation Soteria meeting 27 March 2020.
- 103 Transcript of day 23 hearing 23 September 2020, 1946.
- 104 Exhibit HQI0145_RP Annexures to first witness statement of Commissioner Andrew Crisp, DOJ.600.001.0719.
- 105 Ibid.
- 106 Transcript of day 23 hearing 23 September 2020, 1946.
- 107 Transcript of day 22 hearing 22 September 2020, 1908.
- 108 Ibid 1862-1863.
- 109 Ibid 1822.
- 110 Transcript of day 21 hearing 21 September 2020, 1764.
- 111 Transcript of day 22 hearing 22 September 2020, 1891.
- 112 Transcript of day 22 hearing 22 September 2020, 1902; Exhibit HQI0186_RP Witness statement of Ms Kym Peake, 15 [65].
- 113 Transcript of day 22 hearing 22 September 2020, 1817.
- 114 Ibid.
- 115 Transcript of day 25 hearing 25 September 2020, 2126.
- 116 Transcript of day 22 hearing 22 September 2020, 1898.
- 117 Transcript of day 21 hearing 21 September 2020, 1757.
- 118 Ibid 1759.
- 119 Exhibit HQI0033(2)_RP Transcript and minutes of audio recording of SCC Operation Soteria meeting 27 March 2020.
- 120 Exhibit HQI0164_RP Witness statement of Mr Jason Helps, 12 [47].
- 121 Transcript of day 17 hearing 15 September 2020, 1373.
- 122 Ibid 1357.
- 123 Exhibit HQI0147_P Third witness statement of Commissioner Andrew Crisp, 3-4 [15]-[16].
- 124 Exhibit HQI0144_P First witness statement of Commissioner Andrew Crisp, 16 [32]-[33]; Exhibit HQI0147 Third witness statement of Commissioner Andrew Crisp, 1 [5]; Exhibit HQI0196_P Witness statement of the Hon. Lisa Neville MP, 5 [35].
- 125 Exhibit HQI0144_P First witness statement of Commissioner Andrew Crisp, 16 [34].
- 126 Ibid 16 [35].
- 127 Exhibit HQI00164_RP Witness statement of Mr Jason Helps, 11 [42].
- 128 Ibid 11 [43]-[44].
- 129 Ibid 11 [45].
- 130 Exhibit HQI0149_RP Witness statement of Mr Christopher Eagle, 3 [11]; Transcript of day 17 hearing 15 September 2020, 1433.
- 131 Transcript of day 17 hearing 15 September 2020, 1433.
- 132 Exhibit HQI0144_P First witness statement of Commissioner Andrew Crisp, 16 [34]-[35].
- 133 Transcript of day 17 hearing 15 September 2020, 1372-1373.
- 134 Exhibit HQI0114_P First witness statement of Commissioner Andrew Crisp, 20 [45].
- 135 Exhibit HQI0184_RP Witness statement of Mr Simon Phemister, 17 [84].
- 136 Ibid.
- 137 Exhibit HQI0114_P First witness statement of Commissioner Andrew Crisp, 20 [45]-[50].

- 138 Exhibit HQI0033(3)_RP Audio recording of SCC Operation Soteria meeting 10.00am 28 March 2020;
Exhibit HQI0033(4)_RP Audio recording of SCC Operation Soteria meeting 6.00pm 28 March 2020.
- 139 Exhibit HQI0143(3)_RP Transcript of audio recording of Operation Soteria meeting 6.00pm 28 March 2020, 20.
- 140 Ibid.
- 141 Exhibit HQI0032_P Witness statement of Ms Claire Febey, 15 [63].
- 142 Ibid.
- 143 Exhibit HQI0164_RP Witness statement of Mr Jason Helps, 12 [50].
- 144 Transcript of day 19 hearing 17 September 2020, 1614.
- 145 Exhibit HQI0033(1)_RP Annexures to witness statement of Ms Claire Febey, DJP.101.004.4571; Transcript of day 19 hearing 17 September 2020, 1614.
- 146 Exhibit HQI0032_P Witness statement of Ms Claire Febey, 16-17 [65]; Transcript of day 8 hearing 27 August 2020, 411-412.
- 147 Exhibit HQI0164_RP Witness statement of Mr Jason Helps, 12-13 [51]-[52].
- 148 Exhibit HQI0184_RP Witness statement of Mr Simon Phemister, 17 [84].
- 149 Transcript of day 8 hearing 27 August 2020, 484.
- 150 Transcript of day 22 hearing 22 September 2020, 1834-1835.
- 151 Ibid 1835.
- 152 Exhibit HQI0038_RP Witness statement of Ms Gonul Serbest 5 [16].
- 153 Transcript of day 22 hearing 22 September 2020, 1857.
- 154 Ibid 1905.
- 155 Exhibit HQI0186_RP First witness statement of Ms Kym Peake, 62 [332].
- 156 Exhibit HQI0226_RP Bundle of notices and advices tendered by DHHS, DHS.0001.0004.1702, DHS.0001.0004.1872 and DHS.0001.0011.0658.
- 157 Ibid DHS.0001.0103.0008 and DHS.001.0104. 0094.
- 158 Ibid DHS.0001.0004.1692 and DHS.0001.0004.1702.
- 159 Exhibit HQI0185_RP Annexures to witness statement of Mr Simon Phemister, DJP.105.003.1020, DJP.105.003.1296, DJP.105.003.0817.
- 160 Ibid.
- 161 Exhibit HQI0211_P Witness statement of the Hon. Jenny Mikakos MP, 15 [76]; Exhibit HQI0186_RP First witness statement of Ms Kym Peake, 39 [198].
- 162 Exhibit HQI0210_P Transcript of press conference by the Hon. Daniel Andrews MP 27 March 2020, 2 [15]-3 [14].
- 163 Exhibit HQI0032_RP Witness statement of Ms Claire Febey, 2 [8]; Exhibit HQI0184_RP Witness statement of Mr Simon Phemister, 6-7 [29]; Exhibit HQI0036_RP Witness statement of Ms Katrina Currie, 4 [13], 7 [23]; Transcript of day 8 hearing 27 August 2020, 446-447.
- 164 Transcript of day 25 hearing 25 September 2020, 2156-2157.
- 165 Transcript of day 12 hearing 3 September 2020, 845.
- 166 Exhibit HQI0079_RP Annexures to witness statement of Commander Timothy Tully, VPOL.0002.0005.0124.
- 167 Exhibit HQI0169_RP Witness statement of Chief Commissioner Shane Patton APM, 11 [6.2].
- 168 Ibid [6.4].
- 169 Ibid.
- 170 Ibid; Transcript of day 19 hearing 17 September 2020, 1649.
- 171 Exhibit HQI0173_RP First witness statement of former Chief Commissioner Graham Ashton AM APM, 6 [3.3-3.6].
- 172 Ibid 9 [6.1].
- 173 Ibid 9 [6.2].
- 174 Transcript of day 17 hearing 15 September 2020, 1380.
- 175 Transcript of day 23 hearing 23 September 2020, 1954; Exhibit HQI0196_R Witness statement of the Hon. Lisa Neville MP, 8 [65].
- 176 Exhibit HQI0196_R Witness statement of the Hon. Lisa Neville MP, 8 [65].
- 177 Transcript of day 18 hearing 15 September 2020, 1504-1505.
- 178 Transcript of day 3 hearing 17 August 2020, 52-53.
- 179 Exhibit HQI0169_RP Witness statement of Chief Commissioner Shane Patton APM, 11 [6.4]; Exhibit HQI0173_RP First witness statement of former Chief Commissioner Graham Ashton AM APM, 6 [3.4].
- 180 Exhibit HQI0067_RP Witness statement of Mr Sam Krikelis, 5 [36].
- 181 Transcript of day 22 hearing 22 September 2020, 1820.
- 182 Transcript of day 12 hearing 3 September 2020, 850; Exhibit HQI0069_RP Witness statement of Mr David Millward adopted by Mr Nigel Coppick, 6 [40].
- 183 Exhibit HQI0033_RP Annexures to witness statement of Ms Claire Febey, DJP.102.007.6152; Exhibit HQI0150_RP Annexures to witness statement of Christopher Eagle, DELW.0001.0020.1969.

- 184 See, e.g. Exhibit HQI0255_RP Affidavit of Mr Jason Helps; Exhibit HQI0256_RP Documents referred to in affidavit of Mr Jason Helps; HQI0257_RP Affidavit of Mr Braedon Hogan; and Exhibit HQI0258_RP Documents referred to in affidavit of Mr Braedon Hogan.
- 185 Exhibit HQI0230_RP DHHS emails re VIC Hotel Quarantine arrangements.
- 186 See, e.g. Exhibit HQI0249_RP First Affidavit of Prof. Brett Sutton.
- 187 Further Submission 01 – Counsel Assisting the Board of Inquiry, 5 [16]-[21].
- 188 Transcript of day 22 hearing 22 September 2020, 1829.
- 189 Transcript of day 8 hearing 27 August 2020, 440.
- 190 Exhibit HQI0037_RP Annexures to witness statements of Ms Katrina Currie, DJP.104.008.6765.
- 191 Exhibit HQI0049_RP Witness Statement of Mr Unni Menon, 3 [12].
- 192 Exhibit HQI0237_P Affidavit of Mr Christopher Eccles, 3 [Q4]; Exhibit HQI0243_P Affidavit of Mr Simon Phemister, 2 [11].
- 193 Transcript of day 22 hearing 22 September 2020, 1816.
- 194 Exhibit HQI0237_P Affidavit of Mr Christopher Eccles, 3 [18 Exhibit HQI0243_P Affidavit of Mr Simon Phemister, 4 [14]; Transcript of day 21 hearing 21 September 2020, 1757; Transcript of day 22 hearing 22 September 2020, 1816.
- 195 Rob Holland and Cameron Nolan, see Exhibit HQI0184_RP Witness statement of Mr Simon Phemister, 7 [31].
- 196 Exhibit HQI0032_RP Witness statement of Ms Claire Febey, 2 [8]; Exhibit HQI0184_RP Witness statement of Mr Simon Phemister, 7 [31]; Exhibit HQI0033_RP Annexures to witness statement of Ms Claire Febey, DJP.202.002.0001.
- 197 Exhibit HQI0033_RP Annexures to witness statement of Ms Claire Febey, DJP.202.002.0001.
- 198 Ibid.
- 199 Further Submission 02 – Chief Commissioner of Police, 1 [2], 2-4 [9]-[22].
- 200 DJP.102.007.8920.
- 201 DOJ.502.004.8832.
- 202 The 12.06pm email and EAP plan were not tendered in evidence, and were not available to Victoria Police for the purpose of submissions. Notwithstanding this, I consider that the above finding is open on the face of these documents, and that it is independently supported by the matters discussed at paragraphs 150.1-150.6.
- 203 Exhibit HQI0049_RP Witness Statement of Mr Unni Menon, 3 [12].
- 204 Exhibit HQI0184_RP Witness Statement of Simon Phemister, 6 [25]; Exhibit HQI0243_P Affidavit of Mr Simon Phemister, 3[11].
- 205 Exhibit HQI0037_RP Annexures to witness statement of Ms Katrina Currie, DJP.104.008.6765.
- 206 Exhibit HQI0033_RP Annexures to witness statement of Ms Claire Febey, DJP.202.002.0001.
- 207 Transcript of day 8 hearing 27 August 2020, 402.
- 208 Exhibit HQI0033_RP Annexures to witness statement of Ms Claire Febey, DJP.201.002.0001.
- 209 Exhibit HQI0049_RP Witness Statement of Mr Unni Menon, 3 [12].
- 210 Exhibit HQI0033_RP Annexures to witness statement of Ms Claire Febey, DJP.201.002.0001.
- 211 Transcript of day 8 hearing 27 August 2020, 397.
- 212 See Chapter 6.
- 213 Exhibit HQI0173_RP First witness statement of former Chief Commissioner Graham Ashton AM APM, 2 [2.2].
- 214 Exhibit HQI0244_P Affidavit of former Chief Commissioner Graham Ashton AM APM, 3 [13].
- 215 Exhibit HQI0173_RP First witness statement of former Chief Commissioner Graham Ashton AM APM, 9 [5.5].
- 216 Transcript of day 21 hearing 21 September 2020, 1767.
- 217 Ibid.
- 218 Ibid 1768.
- 219 Exhibit HQI0173_RP First witness statement of former Chief Commissioner Graham Ashton AM APM, 9 [5.6].
- 220 Transcript of day 21 hearing 21 September 2020, 1795-1796.
- 221 Exhibit HQI0238_RP Further DPC documents, HQI.0001.0060.0001.
- 222 Exhibit HQI0237_P Affidavit of Mr Christopher Eccles, 1 [3]; Exhibit HQI0244_P Affidavit of former Chief Commissioner Graham Ashton AM APM, 2 [5].
- 223 Exhibit HQI0173_RP First witness statement of former Chief Commissioner Graham Ashton AM APM, 8 [5.2]; Exhibit HQI0174_RP Annexures to first witness statement of former Chief Commissioner Graham Ashton AM APM, VPOL.0005.0001.0244.
- 224 Exhibit HQI0173_RP First witness statement of former Chief Commissioner Graham Ashton AM APM, 8 [5.3]; Exhibit HQI0174_RP Annexures to first witness statement of former Chief Commissioner Graham Ashton AM APM, VPOL.0005.0001.0244.
- 225 Transcript of day 21 hearing 21 September 2020, 1768.
- 226 Exhibit HQI0237_P Affidavit of Mr Christopher Eccles, 3 [12].
- 227 Ibid 2 [5]-3 [9].
- 228 Exhibit HQI0237_P Affidavit of Mr Christopher Eccles, 1 [3].

- 229 Ibid 2 [5].
- 230 Transcript of day 25 hearing 25 September 2020, 2130-2131.
- 231 Transcript of day 19 hearing 17 September 2020, 1684.
- 232 Submission 05 the Department of Premier and Cabinet, [9].
- 233 Exhibit HQI0173_RP First witness statement of former Chief Commissioner Graham Ashton AM APM, 9 [5.7].
- 234 Transcript of day 19 hearing 17 September 2020, 1665.
- 235 Exhibit HQI0242_RP Premier's Private Office Documents, HQI.0001.0063.0001.
- 236 Transcript of day 23 hearing 23 September 2020, 1948
- 237 Exhibit HQI0246_P Affidavit of the Hon. Lisa Neville MP, [7].
- 238 Exhibit HQI0196_P Witness statement of the Hon. Lisa Neville MP, 5 [35]-[36]; Transcript of day 17 hearing 15 September 2020, 1367.
- 239 Exhibit HQI0196_P Witness statement of the Hon. Lisa Neville MP, 5 [35].
- 240 Exhibit HQI0181_RP Texts between Commissioner Andrew Crisp and Ms Kate Houghton, DPC.9999.0001.0002.
- 241 Exhibit HQI0178_RP Annexures to first witness statement of Mr Christopher Eccles, DPC.0013.0001.0003-0004.
- 242 Transcript of day 23 hearing 23 September 2020, 1951-1952.
- 243 Ibid 1953.
- 244 Transcript of day 23 hearing 23 September 2020, 1956.
- 245 Exhibit HQI0173_RP First witness statement of former Chief Commissioner Graham Ashton AM APM, 3 [2.4].
- 246 Exhibit HQI0174 Attachments to First Witness Statement of Graham Ashton APM, VPOL.0005.0001.0064 .
- 247 Exhibit HQI0147_P Third witness statement of Commissioner Andrew Crisp, 1 [4]-[5].
- 248 Exhibit HQI0144_P First witness statement of Commissioner Andrew Crisp, 16 [32]-[33].
- 249 Transcript of day 17 hearing 15 September 2020, 1368.
- 250 Ibid 1368-1369.
- 251 Ibid 1383.
- 252 Exhibit HQI0173_RP First witness statement of former Chief Commissioner Graham Ashton AM APM, 7 [4.1].
- 253 Exhibit HQI0196_P Witness statement of the Hon. Lisa Neville MP, 5 [39]-[40].
- 254 Submission 04 the Hon. Lisa Neville MP, 2 [7] and 3 [9].
- 255 Transcript of day 23 hearing 23 September 2020, 1947.
- 256 Exhibit HQI0196_RP Witness statement of the Hon. Lisa Neville MP, 6 [46].
- 257 Submission 10 the Hon. Jenny Mikakos MP, 10 [39], referring to DHS.5000.0075.3961.
- 258 HQI0240 Affidavit of the Hon. Daniel Andrews MP, 3 [11]-[12].
- 259 Exhibit HQI0237_P Affidavit of Mr Christopher Eccles, 5 [26]- [27].
- 260 E.g. Exhibit HQI0238_RP Further DPC documents, HQI.0001.0061.0001, DPC.0028.0001.0001.
- 261 Exhibit HQI0210_P Transcript of press conference by the Hon. Daniel Andrews MP on 27 March 2020, 2 [15].
- 262 Transcript of day 25 hearing 25 September 2020, 2128.
- 263 Ibid 2129.
- 264 Exhibit HQI0239_RP Affidavit of the Hon. Daniel Andrews MP, 4-6 [16]-[27].
- 265 Transcript of day 25 hearing 25 September 2020, 2156.
- 266 Transcript of day 25 hearing 25 September 2020, 2145; Exhibit HQI0239_RP Affidavit of the Hon. Daniel Andrews MP, 2 [6].
- 267 Transcript of day 21 hearing 21 September 2020, 1768.
- 268 Ibid 1768-1769.
- 269 Ibid 1790.
- 270 Exhibit HQI0237_P Affidavit of Mr Christopher Eccles, 5 [25].
- 271 Transcript of day 22 hearing 22 September 2020, 1819.
- 272 Exhibit HQI0238_RP Further DPC documents, HQI.0001.0061.0001.
- 273 Exhibit HQI0033(1)_RP Annexures to witness statement of Ms Claire Febey, DJP.500.001.0002.
- 274 Exhibit HQI0173_RP First witness statement of former Chief Commissioner Graham Ashton AM APM, 4 [2.8].
- 275 Ibid 5 [2.9].
- 276 Transcript of day 22 hearing 22 September 2020, 1818; Exhibit HQI0184_RP Witness statement of Mr Simon Phemister, 7 [31]; Exhibit HQI0185(1)_RP Annexures to witness statement of Mr Simon Phemister, DJP.202.002.0001.
- 277 Transcript of day 22 hearing 22 September 2020, 1818-1819; Exhibit HQI0184_RP Witness statement of Mr Simon Phemister, 7 [27].
- 278 Exhibit HQI0033_RP Annexures to witness statement of Ms Claire Febey, DJP.500.001.0005.
- 279 Ibid.
- 280 Exhibit HQI0173_RP First witness statement of former Chief Commissioner Graham Ashton AM APM, 5 [2.11].
- 281 Ibid 6 [2.17].
- 282 Transcript of day 22 hearing 22 September 2020, 1822.
- 283 Transcript of day 21 hearing 21 September 2020, 1765.

- 284 Exhibit HQI0178_RP Annexures to first witness statement of Mr Christopher Eccles, DPC.0013.0001.0003.
- 285 Ibid DPC.0013.0001.0004.
- 286 Exhibit HQI0174_RP Annexures to first witness statement of former Chief Commissioner Graham Ashton AM APM, VPOL.0005.0001.0065.
- 287 Transcript of day 21 hearing 21 September 2020, 1766.
- 288 Ibid.
- 289 Ibid.
- 290 Exhibit HQI0033(2)_RP Audio recording of SCC Operation Soteria meeting 27 March 2020.
- 291 Exhibit HQI0148_RP Annexures to third witness statement of Commissioner Andrew Crisp, DOJ.515.001.0014.
- 292 Transcript of day 22 hearing 22 September 2020, 1819.
- 293 Ibid 1825.
- 294 Ibid 1824.
- 295 Ibid 1825-1826.
- 296 Ibid.
- 297 Ibid 1827.
- 298 Ibid 1835.
- 299 Ibid 1866.
- 300 Ibid.
- 301 Exhibit HQI0186_RP First witness statement of Ms Kym Peake, 5 [121].
- 302 Transcript of day 24 hearing 24 September 2020, 2066.
- 303 Exhibit HQI0222_P Second witness statement of the Hon. Jenny Mikakos, former MP [8]-[11].
- 304 Ibid.
- 305 Transcript of day 24 hearing 24 September 2020, 2068.
- 306 Ibid 2069.
- 307 Transcript of day 23 hearing 23 September 2020, 1930.
- 308 Exhibit HQI0147_P Third witness statement of Commissioner Andrew Crisp, 2 [6]-[9].
- 309 Exhibit HQI0148_RP Annexures to third witness statement of Commissioner Andrew Crisp, DOJ.515.001.0014.
- 310 Exhibit HQI0173_RP First witness statement of former Chief Commissioner Graham Ashton AM APM, 7-8 [4.6].
- 311 Exhibit HQI0144_RP First witness statement of Commissioner Andrew Crisp, 19 [47].
- 312 Transcript of day 17 hearing 15 September 2020, 1378-1380.
- 313 Exhibit HQI0173_RP First witness statement of former Chief Commissioner Graham Ashton AM APM, 7 [4.5].
- 314 Exhibit HQI0172 Witness statement of a 'Victoria Police Superintendent', 3 [12]-[16].
- 315 Exhibit HQI0173_RP First witness statement of former Chief Commissioner Graham Ashton AM APM, 7 [4.5] and [4.8]
- 316 Ibid 7 [4.1], 8 [4.8].
- 317 Submission 01 Chief Commissioner of Victoria Police, 1 [6]-[10], 4 [18].
- 318 Ibid 2 [8].
- 319 Ibid 17 [64].
- 320 Exhibit HQI0148_RP Annexures to third witness statement of Commissioner Andrew Crisp, DOJ.515.001.0014.
- 321 Transcript of day 25 hearing 25 September 2020, 2132.
- 322 E.g. Flight Lieutenant Marina Lysenko, 'ADF praised for rapid response to bushfire assistance', Defence News (Article, 20 February 2020) <<https://news.defence.gov.au/capability/adf-praised-rapid-response-bushfire-assistance>>.
- 323 Transcript of day 17 hearing 15 September 2020, 1385.
- 324 E.g. Exhibit HQI0210_P Transcript of Press Conference of the Hon. Daniel Andrews MP on 27 March 2020.
- 325 Transcript of day 25 hearing 25 September 2020, 2124, referring to Exhibit HQI0178_RP Annexures to first witness statement of Mr Christopher Eccles, DPC.0001.0001.6123.
- 326 Transcript of day 17 hearing 15 September 2020, 1385.
- 327 Exhibit HQI0142_RP Voluntary Submission of the Commonwealth of Australia, 22.
- 328 Ibid 57.
- 329 Exhibit HQI0144_RP First witness statement of Commissioner Andrew Crisp, 29 [69]; Exhibit HQI0142 Voluntary Submission of the Commonwealth of Australia, 12 [56].
- 330 Exhibit HQI0141_P Letter from the Commonwealth of Australia to the Board of Inquiry.
- 331 'Victoria forced to cut ADF hotel quarantine request ahead of Monday start', The Age (Article, 4 December 2020) <<https://www.theage.com.au/politics/victoria/victoria-forced-to-cut-adf-hotel-quarantine-request-ahead-of-monday-start-20201204-p56kr8.html>>.
- 332 Exhibit HQI0142_RP Voluntary Submission of the Commonwealth of Australia, 8 [35].
- 333 Transcript of day 17 hearing 15 September 2020, 1387.
- 334 Exhibit HQI0169_RP Witness statement of Chief Commissioner Shane Patton APM, 5 [3.3].
- 335 Exhibit HQI0142_RP Voluntary Submission of the Commonwealth of Australia, 57.
- 336 Transcript of day 21 hearing 21 September 2020, 1774-1775.

- 337 Transcript of day 25 hearing 25 September 2020, 2151-2152.
- 338 Exhibit HQI0180_RP Annexures to Further Witness Statement of Christopher Eccles, DPC.0014.0001.0004.
- 339 Transcript of day 25 hearing 25 September 2020, 2151.
- 340 Ibid 2152.
- 341 Exhibit HQI0173_RP First witness statement of former Chief Commissioner Graham Ashton AM APM, 8 [5.2]; Exhibit HQI0174_RP Annexures to first witness statement of former Chief Commissioner Graham Ashton AM APM, VPOL.0005.0001.0244.
- 342 Exhibit HQI0238_RP Further DPC documents, HQI.0001.0060.0001.
- 343 Exhibit HQI0173_RP First witness statement of former Chief Commissioner Graham Ashton AM APM, 9 [5.7].
- 344 Exhibit HQI0148 Annexures to third witness statement of Commissioner Andrew Crisp, DOJ.514.001.0001.
- 345 Exhibit HQI0181_RP Texts between Commissioner Andrew Crisp and Ms Kate Houghton, DPC.9999.0001.0002.
- 346 Transcript of day 24 hearing 24 September 2020, 1954.
- 347 Exhibit HQI0178_RP Annexures to first witness statement of Mr Christopher Eccles, DPC.0013.0001.0004.
- 348 Exhibit HQI0128 Witness statement of the Hon. Daniel Andrews MP, [47]; Transcript of day 25 hearing 25 September 2020, 2148-2149.
- 349 Transcript of day 25 hearing 25 September 2020, 2151.
- 350 Exhibit HQI0178_RP Annexures to first witness statement of Mr Christopher Eccles, DPC.0013.0001.0004.
- 351 Exhibit HQI0033(2)_RP Transcript of audio recording of SCC Operation Soteria meeting 27 March 2020, 25.
- 352 Exhibit HQI0144_P First witness statement of Commissioner Andrew Crisp, 29 [74]-[75]; Transcript of day 17 hearing 15 September 2020, 1386-1387.
- 353 Exhibit HQI0164_RP Witness Statement of Mr Jason Helps, 26 [112].
- 354 Transcript of day 23 hearing 23 September 2020, 1956.
- 355 Exhibit HQI0173_RP First witness statement of former Chief Commissioner Graham Ashton AM APM, 11 [12.6].
- 356 Ibid 10 [71].
- 357 Exhibit HQI0169_RP Witness statement of Chief Commissioner Shane Patton APM, 5 [3.3].
- 358 Ibid [3.4]; Transcript of day 19 hearing 17 September 2020, 1647.
- 359 Transcript of day 19 hearing 17 September 2020, 1650.
- 360 Ibid 1676-1678; Transcript of day 8 hearing 27 August 2020, 399-400.
- 361 Exhibit HQI0032_P Witness statement of Ms Claire Febey, 10-11 [41].
- 362 Exhibit HQI0143(3)_RP Transcript of audio recording of Operation Soteria meeting 6.00pm 28 March 2020, 22; Transcript of day 17 hearing 15 September 2020, 1387-1388.
- 363 Exhibit HQI0164_RP Witness statement of Mr Jason Helps, 26 [110].
- 364 Transcript of day 21 hearing 21 September 2020, 1776,
- 365 Ibid.
- 366 Ibid 1771.
- 367 Transcript of day 17 hearing 15 September 2020, 1386-1387.
- 368 Transcript of day 21 hearing 21 September 2020, 1769; Exhibit HQI0179_RP Second witness statement of Mr Christopher Eccles, 5 [22].
- 369 Exhibit HQI0238_RP Further DPC documents, HQI.0001.0060.0001.
- 370 Transcript of day 21 hearing 21 September 2020, 1755.
- 371 Exhibit HQI0173_RP First witness statement of former Chief Commissioner Graham Ashton AM APM, 8 [5.3].
- 372 Exhibit HQI0214_RP Texts between Assistant Commissioner Grainger and Commissioner Andrew Crisp 27 and 28 March 2020 VPOL.0005.0007.0006, Exhibit HQI0147_P Third witness statement of Commissioner Andrew Crisp, 2 [7]-[8].
- 373 Exhibit HQI0214_RP Texts between Assistant Commissioner Grainger and Commissioner Andrew Crisp 27 and 28 March 2020 VPOL.0005.0007.0006.
- 374 Transcript of day 8 hearing 27 August 2020, 432.
- 375 Exhibit HQI0148(2)_RP Transcripts and minutes of audio recording of SCC Operation Soteria meeting 27 March 2020, 12.
- 376 Exhibit HQI0184_RP Witness statement of Mr Simon Phemister, 9 [45].
- 377 Ibid 8 [37].
- 378 Transcript of day 8 hearing 27 August 2020, 432.
- 379 Transcript of day 25 hearing 25 September 2020, 2156.
- 380 Transcript of day 21 hearing 21 September 2020, 1770.
- 381 In October 2018, the Premier announced that the Victorian Government would conduct a review into the private security industry. Submissions closed on 27 July 2020. The Final Report is due in December 2020. See Department of Justice and Community Safety, Review of Victoria's Private Security Industry, <<https://engage.vic.gov.au/private-security-review-2020>>.

CHAPTER 6

Private security

6.1 Introduction

1. In Chapter 5, I considered the evidence regarding the ‘decision’ on 27 March 2020 that private security guards would be the first and primary tier of enforcement at the quarantine hotels. I concluded that the ‘decision’ to use private security guards in that way was a position that was adopted during the State Control Centre (SCC) meeting at 4.30pm on 27 March 2020, following Assistant Commissioner Michael Grainger expressing Victoria Police’s preference in the matter.
2. That ‘decision’ had profound impacts on the efficacy and operation of the Hotel Quarantine Program. How that ‘decision’ was implemented, from the identification of potential security firms to how they worked ‘on the ground’, is the subject to which I now turn.

6.2 The process of identifying security contractors

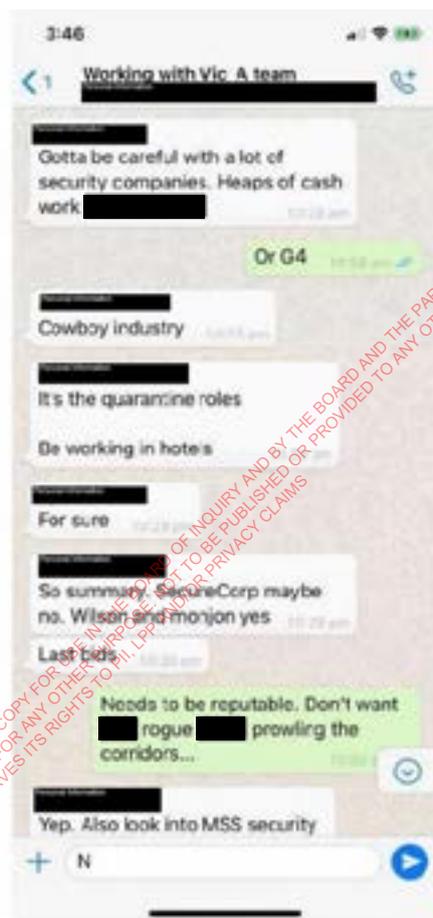
3. At the conclusion of the meeting at the SCC on the afternoon of Friday 27 March 2020, Claire Febey, Executive Director, Priority Projects Unit at the Department of Jobs, Precincts and Regions (DJPR), left the SCC with the engagement of private security as one of the items on her and DJPR’s list of tasks.¹
4. Late on Friday 27 March 2020, Katrina Currie, Executive Director, Employment Delivery, Working for Victoria at DJPR, was nominated as the person responsible for identifying private security firms for the purposes of the Hotel Quarantine Program.² Ms Currie was on secondment, with her substantive position being Executive Director, Employment, Inclusion Group at DJPR.³ For context, Working for Victoria was a program established by the Victorian Government to assist people who had been dislocated from jobs by COVID-19.⁴
5. Although, on the evidence of Ms Febey and others, it was known from the time of the SCC meeting’s conclusion around 6.00pm that private security needed to be engaged, and although Ms Currie had been forewarned earlier in the day of the potential need to find security suppliers,⁵ Ms Currie was not actually asked to make contact with security companies until after 10.00pm that evening when she received an email from Alex Kamenev, Deputy Secretary, Precincts and Suburbs, DJPR.⁶ She and her team were still at work at that time because of the imminent launch of the Working for Victoria scheme.⁷
6. The Secretary of DJPR, Simon Phemister, said, in evidence, that the reason no action was taken earlier in the day was because they were seeking clarity about what the role of private security would be.⁸ It does not appear that any clarity was received, although the ‘ideal’ operating model for the Hotel Quarantine Program was suggested by Cameron Nolan, Executive Director, Priority Projects Unit, DJPR, as follows:

Ideal model in my mind would be a supply of security staff ... who work under the direction of an authorised officer in DHHS. This DHHS team would induct the security guards and provide on-call advice about what to do in certain situations and determine if any incidents should be escalated to the authorised officer and/or VicPol.⁹

It was in this context that Ms Currie set about engaging private security firms. She was informed, on the evening of 27 March 2020, of the requirement to have identified and engaged the relevant services by the evening of 28 March 2020.¹⁰ Ms Currie had experience in the broader employment sector, but no particular experience with the security industry.¹¹ At this stage, there were no clear instructions about the exact nature of the work security would be performing or the companies that Ms Currie should approach.¹²

7. Although Ms Currie had been allocated the task of procuring security because she was seen as having pre-existing contacts with labour firms, she was, in fact, not sure who to approach (though had the idea of Wilson Security Pty Ltd and SECURECorp (Victoria) Pty Ltd being potentially suitable) and sought the assistance of her team within DJPR.¹³ The Inquiry received evidence of a WhatsApp group chat between DJPR employees, where suitable companies were discussed.¹⁴
8. A theme in the WhatsApp messages was that the security companies needed to be reputable, and that there could be problems with some in the industry.¹⁵
9. From these WhatsApp messages, it does not appear that those involved in the group chat knew that there was a *State Purchase Contract: Agreement for the Provision of Security Services* (State Purchase Contract) and that there were publicly available details, including email and mobile numbers, on a website. Ms Currie gave evidence that she did not know about the State Purchase Contract.¹⁶
10. This was an early example of what was a recurring theme in the early days of the Hotel Quarantine Program, that is, people were working hard and in good faith but, unfortunately, without relevant knowledge and expertise to guide them. Ms Currie and her team were working towards midnight looking for the names and contact details of potential firms,¹⁷ effectively reinventing the wheel when, all the time, the information they needed was readily available to them on a website, following a process that had vetted security companies for their suitability for government work.¹⁸ When the Program was to be implemented in a matter of just hours, efficiency was of critical importance. That would have been better served by early engagement with those areas within DJPR, or even the Department of Treasury and Finance (DTF), with experience in procuring security services.
11. Those suggesting potential security providers had some general ideas about the security industry but did not have any knowledge of security contracting and, understandably, no knowledge of what their role in the Hotel Quarantine Program was going to look like. This reflected the absence of any proper discussion at the SCC about the role, and created the context in which the role of security remained unclear and liable to variation without any centralised oversight or consideration of whether those variations were appropriate.

Figure 6.1: Example of WhatsApp messages between DJPR employees discussing security firms



Source: Exhibit HQI0182_RP Working with Vic messages re good security companies, p. 6

12. Following consultation with the Employer Engagement team, the recommendations Ms Currie received as potential providers were Unified Security Group (Australia) Pty Ltd (Unified), Wilson Security Pty Ltd (Wilson), MSS Security Pty Ltd (MSS) and Monjon Australia Pty Ltd.¹⁹ Of those, it was Unified, Wilson and MSS that were engaged to provide security services.
13. Ms Currie explained, in her witness statement, that the basis for the Employer Engagement team recommending these three companies was positive feedback, previous working relationships and previous work on large-scale projects. She explained that:

Unified was recommended because members of the Employer Engagement team had previously received positive feedback about Unified's performance in providing private security which was reflected in the fact that Unified had been awarded large-scale contracts, including a number with Metro Rail across various sites, and had a positive impression of Unified given their previous dealings with the firm;

Wilson was recommended because DJPR had engaged Wilson on a number of occasions in the past and considered that Wilson would have the resources necessary to assist. Further, members of the Employer Engagement team had received positive feedback concerning Wilson's work in the non-government disability sector; and

MSS was recommended because it was considered reputable based on feedback and opinions that had previously been expressed to members of the employer engagement team.²⁰

14. I accept that those providing Ms Currie with suggestions did so to the best of their knowledge and with a desire to be useful, selecting companies that met their sense of a good employer. But they were not the ones who should have been making those assessments.
15. It so happened that MSS and Wilson were members of the panel of firms subject to the State Purchase Contract. Unified was not. Ms Currie did not know this.²¹ Late on Friday 27 March 2020, contact details having been found, she sent an email to Unified and to Wilson asking about their availability to provide security services for the Program from the coming Sunday morning.²²
16. The next morning, on 28 March 2020, David Millward, Chief Executive Officer of Unified, was the first to contact Ms Currie and, so, Unified became the company asked to provide security services at the first hotels being stood up in preparation for international arrivals. Mr Millward said that Unified could allocate 20 guards immediately and 100 over the coming day.²³
17. Later the same morning, Greg Watson, General Manager of Wilson, made contact with Ms Currie, who also had discussions with Jamie Adams, General Manager — Victoria and Tasmania at MSS, on 29 March 2020.²⁴
18. Ms Currie did not recall all of the discussions and largely accepted the recollections of Mr Watson, Mr Millward and Mr Adams about what was discussed.²⁵ With authority from her superiors, she engaged, over the weekend, Unified and Wilson on an informal basis.²⁶ She gave a verbal briefing, aided by work done by others in her Department, as to the nature of the security task.²⁷
19. Nigel Coppick, National Operations Manager of Unified, attended a planning meeting in the early afternoon of 28 March 2020 and then was present at the ‘dry run’ at the Crown hotels. It was during this ‘dry run’ where the required number of guards was substantially increased after Victoria Police reviewed the number of points in the building requiring security cover.²⁸ The following morning, Mo Nagi, Victorian Operations Manager for Unified, who had been hired by Mr Coppick to work on Unified’s operations in the Hotel Quarantine Program,²⁹ attended the Crown hotels along with Mr Coppick and a team of security guards (all subcontractors) to receive the first arrivals.³⁰

6.3 Subsequent procurement decisions

20. By Monday 30 March 2020, Ms Currie was handing over longer-term responsibility for security contracting to the Principal Policy Officer at DJPR, whose role became one of receiving quotes and negotiating terms with each of the three selected suppliers.³¹
21. In the week commencing 30 March 2020, the Principal Policy Officer received quotes from the security companies and discussed them with Ms Currie. Unified was more expensive than Wilson.³²
22. On 30 March 2020, the Principal Policy Officer received advice from procurement officers within DJPR and DTF that providers on the State Purchase Contract should be used.³³ When he forwarded that advice to Ms Currie, she responded that it was necessary to retain Unified as they were already on the ground and that an exemption (from engaging panel firms) should be sought.³⁴
23. Ms Currie gave evidence that she spent 30 March 2020 seeking an exemption from the DJPR procurement policy to permit the engagement of Unified, but then came to understand that no exemption was needed because the COVID-19 pandemic met the definition of an emergency under DJPR’s critical incident procurement protocols and policies.³⁵
24. While it is true that there was scope within the policy for critical or emergency situations, Ms Currie and the Principal Policy Officer received specific counsel on 31 March 2020 from the procurement specialist who advised them:

Need clarity on the rationale for going outside the SPC in this instance. I understand there was an urgency to get things up and running quickly over the weekend but to have a non-approved firm providing security and effectively enforcing government regulation at quarantine sites off the back of some emails and phone calls presents significant risk to individuals involved and the department/Government that is not easily mitigated.

Need to be clear on why this provider was engaged instead of the other SPC providers (noting requests went to Wilson and MSS - who are on the SPC) and whether there is any reason to continue with them (as opposed to switching them out for an SPC provider, for example) in order to assist in determining next steps.³⁶

25. This advice warned Ms Currie and the Principal Policy Officer about risks to individuals and the Government, and invited them to reflect on the suitability of continuing to retain Unified. In my view, that was sound advice. Although DJPR submitted to the contrary,³⁷ the State Purchase Contract represented pre-vetting and pre-approval of security companies that were competent and appropriate for government security work. Procurement guidelines are not to be lightly set aside and should have been followed. Though neither Ms Currie nor the Principal Policy Officer would have known it, Unified had, in fact, applied to join the State Purchase Contract but had been unsuccessful. They were also, as Ms Currie and others discovered, not 'preferred' by the Victorian Trades Hall Council (Trades Hall). Ms Currie gave evidence that she did not know at the time she liaised with Trades Hall, that Trades Hall did not 'prefer' Unified, and would not speculate as to Trades Hall's reasons why it did not 'prefer' Unified.³⁸
26. Ms Currie's initial response was to advocate for a contract with Unified:

I was tasked with standing up a security team on Friday night by the following Saturday morning.

I sought advice from my employer engagement teams on security companies we have worked with through Jobs Victoria and asked for contact details of the firms concerned. I was provided with two options at that time — Wilson and Unified. I emailed Unified and Wilsons at 11.30pm Friday night. Unified replied to me at 6.52am on Saturday morning and I began discussions at 7.00am as to their capability and capacity to deliver servicing at the first two sites by mid-afternoon Saturday. I was advised by text of their capability and this was followed up in telephone conversations. They attended site at 3pm to assess risk and staffing needs; briefed and planned their rosters and secured personnel; and were onsite delivering as required from 5am on Sunday morning.

Wilson replied to me by 8.00am on Saturday morning but by then I had already entered into discussions with Unified. I took up discussions with Wilsons for subsequent sites around 11am. They indicated they could also supply and so I spoke with them again around 4pm and asked them to consider how they could respond. They emailed me a series of questions on Sunday to which I responded by which time Unified had already been tasked with the first hotels. Wilson have been engaged for three subsequent hotels.

Unified is an Aboriginal owned and controlled organisation and has worked with DJPR on related social procurement initiatives. They are accredited with Kinaway and Supply Nation. While they are not a panel provider for security services utilising their services is in keeping with the State Government's social procurement objectives of utilising Aboriginal businesses. A legal exemption should be sought but Unified are delivering and have been delivering services since Sunday. The rationale for the exemption is both immediate need and their responsiveness but also their status as an Aboriginal owned and controlled business under the Government's social procurement objectives.³⁹

27. In her evidence, Ms Currie denied that Unified's status as an Aboriginal business had been a factor in her initial contact with Mr Millward.⁴⁰ I accept her evidence on that point, but this email does suggest a reason why those assisting her offered the name of Unified in the first place. Indeed, the WhatsApp messages confirm that Unified was known to members of the group through its work in inclusive employment.⁴¹
28. It appears that, for a period of time, DJPR did intend to confine Unified to its initial hotel allocations. Negotiations with Trades Hall proceeded on the basis that Unified would not be allocated additional hotels and the Principal Policy Officer, in receiving a formal handover from Ms Currie, confirmed that Unified would remain at the two Crown hotels but be allocated no others.⁴²
29. In circumstances where Unified had been contacted outside ordinary procurement processes and without time for proper consideration of its suitability or capacity, honouring the informal contracts at the Crown hotels but distributing future work to suppliers who were part of the State Purchase Contract would have been the more prudent course for DJPR to adopt.
30. Instead, Unified appears to have won over those DJPR officers working on the frontline in hotels, and to have established itself as the preferred provider on the back of anecdotal reports about how well it was performing. Its elevated status in the minds of DJPR appears to have been set in place well before contracts were actually signed and before either of the other two providers had commenced work. On 30 March 2020, Unified was referred to as being 'a dream' while Wilson was said to have been 'difficult'.⁴³ Ms Currie initially gave evidence that this was linked to Wilson's refusal to undertake activities like bag searches, but she went on to clarify that answer as follows:⁴⁴

Ms Ellyard: So are you able, as you sit here now, to recall what, if anything, you were aware of that led you to have the view that that distinction could be drawn, between the way Unified had presented and the way Wilson had?

Ms Currie: I think, no, I can't. It was to do with their responsiveness and issues to do with the range of different things that they wanted covered off beforehand.

31. On 3 April 2020, the Principal Policy Officer was told by Unified that it had 'significant additional capacity' and could 'mobilise at short notice at any required sites'.⁴⁵ As was conceded by Mr Coppick in his evidence, Unified was reliant on subcontractors for that capacity.⁴⁶ Mr Coppick explained that Unified had a small standing workforce of 89 permanent staff in Victoria.⁴⁷ As already noted, it was also willing to agree to any requests from DJPR for assistance that fell outside the usual scope of security duties, such as going toy shopping, organising and delivering Easter eggs, and undertaking other tasks, out of a desire to be as helpful as possible.⁴⁸
32. On the same day, Gönül Serbest, Chief Executive Officer of Global Victoria, was making complaints about Wilson and consideration was being given to switching them out for Unified. Ms Currie said that Unified could be given additional sites, thus reversing the position agreed with Trades Hall at the beginning of the week.⁴⁹
33. It appears that, on the back of those initial 'concerns' about Wilson being 'difficult' by raising what I find were valid safety concerns, a concluded view was reached that Wilson was not to be preferred. Its initial hotel allocation of two hotels was removed and allocated to Unified, and it was only ever given two further hotels for the remainder of the Program.⁵⁰
34. Unified's position as the initial provider of security over the first weekend of the Program ended up giving it a substantial advantage over the other contractors. Unified was perceived by Global Victoria and DJPR staff to have been performing well in those early days, which led to it being allocated new hotels as they opened.⁵¹
35. Unified also met the expectations of DJPR regarding the kind of assistance that would be available from security. So, when Wilson expressed concern about luggage handling, Ms Serbest thought it was reasonable to expect Wilson to provide this service because it was being done at other hotels.⁵² Unified's willingness to do anything asked of it made it an attractive partner in the work.

36. Of course, in allocating subsequent hotels among its contractors, DJPR was entitled to have regard to issues of past performance as well as issues of capacity. I do not suggest that perceptions and feedback about that past performance were irrelevant.
37. But a review of how hotels were ultimately allocated between the three contractors contained in Mr Phemister's statement reveals a disproportionate allocation to Unified that cannot be justified by anecdotal assessments from frontline DJPR staff. According to Mr Phemister:
- A. MSS was allocated a total of five hotels, one of which was a short-term engagement of two weeks
 - B. Wilson was allocated a total of four hotels, with its initial two hotels being re-allocated to Unified by mid-April
 - C. Unified was allocated 11 CBD hotels plus the one regional hotel used for ship workers in Portland. It was allocated eight hotels in a row between 6 and 26 April, two of which were re-allocations from Wilson.⁵³
38. To take a snapshot of what this meant, in mid-May, Wilson was providing security at one hotel, MSS at four and Unified at eight or nine.⁵⁴ Yet, it was Unified that was not on the State Purchase Contract, not preferred by Trades Hall and who had a small footprint in Melbourne.
39. There also appears to have been different attitudes taken when inappropriate conduct by security guards came to light. While the decision to remove hotels from Wilson was predicated in part on allegations of misconduct by guards, when similar conduct was alleged against MSS and Unified subcontractors it was not deemed a basis for similar action.⁵⁵ Indeed, when significant allegations of bullying and harassment were made about security staff at Rydges on 11 May 2020,⁵⁶ Unified kept it and all its other hotels and was even allocated further work on 19 May and 24 May 2020.⁵⁷ This further suggests an underlying preference for Unified that, I infer, was based on its willingness to meet any requests made of it.
40. I am satisfied that the allocation of hotels to security companies was not based on any proper assessment of the respective companies' capacity and suitability to undertake the work. A substantial percentage of the work, in terms of hotels and money, went to a non-panel firm that, in turn, relied entirely on small subcontractors. DJPR took Unified at its own estimation and on the basis of the professional relationships it had formed.
41. Had there been consideration of such matters as training, infection control and direct supervision of subcontractors, Unified ought to have been compared less favourably with the other subcontractors, who had taken on responsibility for devising their own training and, in the case of Wilson, taking their own expert advice on infection prevention measures.⁵⁸
42. Similarly, if regard were paid to size and experience and the nature of the work, Unified ought to have been ranked behind the other providers, who each had experience in areas more closely linked to the work in the hotels, such as work at courts, hospitals and detention centres.⁵⁹
43. Further, if regard had been paid to costs, the allocation of work might also have been different. Unified was the most expensive,⁶⁰ although its subcontractors were not necessarily earning more than subcontractors for other providers.⁶¹
44. Any proper oversight of the benefits and risks to the Program by both DJPR and DHHS would likely have resulted in at least a different spread of work between the contractors.
45. As I consider below, the three security contractors were not all equal. Their differing sizes and competencies meant exposure to differing levels of risk, particularly in circumstances where other aspects of the Program were not well managed. (See Chapter 8 regarding the role of on-site management by DHHS.)

46. The extent of the whole Hotel Quarantine Program's reliance on small subcontractors is best demonstrated by a review of how many hotels were being supplied with guards by one small subcontracting company. Sterling Services Group (Sterling), a company subcontracted by Unified, had held a private security business licence for less than a year and had never done government work before.⁶² Its director, Sorav 'Sam' Aggarwal, said:

Sterling ... provided security staff to the government security contractor Unified Security for the following hotels and time periods in the Hotel Quarantine Program:

- (a) Novotel Collins: 26 June 2020–10 July 2020
- (b) Travelodge Southbank: 13 April 2020–14 May 2020
- (c) Crown Metropol: 29 March 2020–5 April 2020 (covered partly);
6 April 2020–11 July 2020 (covered fully)
- (d) Holiday Inn Melbourne: 21 May 2020–11 July 2020
- (e) Crowne Plaza: 19 April 2020–3 May 2020
- (f) Pan Pacific South Wharf: 26 April 2020–11 July 2020
- (g) Rydges on Swanston: 11 May 2020–30 May 2020; 14 June 2020–30 June 2020
- (h) Novotel South Wharf: 17 April 2020–1 May 2020; 9 May 2020–24 May 2020;
1 June 2020–17 June 2020
- (i) Crown Promenade: 3 April 2020–14 April 2020 (covered partly);
19 April 2020–11 July 2020 (covered fully)
- (j) Brady Hotel: 17 June 2020–23 June 2020
- (k) Comfort Inn Portland: 19 May 2020–21 May 2020; 20 June–27 June 2020
- (l) Marriott Hotel: 28 June 2020–11 July 2020
- (m) Hotel Grand Chancellor: 26 June 2020–3 July 2020.⁶³

47. Sterling's capacity to source and provide high quality staff was attested to by Mr Coppick,⁶⁴ and I make no finding that either Mr Aggarwal or any of his colleagues did anything other than their best. But the allocation of so much work and responsibility to one small firm exposed the whole Program to risk. That risk was heightened because the role of subcontractors was not sufficiently visible to DJPR and, so, was not monitored. Mr Aggarwal gave uncontradicted evidence that he never saw Unified's head contract with DJPR and was unaware of its terms.⁶⁵ Yet it was his small company that was supplying the majority of the services the State was purchasing from Unified, including services at Rydges, the so-called 'hot hotel'.⁶⁶ Mr Aggarwal and Sterling took over at the Rydges on 11 May 2020 after another subcontractor,⁶⁷ Elite Services, was removed following complaints against it.⁶⁸

6.4 The role initially envisaged for private security

48. As I have noted, at the time DJPR was tasked with engaging security contractors, there were no clear instructions regarding the nature of the work security guards would be required to undertake.⁶⁹
49. Indeed, the precise role that private security and Victoria Police would play in the Hotel Quarantine Program was quite unclear at the initial meetings held when establishing the Program.⁷⁰ While it was Victoria Police's preference for private security companies to be the 'first line of security' at the hotels and police would be called in when required,⁷¹ there was no more detailed discussion about what 'first line' or 'first tier' meant or what the actual duties of security would be. A summary by Mr Nolan of 'the ideal' model was Ms Currie's starting point and her discussions with security firms were on the assumption that security firms would:

- A. support the Chief Health Officer (CHO), Authorised Officers and Victoria Police in the enforcement of isolation
 - B. ensure quarantined guests did not leave the hotel during their quarantine period without permission from the Authorised Officer
 - C. ensure disputes with quarantine guests were de-escalated without physical contact and, if this could not be done, escalate the matter to Victoria Police
 - D. provide advice to quarantine guests on which areas of the hotel they could enter.⁷²
50. Evidence received from Wilson, Unified and MSS around the nature of services to be provided, in the first instance, largely reflected that security guards would provide ‘on the ground’ support to enforce isolation and ensure guests stayed in their rooms. The evidence before the Inquiry is that this limited role would have been consistent with the use of private security in many other contexts and, thus, would have been seen as uncontroversial, notwithstanding the limited understanding at that time of the complexities of the quarantine hotel sites.
51. Indeed, evidence provided by Wilson highlighted that it held an initial understanding that the role of security guards was to support the CHO in the enforcement of quarantine conditions by preventing people from leaving the hotel. It was understood that security guards would implement a ‘hands off’ approach and any non-compliance would be escalated to Victoria Police.⁷³ MSS also expected its guards’ role to be ‘reasonably simplistic’ and primarily in relation to ‘access control to each of the facilities, presence on each of the floors ... and then providing generally a security presence on-site, with some infection control awareness’.⁷⁴
52. According to Mr Coppick from Unified, between 28 March and 2 April 2020, his company received very little information and/or guidance from Victorian Government representatives in relation to the duties and responsibilities of its security guards.⁷⁵ I accept this evidence as consistent with the evolving understanding on the part of DJPR and others of the sheer logistical scale of the Hotel Quarantine Program and the speed with which it was set up. It is clear that the logistics were being worked out ‘on the run’.
53. Wilson’s Purchase Order Contract (POC) was finalised on 6 May 2020.⁷⁶ Prior to this, it was acting in accordance with the overarching contract already established by being on the panel of preferred contractors with the Victorian Government.⁷⁷ The POC included agreement about the rate of pay for guards and supervisors. The rate was inclusive of Wilson’s costs, like supplying all of its own PPE.⁷⁸ Similarly, MSS commenced working at the hotels prior to its POC being finalised.⁷⁹ The duties, as set out in the contracts, appeared to reflect the uncertainty of what specific roles security would play in the Hotel Quarantine Program.⁸⁰
54. With reference to MSS’s POC, Schedule 3, Specifications (as of 23 April 2020) outlined general expectations of security guards when carrying out their roles as part of the Hotel Quarantine Program. It noted that MSS, the Service Provider, must provide services that included, but were not limited to:
- A. before check-in: ensure there is an adequate number of personnel on the floors where guests are staying
 - B. during check-in: accompany guests in lifts to their rooms (no more than four people per lift), assist with arriving buses i.e. helping with bags, being present to manage onsite issues
 - C. once checked-in: maintain presence on the floors, lobby and front door, receive and check parcels, manage food deliveries, assist with outdoor breaks, only allow authorised persons to enter each location
 - D. during check-out: assist by escorting guests to the lobby and assist with luggage if require.
 - E. escalation of issues: guest health related requests/concerns must be communications to Authorised Officers/nurses, food complaints to hotel staff, onsite queries to designated location manager
 - F. at all times: respond to routine, emergency incidents, in case of emergency must call 000.⁸¹

55. These specifications were also outlined in Wilson's signed contract⁸² and in Unified's Agreement for Professional Services.⁸³
56. Wilson Security had an initial understanding that Victoria Police would have a permanent presence at each hotel site, however, it later became clear this would not be the case.⁸⁴

6.5 The evolving role of private security

57. The specifications in the contracts mentioned above were, notably, included at a later stage. Mr Watson said that, when Wilson security guards were first deployed, they had a role to 'observe and report'. By early April 2020, the services that the Government had requested changed to include bag searches, food and care package deliveries and the facilitation of exercise breaks.⁸⁵
58. This demonstrated how the role of security guards changed significantly over time. While, initially, there was an expectation that they would simply monitor guest activity and ensure guests stayed in their rooms for the 14-day quarantine period (static guarding), this later changed and security guards had the responsibility for facilitating fresh air breaks for guests and managing deliveries.⁸⁶
59. Wilson raised concerns about the expanded roles guards were expected to play in relation to infection risks for its workers, legal powers of guards and their health and safety. Generally, the request for guards to engage in duties outside their initial remit was being communicated on the ground, without first being raised at a management level. This caused issues between Wilson and DJPR, as guards were refusing to do certain tasks without Wilson first approving it.⁸⁷ As set out above, I am satisfied that Wilson's concerns contributed to the perception that it was 'difficult' and to consequent decisions about how security guards should be allocated to hotels.
60. For example, in relation to handling luggage, there were infection control concerns around touching items, as well as general health and safety concerns because guards were not trained (as it was not part of normal guarding duties) to handle heavy items. Wilson was concerned the union would step in because luggage handling was not in the enterprise agreement.⁸⁸ Questions arose about the lawfulness of baggage searches; Wilson negotiated a limited form of search.⁸⁹ MSS appears to have been willing to undertake baggage searches:

Ms Ellyard: Were you ever asked to do things like searching bags, for example?

Sam Krikelis: Yes, we were. So, we were asked to search the care packages that would come from the guests' families and friends. We were looking for items that were, I guess, restricted; cigarettes, lighters, et cetera and for items that were prohibited, such as drugs. But we do that a lot at our events, so it was nothing different for our staff to undertake those tasks.⁹⁰

61. It does not appear that those within DJPR who were pressing for security guards to take on additional duties were alive to potential industrial issues or that there was any thought given to the appropriateness of using private security guards as a workforce for performing non-security tasks. It may be that the presence of large numbers of security guards standing at entrances and on each floor gave the impression of an underused workforce that was available to fill in where no other personnel were available.
62. When Mr Nagi and Mr Coppick were asked about the further tasks that Unified staff and subcontractors were asked to do, such as the delivery of Easter eggs and Mother's Day presents and buying toys for children in the hotels, they agreed that these were not security-related tasks, but Unified took the view that they were there to provide support to the Government, in whatever capacity.⁹¹ It is noteworthy that neither Wilson nor MSS was asked to go shopping for toys. I infer from the industrial safety issues, quite properly being raised by Wilson, that it was understood it would not have agreed to take on such tasks.

63. The most significant expansion of the role of private security guards came with the introduction of fresh air breaks. When initially contacted, all security companies were told that guests would not be leaving their hotel rooms.⁹² It does appear that the initial conception of those establishing the Program was that guests would enter their rooms and not leave them until 14 days later.
64. It appears that slightly different arrangements were in place at each hotel depending on the available areas for fresh air breaks (for example, some hotels could use rooftop gardens whereas others relied on small spaces outside the building).⁹³
65. The introduction of fresh air breaks had two implications for security guards:
 - A. it increased the potential for direct contact between security guards and quarantined guests, some of whom were, or could be, infectious
 - B. it meant that guests were not remaining in their rooms and were moving through common areas also used by security and hotel staff, increasing the risk of infection through the contamination of those common areas (particularly in circumstances where there was no agency responsible for infection control supervision on-site, a matter I deal with in Chapter 8).
66. Fresh air breaks, thus, fundamentally changed the role of private security from static guarding outside the areas where quarantined guests were located to a much more complex role that included the potential for direct contact with those guests and contact with surfaces and spaces that those guests had touched or passed through.
67. This is not to suggest that fresh air breaks should not have occurred; indeed, as set out in Chapter 11.3 (and recommended in the facility-based model, as per the Interim, and now Final, Report Recommendation 45), they were an appropriate part of a balanced and responsive quarantine program. However, the introduction of those breaks ought to have occurred in the context of a proper re-evaluation of the infection control measures in place in hotels and an assessment of the increased risks posed to security staff. For instance, the closer contact with guests heightened the significance of PPE and infection prevention training for security guards and made it even more important that there be a high level of understanding, compliance and expert supervision of security guards about their need for scrupulous attention to PPE usage. It raised the question whether, once it was no longer static guarding work with minimal contact with quarantined travellers or areas used by those travellers, the cohort of people comprising the private security workforce was the right cohort for the work. I deal with that issue later.
68. But no such re-evaluation or risk assessment occurred. Although Victoria Police did raise some concerns about fresh air breaks at the Pan Pacific and the potential for those in quarantine to mingle with members of the public,⁹⁴ there appears to have been no thought given to the deeper and more significant ramifications fresh air breaks held for the use of private security guards.
69. The same was true of the expanded role of security in luggage handling and parcel delivery. The use of security in that role began from the first day of the Program in response to the need for those services and in light of Unified's willingness to provide those services and to do anything asked of it by DJPR.⁹⁵ By the time the contracts were finalised, some reference to those activities had been included in the contracted scope of works,⁹⁶ but without any consideration of whether their inclusion altered the suitability of private security guards for the expanded role they would play. Like fresh air breaks, these activities increased the potential level of direct contact with quarantining travellers and also increased the extent to which private security would be handling items that were at risk of carrying the virus. Again, there was no analysis of the suitability of private security guards for those tasks and no assessment of how those tasks altered the workplaces of those undertaking them.

70. My view is that at least one reason this re-evaluation and risk assessment did not occur was because no person or agency regarded themselves as responsible for the initial decision to engage private security and no one had articulated the assumptions that underpinned this decision. The initial decision to use private security was, as I have found in Chapter 5, a decision made by acquiescence to a preferred position expressed by Victoria Police, but those party to the decision were not alert to their roles in the decision and none of them assumed accountability for it.
71. Furthermore, given there was no clear understanding or description, at that time, of what the role of private security guards would be, assumptions were made about the suitability of such a workforce based on previous experience of working with security guards at venues such as sporting events. This was compounded by there being no record of discussion about the suitability of such a workforce, even for the initial understanding of the role, and there being no person or agency accepting they had made the decision to use this workforce. This was further compounded by the positions taken by DJPR and DHHS about who was accountable for these contracted workers in circumstances where no one agency considered itself 'in charge' of the operation on-site.
72. Ms Serbest was not party to the initial decision to use security guards. Once she became involved in logistical arrangements for the Program, it appears she sought the support of security guards to deliver a range of additional services as she and her team required.⁹⁷

Chair: So that means that was communicated to you by the people that participated in the dry run? It was being articulated, 'This is what the role of private security is', rather than a document being provided to you so that you could understand that with clarity?

Ms Serbest: Correct. There were times though, as things shifted and evolved, so it wasn't something that was fixed. It would ... different policies would come onboard, and different requirements would need to be addressed, such as parcels being delivered to guests and things like that.

Chair: And the understanding that you were, as I understand what you're saying, the understanding was an iterative process, in other words, bit by bit you were understanding what the role of private security guards was on the sites that you were familiar with?

Ms Serbest: I would say it was quite clear from that first day what they would be doing, but as policies changed and as policies got introduced, whether they would be, as I mentioned, parcels from families coming into the hotels, Uber Eats policies for people with dietary requirements or fresh air breaks, the expectations on security changed.⁹⁸

73. As already noted, Unified was willing to do what was being asked of it. Wilson raised concerns in some cases that it was being asked to do things beyond the scope of security guards' ordinary duties.
74. It was not for Ms Serbest to appreciate or analyse the implications of altering the role security guards were playing. She understood that the private security guards were a resource available to her and she used that resource. She appears to have drawn negative inferences when the help she sought was not forthcoming and to have been unaware that what she was asking security guards to do was materially different from what they would ordinarily do.⁹⁹
75. In circumstances where it was DJPR that had contracted the three security providers and set the scope of their duties, responsibility for revisiting the scope of those duties lay with it. But because DJPR did not see itself as 'owning' the decision to engage private security, it appears not to have seen itself as responsible for monitoring the appropriateness of that decision.
76. The Principal Policy Officer, as set out below, was responsible for contract management. But his role did not extend to monitoring, as a matter of governance or principle, the continued suitability of private security for what had become a much more multi-faceted role than the one Ms Currie had contemplated when she spoke with Mr Millward on the morning of 28 March 2020.¹⁰⁰

77. No-one thought about it other than — to some extent — the security companies that were being asked to perform duties in a high-risk environment and outside their areas of training.
78. This issue underscores, yet again, the need for a governance structure within a quarantine program that has clear lines of accountability and clarity of roles at each level within it, including on the hotel site, to ensure that a constant monitoring and supervision by the agency with the responsibility for the Program is watching every aspect of how the Program is or is not working and where potential risks are coming from and how to address those risks in a timely way (consistent with Recommendations 17 and 18).

6.6 The terms of the written contracts ultimately entered into, particularly as they related to infection prevention and training, and the deficiencies associated with those terms

79. As I have said above, the State — through DJPR — entered into three contracts with security services providers: MSS, Unified and Wilson.¹⁰¹ Specifically:
 - A. a Purchase Order Contract (POC) between DJPR and MSS was executed on 23 April 2020 (MSS Contract).¹⁰² This was 17 days after MSS had started providing security services from 6 April 2020¹⁰³
 - B. a POC was also entered into between DJPR and Wilson for security services in relation to the Hotel Quarantine Program on 6 May 2020 (Wilson Contract),¹⁰⁴ covering the period from 30 March to 30 June 2020. Wilson did not have a prior POC under which it was providing services during the period from 30 March to 5 May 2020.¹⁰⁵ MSS and Wilson were engaged on terms set out in a POC as both firms were panel members of the State Purchase Contract. The terms were substantively the same, save for their respective fees and charges: Wilson had a higher rate of pay for its security guards but did not charge for the provision of its own PPE, whereas MSS had lower rates but charged cost plus 10 per cent for its PPE¹⁰⁶
 - C. the contract for services to be provided by Unified was entered into on 9 April 2020 (Unified Contract),¹⁰⁷ some 11 days after Unified had started providing security services across two quarantine hotels on 29 March 2020.¹⁰⁸ The Unified Contract was bespoke but based on the MSS and Wilson contracts¹⁰⁹
80. Each of the three contracts contained the same or substantially similar terms. The key terms relevant to the Inquiry are set out below.

Key terms

WHAT AND HOW WERE THE SERVICES TO BE PROVIDED?

81. Each of the contracts described the services to be provided in the same way, that is:

Service Provider must provide security services, including all ancillary services associated with the provision of security ('Services') at the Hotels notified by the Department (the Sites) which will include but not be limited to the following Services...¹¹⁰

82. I have described what those 'ancillary services' were above, at paragraph 54, noting that the role of security guards was 'iterative' as different policies were implemented and the functions the guards performed expanded.

83. Those expansions were reflected in directions given to security service providers, which were then included in the contracts over time. The main changes dealt with Department of Health and Human Services (DHHS) policies regarding exercise breaks and the provision of deliveries to guests.¹¹¹

84. They were made as a result of DHHS having developed policies,¹¹² then having communicated those policies to the Principal Policy Officer, who then passed those policies on to the security service providers.¹¹³ There was therefore an artificiality in DJPR's role as responsible for the terms of those contracts when it came to describing the role of security guards.

85. Each of the Wilson, MSS and Unified contracts required those providers to follow the direction of DJPR.¹¹⁴ In practice, on the changing roles of security guards, DJPR acted at the direction of DHHS such that DJPR essentially passed on welfare-related directions to Wilson, MSS and Unified, including to support policy changes developed by DHHS.¹¹⁵

86. For example, at DHHS request, the Principal Policy Officer asked Unified for an additional three staff to be rostered for each shift between 8:00am and 8:00pm in order to implement and supervise fresh air and exercise breaks.¹¹⁶

87. By way of further example, when Ms Serbest was asked about what security would do when clarity was needed about those policies, she said that, where there were significant changes to a role, security services providers would seek guidance and direction from DHHS.¹¹⁷

88. The contracts set out the standard to which those services were to be performed. They each obliged Wilson, MSS and Unified to provide the services with, among other things, due care and skill.¹¹⁸ Wilson and MSS were required to 'ensure the highest quality of work and the delivery of Security Services with the utmost efficiency'.¹¹⁹ Similarly, Unified was required to ensure that the services were 'adequate and suitable for the purposes for which they are required',¹²⁰ and to use 'appropriately skilled and qualified Personnel to provide the Services'.¹²¹

CONTRACTORS WERE PERMITTED TO SUBCONTRACT

89. One of the main challenges for security contractors was meeting the need to deploy a large number of security personnel at very short notice.¹²² Given the circumstances, the head contractors were dependent on subcontractors to fulfil a substantial portion of the number of security positions.

90. Each of the contracts between the State (through DJPR) and the contractors included provisions permitting the engagement of subcontractors. The requirements for doing so, however, were different.

91. Clause 26.1 of the Unified Contract provided that Unified 'must not engage subcontractors to conduct the whole or any part of the Services without the prior written approval of [DJPR]'.¹²³

92. That requirement was not as onerous as the one imposed on MSS and Wilson. Clauses 6(a) and 6(b) of the Wilson and MSS contracts stated as follows:

- (a) The Service Provider must not subcontract any of its obligations under this POC to any third party unless the third party receives the prior written approval of the Purchaser in accordance with this clause 6. A breach of, or failure to comply with, this clause 6 by the Service Provider will constitute a material breach of this [Purchase Order Contract].
- (b) Prior to the engagement of any Subcontractor, the Service Provider must notify the Purchaser of its intention to subcontract particular obligations, and seek the Purchaser's written approval. Such notice must be provided within a reasonable time and contain the following information:
 - ...
 - (vii) acknowledgement from the Subcontractor that it will comply with all of the obligations arising under the POC;
 - ...
 - (x) a statement of compliance from the relevant Subcontractor(s) with this POC and all rights and obligations arising under it, including audit requirements.

93. Under its contract with DJPR, Unified was not required to inform the subcontractor of the head contractor's obligations under the contract with DJPR and provide an acknowledgment that Unified's subcontractors would comply with the same obligations as imposed on Unified (particularly with respect to training and infection prevention and control measures).
94. No reasons were given as to why the Unified Contract was drafted in this way, and the difference is perhaps surprising if there was an intention to promote substantive parity in terms between the three service providers. I infer that a reason for the difference may have been the lack of proper understanding by those preparing the terms of the Unified Contract as to the prevalence of subcontracting within the security services industry and the reliance that Unified would actually place on subcontractors.
95. The compliance or otherwise with these subcontracting requirements, and their consequences, is considered below.

RISK WAS ALLOCATED TO CONTRACTORS

96. The contracts explicitly recognised the risk of transmission of COVID-19 to security guards and the harm that it may cause. The contracts sought to transfer liability for that harm to the security companies, as follows:

The Service Provider acknowledges and agrees that it and its Personnel, while delivering the Services, are likely to come into contact with people who have or may potentially have COVID-19.¹²³

The Service Provider releases and indemnifies...[the Department] against any loss, damages, cost or expense...incurred by the Department arising out of, or in any way connected with... personal injury, including sickness and death (including but not limited to in relation to exposure to or infection from COVID-19).¹²⁴

97. Against that background, the contracts obliged Wilson, MSS and Unified to take certain steps towards protecting the safety and wellbeing of their security staff.

TRAINING AND INFECTION PREVENTION AND CONTROL OBLIGATIONS WERE IMPOSED

98. The contracts obliged MSS and Wilson to ensure that their security guards (that is, Service Provider Personnel) wore 'all necessary personal protective equipment (that complies with the relevant public health standards including but not limited to in relation to COVID-19) at all times while performing of the Security Services'.¹²⁵ The Unified Contract contained a provision in substantively the same terms.¹²⁶

99. Wilson, MSS and Unified were each responsible for ensuring that, before their personnel performed the services, they:
- A. 'received adequate training in security, workplace health and safety, customer service and risk management as applicable for the provision of security services and, including but not limited to, in relation to COVID-19'¹²⁷
 - B. met 'all relevant safety induction requirements for the Designated Locations [i.e. quarantine hotels]'¹²⁸
 - C. 'have undertaken the Australian Government Department of Health COVID-19 infection control training module, or any and all other COVID-19 awareness training as directed [DJPR]'.¹²⁹

CERTAIN TERMS ENTERED INTO WERE NOT SUITABLE FOR THE NATURE OF THE PROGRAM

100. These contracts with Wilson, MSS and Unified purported to structure their engagement in the Hotel Quarantine Program with the contractor carrying the entire responsibility to protect its workforce against the risk of transmission of COVID-19 and indemnify the State against any risk to which its workers may be exposed.

THE CONTRACTS DID NOT SUFFICIENTLY PROVIDE FOR DHHS TO GIVE DIRECTIONS

101. At the outset, it is important to note that the contracts were between the State of Victoria (through DJPR) and Wilson, MSS and Unified. There was no requirement in the contracts that security services personnel be subject to the direction of DHHS. It was a deficiency that these contracts did not explicitly subject security service providers to the direction of DHHS in the performance of their services. An assumption on the part of DJPR that security would work to Authorised Officers' directions was not reflected in the terms of the contracts or in the schedule of duties. The Principal Policy Officer did not, it would appear, receive any direction that the contracts specified the obligation to take directions from Authorised Officers.¹³⁰
102. The Inquiry heard evidence that security guards considered they were working to assist Authorised Officers and some considered themselves to be subject to their direction.¹³¹ Sam Krikelis, Business Manager for Events Services at MSS, gave evidence that security guards would raise issues with the Authorised Officer.¹³² Mr Nagi said that Authorised Officers could give direction to, or make requests of, the security staff.¹³³
103. On 30 March 2020, Mr Watson of Wilson was provided with a 'draft document', titled *Security Consultants — Roles and Responsibilities for Hotel Quarantine*, which stated that 'security personnel had been engaged to support authorised officers from [DHHS] and Victoria Police to uphold mandatory quarantine directions from CHO'.¹³⁴ That draft document was given to Wilson by DJPR. It was created by DJPR as a draft for DHHS, following discussions with DHHS on briefing security guards on how they should assist Authorised Officers to enforce the CHO's directions inside hotels.¹³⁵ DJPR understood that DHHS was to provide written material to security contractors so they could properly understand their role in enforcing those directions.¹³⁶ It suggested to DHHS that DHHS update the draft document and formally provide it to security managers at each site.¹³⁷ There was no suggestion from DJPR witnesses, Ms Febey or Mr Phemister, that this was actually done. The fact that DHHS submitted that Authorised Officers were not responsible for, or unable to direct, security guards,¹³⁸ leads me to infer that DHHS did not circulate that document to each of the contracted security services providers. This demonstrated a lack of agreement between DHHS and DJPR as to the role of security guards.
104. Explicit provision in the contracts would have provided greater clarity and certainty as to who was in charge of security services personnel, which may have led to a greater focus on the Government agencies supervising the work of security services personnel.

THE RESPONSIBILITY FOR PROTECTING AGAINST RISK SHOULD HAVE REMAINED WITH THE STATE

105. It was not appropriate that the contracts allocated the risk of COVID-19 transmission on to security service providers in the manner it did.
106. The contracts with security services providers effectively sought to impose the primary responsibilities relating to infection prevention and control on those private providers. This included obligations with respect to staff training and the supply of PPE. These were significant responsibilities to outsource, especially in the context of a government-led quarantine program, the primary aim of which was to contain the spread of a highly infectious disease.
107. Shifting a burden to those contractors who were not specialised in the areas of infection prevention and control was inappropriate and ought not have occurred.
108. By requiring all returned travellers to be detained in a hotel setting, the Government thereby concentrated, within the Program, a large number of potential carriers of the COVID-19 virus. This created risks of infection transmission as between those in quarantine and those working at quarantine hotels. The Government had a corresponding responsibility to take appropriate action to ensure appropriate systems were in place to address the risk that accompanies the creation of suspected or known hot spots.
109. DHHS submitted that the risks were not created or carried by the Hotel Quarantine Program but, rather, risks arose from COVID-19 itself and the entry into Victoria of travellers potentially infected with COVID-19.¹³⁹ What was required was a choice, it was submitted, as to how best to deal with the risk.¹⁴⁰
110. The DHHS submission did not recognise that if the State mandates potentially infected people into the quarantine facility that it had created to avoid community transmission, it had then accepted the responsibility to take all necessary actions to keep the people in quarantine safe and minimise the risk of cross infection or community transmission from that quarantine facility (see also Chapter 11.1 for a discussion on the obligations of the State under the *Victorian Charter of Human Rights and Responsibilities Act 2006* (Vic)).
111. DHHS otherwise did not make submissions as to the contractual apportionment of responsibility for infection prevention and control measures in the context of security services; it did, however, consider that terms relating to PPE and training requirements on hotels were ‘reasonable and prudent’ and consistent with hotels’ pre-existing legal obligations.¹⁴¹ I infer that the same approach would be taken with respect to security guards.
112. DJPR did make submissions as to the contractual apportionment of responsibility for infection prevention and control measures.
113. DJPR submitted that security contractors were under a positive legal duty, themselves, to control risk.¹⁴² It submitted that the contractors, as employers, had health and safety obligations under the *Occupational Health and Safety Act 2004* (Vic) at common law and as implied into employment contracts with their security services personnel.¹⁴³ It was reasonable and appropriate — so submitted DJPR — that contractors had responsibility for matters that were within their control.¹⁴⁴
114. DJPR went further to submit that it would be inappropriate for the State to seek to assume contractors’ own obligations with respect to their workforces because:
 - A. obligations on contractors provide an extra layer of protection for workers
 - B. the State and contractors exercise a different level of control over relevant workers and workplaces: here, DJPR submitted that contractors have particular roles with respect to on-site supervision arrangements, communication, disciplinary action and counselling
 - C. it is appropriate for the State to limit its risk through contracts
 - D. it was appropriate to require contractors to source their own PPE given the State’s concern that it would be unable to source sufficient PPE.¹⁴⁵

115. DJPR submitted that its contracts did not purport to transfer to contractors or diminish the State's infection prevention and control responsibilities, nor did the State seek to contract out of its obligations under the *Occupational Health and Safety Act 2004*.¹⁴⁶
116. This Inquiry was not the proper venue for rulings and findings with respect to duties owed by these contractors at employment, contract or tort law. Suffice to say, as noted above in paragraphs 105 and 106, it was not appropriate for the State to seek to impose the risk of transmission of COVID-19 onto the security service providers in the way in which these contracts purported to do.
117. The Hotel Quarantine Program was not just a workplace or a private arrangement between employer and employee, or contractor and principal. It should not be seen solely through that lens. It was, fundamentally, a measure to protect the public from a significant public health threat.
118. There was simply too much at stake for the State to have conferred such responsibilities on private security service providers whose ordinary roles were so far removed from infection prevention and control measures.
119. Further, the state of specialist knowledge about COVID-19 was evolving over the months of the Hotel Quarantine Program. That knowledge was specialised and properly located within the ambit of DHHS.
120. For DJPR to determine that security service providers could or should have been making assessments about 'risk management' and what was 'adequate training' and 'relevant public health standards' for COVID-19 was inappropriate as a matter of public safety. Private security service providers simply could not have been expected to have had the specific expertise or experience in infection prevention control and use of personal protective equipment to be making such assessments and, certainly, not to the degree required to contain COVID-19, a new virus that was the subject of an evolving understanding in the medical and scientific communities.

RELIANCE ON THE OBLIGATION TO CONDUCT THE ONLINE TRAINING MODULE WAS NOT APPROPRIATE

121. Ms Currie gave the following evidence as to the inclusion, in each of the contracts, of the requirement for security services personnel to complete the Commonwealth Government Department of Health's COVID-19 online training module:

I had become aware of the training program as part of my work for the 'Working for Victoria' scheme and I considered that, as a minimum, it would be beneficial if private security guards had completed this training before commencing the performance of their duties. I subsequently requested that this requirement be included in the written agreements with each private security company.¹⁴⁷

122. I make no criticism of Ms Currie in purporting to include such a term into the contracts. Indeed, she is to be commended for being alive to the need for relevant training in those initial days. However, the training she nominated on 28 March 2020, and that was later specified in the contracts, was not sufficiently specific in the context of a quarantine program and was 'clearly misleading' for quarantine staff with respect to the use of masks.¹⁴⁸ It was a failure in preparing those contracts that the content of such training was not based on public health advice. Ms Currie did not have relevant expertise in public health, nor was any public health advice sought or given about the type of training that would be appropriate for non-health professionals working in close proximity to people potentially infected with COVID-19.
123. While it may be that the state of knowledge about COVID-19 was more limited in March 2020 than it was in June or July 2020, and accessible training modules were not in abundance at the time security companies were engaged, it remained fundamentally important that whatever training the State was requiring security companies undertake, such training would be fit for purpose.

124. Professor Lindsay Grayson, Director of the Infectious Disease Department at Austin Health, gave evidence before the Inquiry as to the utility of the Commonwealth Government Department of Health's COVID-19 online training module in the hotel quarantine context. He stated that this training module was not fit for purpose for those working in an environment where they were likely to be in contact with a potentially infectious patient.¹⁴⁹ He stated that:

My assessment of this training module is that it is hard to know who their target audience is. Elements of it, indeed, the majority of it, is like a training module for the general public rather than someone who is going to come into direct contact, or indeed, be responsible for managing COVID patients ... when I did the module some time back, I had assumed, just by the way it was structured, that this was really as a sort of a community education about infection control rather than a specific document related to staff of any sort who would be directly managing potential cases.¹⁵⁰

125. Prof. Grayson concluded that the module was confused in its target audience, having regard to the level at which it pitched information and the detail with which the information was provided.¹⁵¹
126. In light of Prof. Grayson's evidence, a requirement to undertake COVID-19 related training should have been specifically tailored for non-health professionals working in a quarantine environment. That it was not, and that it was potentially confusing, meant that it was even more important that contractual requirements as to PPE and training were clear, specific and relevant.
127. Ms Currie also had a not unreasonable assumption, which she conveyed to security contractors in her initial discussions, that DHHS would provide on-site training and infection control. I consider the sufficiency of the steps taken by DHHS to provide that training and infection control in Chapter 8.

Requirements were vague and led to inconsistent PPE practices among security companies

128. Contractual terms for adequate training and PPE required security companies to work out, for themselves, what constituted adequate training and PPE that complied with 'relevant public health standards'. The contracts certainly did not define what those standards were or where they could be found. If, in fact, such standards existed, to ensure certainty and consistency, they should have been specifically referenced. And, if the drafters of the contracts did not know what those standards were, then it was unreasonable to expect that private security providers would know and almost impossible for DJPR to monitor and potentially enforce compliance with those requirements.
129. There was evidence that security companies were issued with a document — *Operation Soteria — PPE Advice for Hotel-Based Security Staff and AOs in Contact with Quarantined Clients* — that set out when PPE ought to be used.¹⁵² That document was dated 5 May 2020.
130. To the extent that document constituted a relevant public health standard, it ought to have been given to the security companies much earlier than it was. It was not provided to Unified until 12 May 2020, some six weeks after Unified commenced its services;¹⁵³ MSS did not receive that guidance until 29 May 2020;¹⁵⁴ and Wilson received it on or around the same day.¹⁵⁵
131. Each contractor had different ways of giving effect to its obligations with respect to infection control and PPE. The extent to which PPE and training obligations were discharged varied between the three contractors.

132. Mr Watson gave evidence that Wilson provided more than 30,000 masks, 81,000 pairs of gloves and 150 litres of hand sanitiser to its security guards.¹⁵⁶ It also provided safety goggles and surgical gowns to its guards.¹⁵⁷
133. He gave evidence that Wilson took a range of different measures to manage risk. Those measures included having previously engaged an epidemiologist as a consultant to the company to provide advice on training staff, procedures, policies and guidance through the pandemic.¹⁵⁸ Mr Watson said that Wilson developed a process to continuously source PPE¹⁵⁹ and implemented guidelines and policies regarding the use of PPE, physical distancing, temperature checking and rostering requirements.¹⁶⁰
134. Mr Adams gave evidence that MSS sourced, in sufficient quantities, its own disposable gloves, masks and sanitiser for its guards (including subcontractors).¹⁶¹
135. He said MSS developed its own infection control training module which all permanent employees were required to complete and was subsequently sent to contractors for completion by their guards.¹⁶² Based on initial discussions with DJPR, MSS was of the view that DHHS staff would be on-site to provide guidance and assistance along the way.¹⁶³ The evidence of MSS was that it also provided COVID-19 information updates.¹⁶⁴
136. Unlike for Unified, there was no explicit requirement in the MSS and Wilson contracts for MSS and Wilson to supply their personnel with PPE; only that they had to ensure their personnel wore all necessary (and compliant) PPE.¹⁶⁵ The evidence before the Inquiry was that it was an expectation that they do so and they, in fact, did so.¹⁶⁶
137. With respect to Unified, in addition to the Commonwealth's module, Unified stated that its guards were inducted on-site, which included training on the use of PPE and some basic standard operating procedures.¹⁶⁷ Like MSS, Unified had an expectation that DHHS would offer training on-site, but its experience was that no guidance was received until late April or early May.¹⁶⁸
138. This had consequences for the risk of transmission within hotels. Unified and its subcontractors were more reliant on DHHS training and guidance to reduce the risk of transmission and, so, were vulnerable if that training or guidance was not delivered (or not delivered in a timely way). In the case of other contractors, security guards may well have been better equipped to manage the risk of infection through more rigorous training, policies and practices implemented by the security contractor who had engaged them, whether directly or through a subcontractor.
139. Outbreaks occurred at a hotel staffed by Unified and a hotel staffed by MSS.¹⁶⁹ It is true that neither company had infection prevention measures in place that matched the standard that Wilson used at its hotels.¹⁷⁰ In the absence of evidence about the number of COVID-positive guests at hotels staffed by Wilson, I can draw no firm conclusions as to whether Wilson's heightened training and infection control measures, in fact, prevented or reduced the risk of outbreaks. The risk of an outbreak was much higher at the Rydges than at any other hotel because of its status as a 'hot hotel' and I accept that care needs to be taken in drawing inferences from the absence of outbreaks at hotels where the number of infected guests was likely to have been much lower.
140. The efficacy of the measures taken by each of the head contractors may be considered against evidence of how infection prevention and control measures were applied by security guards at the hotel.

141. In that context, evidence presented to the Inquiry highlighted varying levels of knowledge and support around infection control and appropriate use of PPE, depending on which guards were hired and where they were working, noting that this was but a small selection of examples:
- A. Witness Security Guard 1 said he ‘went through use of [PPE], policies about keeping your distance from other people, and the processes for escalating incidents’ on his first day working at Crowne Plaza.¹⁷¹ His PPE training was about wearing masks and gloves, how to put the mask on, and he was told to use as much hand sanitiser as he wanted, to stay four metres away from guests with a maximum of three people in the lift. He stated he did not see any guards not wearing a mask properly.¹⁷²
 - B. Security Guard 1 said there were factsheets around the Crowne Plaza hotel that had information about wearing PPE and social distancing, and protocols for what to do if someone came out of their room. Security guards were not allowed to make any physical contact with the guests if this occurred; they would escalate the situation with the shift supervisor. There was no handbook or information distributed to the security guards.¹⁷³
 - C. By contrast, Kaan Ofli, a returned traveller who was quarantining with his partner, was told by a security guard at the Pan Pacific that he was overwhelmed as he did not have experience managing a team and he had not been properly trained.¹⁷⁴
 - D. Returned traveller Liliana Ratcliff stated she observed security guards not practising social distancing with each other, leaning on surfaces and not wearing gloves, which gave her a ‘sense of panic’ as she knew it was not safe.¹⁷⁵
 - E. Similarly, witness Michael Tait, who worked as a nurse in the hotel quarantine program, observed that security guards did not understand how to correctly handle PPE.¹⁷⁶ He explained that they became offended when nurses said they needed to wear their masks, and witnessed PPE constantly thrown on the floor instead of being disposed of correctly by security guards.¹⁷⁷
142. This evidence of individual observations was, to some extent, contradicted by security contractors and subcontractors who said that there was training on PPE and that attention was paid to ensuring social distancing and hygiene. However, I am satisfied that, particularly at the Rydges and the Stamford Plaza hotels where outbreaks ultimately occurred, the practices of security guards fell short of necessary standards of infection prevention.
143. I base my conclusion largely on the evidence from the observations of the DHHS outbreak teams that attended both of these sites in the wake of the outbreaks at the Rydges and the Stamford. (The outbreaks are discussed in Chapter 9)

Figure 6.2: Narrative from Security Guard 4 about their experience with infection control training and PPE

‘On my first day I got no instructions or training. I was told to just “sit there and do nothing”. I was told that ‘if any of the people came out of their rooms, tell them to go back into their room’.

I didn’t have a mask or any PPE. They did have good hand sanitiser (alcohol based) at first, but after this we were just given hand wash, not proper sanitiser.

My friends who were also guards would help the travellers with their luggage and share lifts with them when they arrived from the airport. They didn’t have a mask or any other PPE either. We didn’t know if any of the travellers had the virus. Our subcontractor told us nothing’.

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.

6.7 The management of security services contracts

- 144. As a mechanism to ensure security services personnel were appropriately trained and performed their services to an acceptable standard, contract management became a critical component of the administration of the Hotel Quarantine Program.
- 145. There were deficiencies in the arrangements for managing contracts with security service providers Wilson, MSS and Unified (collectively, the head contracts), affecting the success of the Hotel Quarantine Program.
- 146. Before dealing with particular instances in which contract management led to deficiencies, a foundational question must first be answered; that is, was the contract management function properly located within DJPR in the first place?
- 147. It was accepted that DJPR was responsible for procuring security services and, also, managing the head contracts.¹⁷⁸ I have earlier referred to the head contracts requiring Wilson, MSS and Unified to comply with directions given by DJPR.

DHHS should have managed the head contracts

- 148. It does not necessarily follow that, if DJPR entered into the head contracts, it should also *manage* those contracts, including by way of giving directions to the security service providers.
- 149. A consistent theme arising from the evidence was that DJPR was responsible for ‘logistics’ whereas DHHS was responsible for returned travellers’ health and wellbeing.¹⁷⁹ The distinction had some use in terms of differentiating between the set-up of the Program, on one hand, and the administration and operation of the Program on the other.
- 150. If that was the case, then the provision of security services, in order to enforce the quarantine regime imposed under legislation administered by DHHS, fell more appropriately into the latter category. Mr Krikelis, of MSS, aptly described the distinction between DJPR’s and DHHS’ responsibilities as follows: ‘the role of DJPR appeared to me to be more directed at ensuring the operation was carried out, rather than *how* it was carried out’.¹⁸⁰ In terms of how the security operation was carried out, Mr Krikelis said that ‘it was DHHS which provided guidance regarding the way in which security services were to be performed’.¹⁸¹ Mr Nagi gave evidence that Authorised Officers could, in a practical sense, give directions and make requests of security staff.¹⁸²
- 151. Mr Watson, on behalf of Wilson, expressed a similar sentiment when he said that, in practice, the Authorised Officer was in charge of a particular site.¹⁸³
- 152. This view was both common and understandable. Given the entire Hotel Quarantine Program was about placing returned travellers into quarantine for public health reasons, and it was the powers of detention being exercised by Authorised Officers that kept those people in detention or allowed them to move around, it made sense, in the absence of any other person apparently ‘in charge’ on-site, to assume it was the Authorised Officers who were ‘in charge’.¹⁸⁴
- 153. As stated in Chapter 8, DHHS Authorised Officers were ‘in charge’ of people in quarantine at hotels, including because people were there as a result of their legislative powers of detention, and it was the security guards’ function to assist Authorised Officers to enforce that detention. It is clear that all three security head contractors, themselves, understood that to be their function, and that they gained that impression from DJPR’s initial work in drawing up the proposed scope of security guards’ duties.¹⁸⁵

154. DHHS was better placed than DJPR to manage the head contracts. Witnesses, including former DHHS Secretary, Kym Peake, and former Minister, Jenny Mikakos, gave evidence that there was no legal or practical preclusion from the management of service contracts being transferred to DHHS as Control Agency.¹⁸⁶ Indeed, the State of Victoria was the contracting agency. The ability to make that transfer as between government departments was further made apparent when the hotel accommodation contracts were transferred to DHHS on 1 July 2020¹⁸⁷ and again when the Department of Justice and Community Safety (DJCS), through Corrections Victoria, assumed responsibility for the supervision of returned travellers in the Hotel Quarantine Program by 11 July 2020.¹⁸⁸
155. Fragmenting responsibilities between procurement and management of the security services providers led to deficiencies in the Hotel Quarantine Program. Mr Adams, of MSS, gave evidence that different reporting and accountability lines:

... does create, and it did create, difficulties, in the sense that ... our customer being a contracting department of the Government, with a number of other stakeholders who have not only responsibility but authority to make decisions at a site level. Those decisions ... were not consistent. There was no clear demarcation of responsibility.¹⁸⁹

156. A stark example of the confusion caused was the contradictory information given to security guards as to when PPE should have been worn. As stated above, the head contracts required security personnel to wear PPE 'at all times'.¹⁹⁰ That was also DJPR's position.¹⁹¹ But DHHS took a different approach. Mr Nagi, of Unified, gave the following evidence in this regard:

Unified Security also received PPE Advice documents from the DHHS which applied to security guards ... these documents caused confusion as they contradicted the instructions that Unified was providing to guards, that is, to always wear PPE.¹⁹²

157. As control agency of the services provided pursuant to the head contracts, DHHS should have been responsible for the management of the delivery of those services. To promote consistency and enable clear lines of accountability, responsibility and supervision of security service providers, DHHS and DJPR should have arranged, at the outset, for the transfer of responsibility for the administration of contracts to DHHS.

Complaints against security service providers were dealt with

158. Instead, DJPR managed the head contracts through the Principal Policy Officer, who was listed as the DJPR contact on each of the head contracts.¹⁹³ His duties included being the general point of contact for security providers regarding any contractual issues, relaying instructions to security providers and, at the direction of Rachaele May, Executive Director, Emergency Coordination and Resilience at DJPR, requesting responses from security providers to issues raised by DHHS, DJPR staff, hotel staff or returned travellers.¹⁹⁴
159. Even though the Principal Policy Officer was the contract manager, he was never deployed to hotel sites; rather, he relied on receiving reports from DJPR or DHHS staff.¹⁹⁵ In contrast, DHHS maintained a constant presence at hotels through Authorised Officers and Team Leaders.¹⁹⁶
160. Further, not only was the Principal Policy Officer absent from sites, he had no background or experience in public health or infection control¹⁹⁷ and, therefore, had no sense of the dangers that any of these complaints posed to the efficacy of the whole Program.
161. The Principal Policy Officer generally received complaints regarding the conduct of security guards and relayed those to the relevant security services provider for response.¹⁹⁸

162. One returned traveller told the Inquiry Intake Team that she flirted with security guards in order to receive more fresh air breaks to support her mental health and wellbeing. This led to a guard asking to stay with her after she left quarantine:

The extra fresh air breaks helped me feel much better emotionally, which was really important because my mental health was very poor at the time. I understand the guards broke rules in the way they interacted with me ... After quarantine ended, the security guard asked if he could stay with me at my house. I told a white lie because I did not want him to stay with me.¹⁹⁹

163. The Inquiry was provided with a statement from the Principal Policy Officer, who described 12 complaints about the conduct of security guards at hotels.²⁰⁰ Those complaints were made variously against staff engaged by Wilson, MSS and Unified. The following is a sample of the complaints and outcomes identified by the Principal Policy Officer:
- A. On 7 April 2020, a complaint was made against guards engaged by Wilson relating to misuse of equipment and poor customer service.²⁰¹ The matter was raised with Wilson and dealt with appropriately.
 - B. On 12 April 2020, a complaint was made against a guard engaged by Wilson alleging that the guard was 'overly friendly' with a guest.²⁰² Another complaint was made against a Wilson-engaged security guard on 14 April 2020, also alleging the guard was 'overly friendly' with a guest.²⁰³ After the complaints were raised with Wilson, Wilson terminated the engagement of the relevant guards.²⁰⁴
 - C. On 28 April 2020, a complaint was received relating to the conduct of security guards engaged by Unified, including allegations that staff were consuming alcohol while working. After the complaints were raised with Unified, Unified stood down the crew working on the relevant evening amongst taking other steps.²⁰⁵
 - D. On 11 May 2020, a complaint was received about the conduct of guards engaged by one of Unified's subcontractors, which was investigated and resulted in the standing down of the entire team of guards that was working that evening.²⁰⁶ The subcontracting arrangement was also terminated by Unified as a result.²⁰⁷ Unified advised it would take additional steps, including a commitment to provide harassment and bullying training to its staff.²⁰⁸
 - E. On 14 June 2020, a complaint was made against MSS security guards regarding a lack of appropriate social distancing and misuse of PPE.²⁰⁹ MSS agreed to provide further advice and guidance on the need to have smaller meetings and the role of PPE, amongst other things.²¹⁰
164. The conduct of security guards, such as that described by the Principal Policy Officer, was unacceptable. Such behaviour affected the wellbeing of those subject to quarantine. It also risked the spread of COVID-19, particularly in instances of conduct related to misuse of PPE and failures to exercise proper physical distancing.
165. The evidence did not provide a basis for concluding that that inappropriate conduct by security guards was systemic or widespread, or that appropriate remedial action was not taken by DJPR or the security service providers. Rather, the evidence before the Inquiry was that Wilson, MSS and Unified took steps to resolve those complaints and reduce the risk of that conduct reoccurring.²¹¹ That was so, even to the extent that, in one case, a subcontracting arrangement was terminated as a result of a complaint.²¹²
166. The arrangements for subcontracting, however, posed their own significant challenges for the Hotel Quarantine Program.

6.8 Subcontracting terms were not appropriately managed

167. As set out above, each of the contracts permitted Wilson, MSS and Unified to engage subcontractors.²¹³ There was a process for giving effect to the subcontracting provisions under the standard POC used for Wilson and MSS, which involved the submission of a 'Notice of Intent' form, together with relevant documents.²¹⁴ That involved the contractor providing in the Notice of Intent, the details required by clause 6 of those contracts and copies of documents, including:
- A. an acknowledgment from the subcontractor that it will comply with all the obligations arising under the Purchase Order Contract
 - B. a statement of compliance from the subcontractor with the contract and all rights and obligations arising under it.²¹⁵
168. Such requirements were, on their face, intended to give the purchaser oversight of the suitability and capability of the proposed subcontractor to provide the services to DJPR's satisfaction. In the context of the Hotel Quarantine Program, they purported to give assurance to DJPR that the subcontractor had complied with the requirements for COVID-19-related training and PPE use (or that they would have complied with them before the services were provided).
169. Once those documents were provided and the material was considered, the purchaser (in this case, DJPR) may approve the engagement by countersigning the Notice of Intent. That Notice invited the purchaser to give reasons for the decision and specify any conditions or restrictions on the engagement.
170. In the Hotel Quarantine Program, each of Wilson, MSS and Unified used subcontractors.

WILSON

171. Wilson engaged 10 security services providers as subcontractors between 3 April and 5 July 2020 across four hotels.²¹⁶ That represented approximately 650 security guards under subcontracting arrangements, with the total 'peak' numbers being as follows:²¹⁷
- A. 168 guards at Crowne Plaza
 - B. 180 guards at the Pan Pacific Hotel
 - C. 160 guards at the Mercure Hotel
 - D. 145 guards at the Pullman Hotel.
172. In choosing which subcontractors to engage, Wilson prioritised those with whom it had previously worked, then would consider the availability of contractors that had served the aviation industry and, thereafter, those from the hospitality industry. It considered security guards from the aviation industry were known to be well trained with high service standards and those from the hospitality industry would have customer service skills appropriate for the Hotel Quarantine Program.²¹⁸
173. Ultimately, Wilson hired a mix of subcontractors; some had pre-existing relationships with Wilson, while others had just started with Wilson in retail work, as there was a retail 'surge' prior to the Hotel Quarantine Program.²¹⁹

MSS

174. Prior to hotel quarantine, in early 2019, MSS conducted a Request For Tender (RFT) process. MSS invited all existing subcontractors, along with other entities that had expressed an interest in working with MSS, to participate in the RFT process. MSS offered subcontract agreements to parties it believed were businesses with ‘genuine employees’ who were remunerated correctly, at least, in accordance with the applicable Security Services Industry Award, had the capacity to consistently deliver on the resources required and were able and reliable in delivering training requirements.²²⁰
175. MSS engaged four security services providers as subcontractors between 6 April and 10 July 2020 across four hotels.²²¹
176. The Inquiry received evidence that MSS was asked, on 14 May 2020, to provide Notices of Intent for any subcontractors.²²² MSS had been providing security services to the Hotel Quarantine Program, including via subcontractors, since 6 April 2020.²²³ On 14 May 2020, MSS provided Notices of Intent to DJPR, but did not provide signed acknowledgements, until 10 June 2020, that the proposed subcontractors would comply with the terms of the MSS Contract.²²⁴
177. The Principal Policy Officer approved the engagement of four subcontractors on 10 June 2020,²²⁵ some two months after subcontractors commenced work.

UNIFIED

178. Unified also had pre-existing relationships with subcontractors, which it called ‘service partners’. Unified worked with its service partners to fulfil the numbers of security guards needed at any one time.²²⁶
179. Between 29 March and 11 July 2020 and across 13 hotels, Unified engaged five security services providers as subcontractors.²²⁷ Mr Coppick gave evidence of two instances of further (impermissible) subcontracting by those subcontractors.²²⁸
180. The Principal Policy Officer gave evidence of knowledge of only one Unified subcontractor. He said that Unified did not inform him that Unified had engaged Acost Security Services as a subcontractor.²²⁹ It was only in June 2020, after a media enquiry, that the Principal Policy Officer became aware of its engagement.²³⁰ The Principal Policy Officer did not give evidence about having approved the use of the subcontractors used by Unified. There was no evidence of Unified having formally notified DJPR of the use of its subcontractors or having complied with its contractual requirements to seek DJPR’s prior approval for the use of those subcontractors.²³¹

Non-compliance with requirement to obtain prior written approval

181. The evidence was that Wilson, MSS and Unified did not comply with their obligations to seek prior written approval to use subcontractors in accordance with the terms of their contracts.²³²
182. While the obligation was on Wilson, MSS and Unified to seek and obtain that prior written approval, that did not absolve DJPR from seeking to enforce the subcontracting terms (which it later did, certainly with respect to MSS).²³³ DJPR should have been more vigilant and proactive in requiring Wilson, MSS and Unified to seek written prior approval, as per their respective contracts. That was particularly so when DJPR was on notice that subcontractors would be used,²³⁴ regardless of the extent to which DJPR was aware of the prevalence of subcontracting within the security industry. Had the task of procuring security services providers been given to people with greater knowledge of the industry, it is reasonable to assume that those people would have had a greater awareness of the common practice of subcontracting in the security industry, in particular in circumstances where large ‘surge’ workforces are required.

183. In submissions, DJPR acknowledged that it 'could have done more to scrutinise and respond to the extent of subcontracting by the private security companies engaged by it ... once that issue came to DJPR's attention'.²³⁵ That concession is properly made. The issue of subcontracting first came to DJPR's attention during discussions between Ms Currie and Wilson on 28 March 2020.²³⁶ The terms of the contracts DJPR initiated made it clear it was contemplated and understood that subcontracting may occur.
184. Mr Phemister gave evidence about 'post-incident reviews' that were undertaken for all subcontractors.²³⁷ With respect to subcontractors that were not approved prior to their commencement in the Program, Mr Phemister said that '[t]hose post-incident reviews found that we would have, in all likelihood, permitted the subcontracting'.²³⁸ That is, of course, a fortunate outcome, but it does not relieve DJPR of the need, prior to their engagement, to have considered the proposed subcontractors in order to satisfy themselves as to their competence and suitability. As set out elsewhere in this chapter, the heavy reliance on subcontracting posed a significant risk to the Hotel Quarantine Program.
185. The requirement for DJPR to give written prior approval to subcontractors,²³⁹ having been satisfied of the subcontractors' agreement to comply with the terms of each relevant head contract, was an important one. It would have allowed DJPR to satisfy itself that those subcontracted to provide security services had, at the very least, 'adequate training' in relation to COVID-19 as designated by the head contracts and knew of, and were subject to, the requirement contained in the head contracts to wear PPE 'at all times'.²⁴⁰
186. These requirements were (at least) basic infection prevention and control measures. They were imposed as a way to protect the health and safety of security guards and returned travellers alike.
187. Non-compliance with the subcontracting provisions meant DJPR could not satisfy itself that, before they commenced work, subcontractors were being given basic training with respect to the risk of infection. It meant that DJPR did not implement a crucial contractual mechanism that was there to minimise risk of infection transmission.
188. In the context of Unified's services, it also meant that the overwhelming majority of its approximately 1,754 security staff²⁴¹ were subcontracted security staff engaged without DJPR having considered whether they were competent, suitable or sufficiently trained to perform those services safely. As set out earlier in this chapter, Unified was relying heavily on small subcontracting companies and DJPR was not even aware of that fact,²⁴² leading it to allocate more and more hotels to Unified without any proper assessment of its capacity to cover such a substantial percentage of the whole Hotel Quarantine Program's first tier of enforcement.
189. This was a failure of proper contract management on the part of DJPR. However, to an extent, this failure is shared with Wilson, MSS and Unified. There was evidence as to some subcontractors not being aware of their obligations under the head contracts until well into the delivery of service. In fact, Sterling Security Group, a subcontractor for Unified, never saw the Unified Contract.²⁴³ Moreover, The Security Hub was first approached by Wilson and then MSS in early April to provide services but was only provided with the terms of the head contract by Wilson and MSS in May and June respectively.²⁴⁴

Vulnerabilities of the private security workforce

190. The issue arose before me as to whether security guards were the right cohort to provide the services they actually provided within hotels. To the extent that security guards were engaged in the Hotel Quarantine Program to provide static guarding services at points of exit and entry and stationed at points inside hotels to ensure people in quarantine stayed in their rooms,²⁴⁵ it was not unreasonable to expect that private security guards were a suitable cohort. This assessment, by the former Chief Commissioner of Police, Emergency Services Commissioner and Minister for Police and Emergency Services, was made in that context and with the qualification that their performance was properly supervised and they were properly trained for this work.²⁴⁶
191. However, that was not the extent of the services provided by security guards, as I have set out above in Sections 6.4 and 6.5.
192. The evidence was that private security companies had the flexibility and capacity to scale up quickly and to provide the hundreds of guards that were required.²⁴⁷ They did that through subcontracting and reliance on a workforce of casual and part-time workers, many of whom had lost previous work due to COVID-19-related shutdowns. That flexibility was necessary because arrival numbers changed every day. It is not difficult to see the rationale for using private security to meet such a fluctuating demand, and to do so using subcontractors who, themselves, could call on a readily available and flexible workforce.
193. But that ‘flexibility’ carried with it substantial potential vulnerabilities. The State Government was on notice of those vulnerabilities, including the risk of inadequately trained staff, underpayment of wages and poor working conditions, all of which had been identified as issues being considered in a review of licensing and regulatory arrangements in the private security industry²⁴⁸ that commenced prior to the Hotel Quarantine Program. I turn to this review below, at paragraph 200.²⁴⁹

6.9 The security industry relies heavily on subcontracting

194. Subcontracting is common in the security industry.²⁵⁰ Ms Currie, who identified the three security companies, gave evidence that she did not comprehend that subcontracting was the way the industry worked or that the companies would use subcontractors.²⁵¹ That evidence was challenged.²⁵² I am satisfied that DJPR was not aware of the extent to which the security services industry was reliant on subcontractors. That lack of awareness was reflected in DJPR’s failure to properly manage the contracts with each of MSS, Wilson and Unified insofar as they placed obligations on the security companies with respect to subcontracting.

Subcontractors recruited security guards quickly and often informally

195. Each subcontractor had a limited number of staff on its books and relied on databases of guards, as well as word of mouth and online advertising, to recruit sufficient numbers. For example, Sterling primarily sourced guards from its database, however, due to the large number required, the company also received word of mouth recommendations, which would be followed by phone interviews.²⁵³ About half of the United Risk Management (URM) guards who worked on the program were previous employees of URM. The remaining staff were recruited through word of mouth and advertising on Gumtree.²⁵⁴

196. There was evidence that some guards were hired through social media, including WhatsApp, LinkedIn and Facebook,²⁵⁵ and recruitment websites such as Seek.²⁵⁶
197. Security 16, a guard who worked at the Rydges and Marriott hotels, gave evidence that he was recruited by subcontractor Silvans Security Services via WhatsApp:

All of the arrangements were made using What's App and it was very casual. I was not asked to provide my visa or any hard-copy documents. I was not asked to undertake any extra training or read any other information about COVID-19 or infection control.²⁵⁷

198. Such recruitment processes were totally inappropriate in the context of a quarantine environment. The ad hoc, arms-length and impersonal nature of recruiting security staff reflected the need to satisfy the demands of the Hotel Quarantine Program (in terms of the number of security guards required) and to do so with very little notice. It also meant that there could not have been sufficient consideration as to whether the security guards being recruited by subcontractors actually had the training, experience, skills and competence to perform the services required and to perform them safely in such a dangerous environment.
199. As one subcontractor, who gave information to the Inquiry via the Intake Team, stated:

I think the Hotel Quarantine Program was very rushed. To find 450 guards within a few days is a big task for a short amount of time. The Government put a lot of pressure on contractors, and the contractors put a lot of pressure on subcontractors.²⁵⁸

6.10 The security industry has inherent characteristics that make security guards a vulnerable cohort

200. The private security industry was the subject of an existing review by the Victorian Government at the time the Hotel Quarantine Program commenced.²⁵⁹
201. The Premier gave evidence that he was aware of concerns in sections of the community and the private security industry about how the industry operates.²⁶⁰ The Premier was taken to a document, *Victoria's Private Security Industry — Issues Paper for Consultation* (Issues Paper), which invited comments and responses to the review into the industry.²⁶¹ The Issues Paper identified a number of characteristics of the private security industry that were concerns within the industry, generally, including:
- A. the industry attracted culturally and linguistically diverse people for whom English is a second language, as well as people with low levels of education.²⁶² The Issues Paper noted that '[poor] levels of language, literacy and numeracy skills ... is a continuing concern ...'²⁶³
 - B. concerns as to job security and workplace rights, including concerns about 'sham contracting', insecure work and underpayment of wages and superannuation in the industry, and the extent to which workers can understand their rights and obligations.²⁶⁴ The Issues Paper noted reports of 'widespread use of casual labour hire across the industry where permanent employment would be more appropriate'.²⁶⁵

202. The Government was already aware of the insecure nature of private security work, and the prevalence of subcontracting in a range of industries (including the private security industry), by reason of the *Victorian Inquiry into the Labour Hire Industry and Insecure Work*.²⁶⁶
203. In the specific context of the Hotel Quarantine Program, those concerns manifested and contributed to private security not being the appropriate cohort to provide security services in the Hotel Quarantine Program.
204. Dr Clare Looker, Senior Medical Advisor at DHHS, reflecting on the use of private security guards and DHHS's ability to contain the outbreaks in that cohort, identified social or health vulnerabilities in the security guard cohort, including in the following respects:
- A. in many cases, guards lived in crowded or dense housing, such that many of DHHS's usual outbreak control measures were harder to successfully implement²⁶⁷
 - B. the age of the cohort was relevant; Dr Looker said that as a young, fit and socially-active cohort, they tended not to seek testing until it was required at Day 11, by which time there had been cases that had transmitted within their household²⁶⁸
 - C. language and cultural issues and, at times, distrust or caution about government services.²⁶⁹
205. I accept Dr Looker's evidence that those factors may have each contributed to COVID-19 outbreaks and to some of the difficulties faced by contact tracing teams in the wake of the outbreaks.
206. Professor Brett Sutton, CHO, gave evidence in similar terms as to the characteristics of private security guards creating significant risks of COVID-19 transmission from the Hotel Quarantine Program into the community.²⁷⁰ That evidence was consistent with some of the concerns identified in the Issues Paper referred to above.
207. That is, the language and cultural barriers, faced by many of those in the industry, may have impeded their understanding and acceptance of infection prevention and control measures.²⁷¹
208. As to the nature of the workforce, Ishu Gupta, Managing Director of The Security Hub, said, 'because [security guards] are on casual employment, and as per fair work laws ... they are within their own rights to work with other contractors if they find work'.²⁷²
209. As Security Guard 2 told the Inquiry:

My main concern about working at the hotels was the amount of movement of staff between locations — guards, DHHS staff and nurses. It seemed to me that they moved from hotel to hotel, and the nurses moved between hotels and hospitals. All this movement made me feel like something bad was bound to happen — which it did.²⁷³

210. The movement of staff created risks. To refer to Prof. Sutton's evidence:

The casualised labour that was involved meant that a number of them had other work that they needed to do, which brought the risk of transmission to other workplaces and other individuals. The casualised nature of their work and the dependency they had on that work led to an incentive to stay at work, both in hotel quarantine work but in their other work, I would imagine, while potentially symptomatic, even potentially while diagnosed and aware of that diagnosis.²⁷⁴

211. Such concerns were borne out by the accounts of some guards, themselves, who contacted the Inquiry Intake Team and shared their experiences of being part of a casualised workforce and working in the Hotel Quarantine Program with the Inquiry.

Figure 6.3: Quotes from security guards regarding their experiences working in the Hotel Quarantine Program while being part of a casualised workforce

Security Guard 2: ‘Some guards were very tired because they would finish their 12 hour shifts and then go to work at other jobs. I also was concerned that some of the subcontracted guards were poorly paid’.

Security Guard 5: ‘Some guards did “back-to-back” 12 hour shifts at the same hotel and would fall asleep the next day. I would often try to wake them’.

Security Guard 6: ‘Some guards would finish their shifts and then go and deliver Uber Eats or do cleaning jobs. I think they did this because they were not paid very well’.

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.

212. It follows that, where security guards were dependent on (low) wages, disclosing symptoms of COVID-19 to their employer would risk them losing work and income. Where security guards had no incentive to report those symptoms, it created a risk that potentially infected security guards would continue to work within hotels and increase the risk of transmission, particularly where embedded measures for infection prevention and control were insufficient.
213. Indeed, one guard told the Inquiry Intake Team that when he told his subcontractor he had been diagnosed with COVID-19, the subcontractor was not very supportive. The subcontractor told the guard that he would pay him for three weeks, for the shifts he was unable to do, but only paid him for two weeks and, since then, refused all his calls.²⁷⁵
214. Moreover, the unpredictability of work for security guards, understandably, would be likely to lead to guards wanting to accept work when it is offered to them. The impetus to accept and maintain work is strengthened during the COVID-19 pandemic when many security guards had their hours reduced or had no work at all.²⁷⁶
215. The need to maintain an income in the face of unpredictability and uncertainty would provide an incentive for security guards to do what was requested of them or risk not receiving work. That is so, even if it meant that security guards would be performing work beyond the scope of their capability or role as they understood it to be.
216. In that context, that no doubt contributed to security guards being willing to and performing tasks outside the security services they ordinarily provided. That involved exposure to a risk of COVID-19 transmission. That security guards did not refuse to perform those functions when they could and should have, on the basis that it posed a health risk to them, illustrated their vulnerability, particularly at that time. Job security, including through ongoing employment and associated entitlements, is likely to have alleviated such a willingness to accept the ‘role creep’ that ultimately created risks for the entire Program.
217. The risk inherent in security guards being willing to expose themselves to possible infection, in order to maintain their income, is exacerbated by the power imbalance between security guards, on one hand, and their employers, on the other. That is particularly so where there is a language barrier between employees and employers, or where workplace rights are not well known.
218. Security guards are relatively less organised in terms of industrial relations than the Victoria Police members who now perform security services at health hotels. Well-organised, unionised workforces would no doubt be more willing to assert their rights to safe workplaces and for there to be proper standards, protections and arrangements in respect of their members’ health. It is noteworthy that the Crisis Council of Cabinet was briefed on the need to liaise with relevant unions in June and July 2020 when considering the use of government employees in the Program, since those unions would be alive to the occupational health and safety issues their members would face.²⁷⁷

219. There also exists, in the security industry, an inherent power imbalance between the head contractor and the subcontractor, regardless of whether or not a particular head contractor treats guards engaged through subcontracting in the same way as its own employees. The power imbalance reflects the reliance that subcontractors have on head contractors to provide them with work. That was evident through the statements given by representatives of subcontractors as to the small margins they received in providing security guards to head contractors.
220. The Inquiry heard evidence from a representative sample of three of the engaged subcontracting firms. As to the rates of pay charged to the head contractors, Mr Gupta, of The Security Hub, said that they operated at a margin of four to five per cent.²⁷⁸ Rob Paciocco, Director, Black Tie Security, said that they ‘made three per cent’ on top of the casual award rates²⁷⁹ and Mr Aggarwal, Director of Sterling, said that their margin was ‘a bare minimum margin’.²⁸⁰ Mr Paciocco explained the reason for the margin as follows:
- We were probably going to record a record month since we have been open, since 2014, in March, to within 72 hours having no work at all. So, reaching out to Wilson initially, it really was about survival and about holding onto, you know, a number of good people who it had taken years to recruit, so I don’t lose them to other companies when things eventually do pick up.²⁸¹
221. Similar sentiments were expressed by Mr Gupta and Mina Attalah, Managing Director at United.²⁸² Mr Gupta went further to say that ‘head contractors enjoy the position of subcontractors in this space and that’s how it has always been’.²⁸³
222. MSS submitted that there was no evidence that any consideration was given to the vulnerability of security guards, the density of their private living arrangements or any other cultural, educational, linguistic or socio-economic factor.²⁸⁴ Counsel Assisting the Inquiry similarly submitted that there was no evidence that the factors referred to above were considered when the role of security guards was discussed or as the role expanded, despite the existence of the Issues Paper.²⁸⁵
223. MSS submitted that the Government was ‘clearly well aware’ that private security guards, as a cohort, were vulnerable in a range of respects, which meant that the risks posed by the Program and its lack of a proper structure were necessarily increased.²⁸⁶ It is clear that those tasked with procuring private security services did not and were not instructed to do anything other than procure those services.
224. Wilson, on the other hand, submitted that security guards as a cohort did not pose a risk to infection simply because they were a casualised or unskilled workforce²⁸⁷ and referred to its own employee and subcontractor management practices.²⁸⁸ Wilson contended that Counsel Assisting’s submissions as to the systemic issues faced by security guards as a cohort were broadly stated, made without evidence, were not put to witnesses and, in some cases, were wrong.²⁸⁹
225. On the basis of Dr Looker’s and Prof. Sutton’s evidence, the issues raised in the Issues Paper and the evidence that emerged more generally during the Inquiry, I conclude that there were aspects of the private security industry as referred to here that made this cohort vulnerable to the risks that eventuated.
226. But I do not impute onto those DJPR officers clear awareness of these vulnerabilities in circumstances where there was no policy analysis as to the merits of procuring private security guards to provide those services. Had proper consideration been given in the usual policy development process, with the benefit of proper reflection as to whether security guards were the appropriate cohort to provide security services, then the issues raised in the Issues Paper ought to have been raised and considered.
227. On the evidence given by representatives of the sample of subcontractors called before the Inquiry, as a cohort, there remains a general imbalance of power between head contractors and subcontractors; subcontractors would not want to risk a steady stream of work from head contractors.

228. A theme arising from those within the private security industry who gave evidence or provided information to the Inquiry was that they would (if given the opportunity) be willing to participate in a future Hotel Quarantine Program.
229. I have considered whether such future engagement might be appropriate and, if so, on what conditions. I have given weight to the evidence of Prof. Grayson as to the need for people to be appropriately and continuously trained, resourced with correct PPE and for any such quarantine structure to have in place clear oversight from those with infection control expertise.²⁹⁰
230. Private security guards were not the appropriate cohort for the Hotel Quarantine Program in the circumstances that unfolded. Nor would they be the appropriate cohort in any future program without addressing the issues that I identified in the Interim Report, and which I consider further below, being:²⁹¹
- A. personnel working at multiple sites
 - B. the nature and level of training and understanding about infection prevention and control requirements, including the use of personal protective equipment, social distancing and hand sanitising
 - C. on-site supervision
 - D. role clarity as to the work to be performed by on-site security
 - E. the challenges of having personnel, in a highly complex and dangerous environment, who are engaged on a casual basis and not engaged directly by the management of the facility to enable support and instruction as to requirements in the event of a positive transmission.
231. To that end, I have recommended in the Interim Report — and do so again in this Final Report — that a future model of hotel quarantine should use a security cohort that, at least:
- A. makes every effort to ensure that on-site personnel do not work in other environments²⁹²
 - B. is engaged on a salaried basis and is appropriately remunerated²⁹³
 - C. is appropriately trained in infection control requirements and should understand personal protective equipment usage, physical distancing and hand hygiene²⁹⁴
 - D. is subject to ongoing monitoring and supervision by personnel with expertise in infection prevention and control, including with respect to individual behaviour, use of personal protective equipment and cleaning practices²⁹⁵
 - E. has been given role clarity by the Quarantine Governing Body,²⁹⁶ and that the Site Manager ensures that they understand their roles and responsibilities.²⁹⁷
232. Unless a future Hotel Quarantine Program incorporates those measures into its design, security guards are not an appropriate cohort to be on the frontline in compliance and enforcement at quarantine hotels. In fact, it seems the State Government had, itself, already formed this view in June and July 2020 when it established the alternative model of hotel quarantine using Residential Services Officers.²⁹⁸

6.11 The potential use of Victoria Police

233. If private security guards were not the appropriate cohort to provide security services because they were inherently vulnerable, then the question that follows is, what cohort would be?
234. Victoria Police would be an obvious contender.
235. Prof. Sutton made two formal requests for police assistance as part of the pandemic response; the first was on 16 March, and the second on 29 March 2020.²⁹⁹ The requests were for police to support, to the extent that it was feasible, Authorised Officers in the exercise of their functions.³⁰⁰ The precise nature of the support was left for those running the operation to determine but, according to Prof. Sutton, the purpose was to ensure compliance with quarantine orders.³⁰¹
236. The Inquiry heard evidence that there was, at times, advocacy for a 24/7 police presence to support the private security guards, from as early as the first weekend.³⁰² In evidence, Ms Febey expressed the view that a police presence was required and that she pressed for DHHS to take up this issue in its capacity as the control agency.³⁰³ The evidence of Chief Commissioner of Police, Shane Patton, was that Victoria Police had not received an official request to maintain a constant presence at each hotel.³⁰⁴ That evidence was not challenged and is accepted. It appears that, whatever the views of some inside the Program, those views did not find their way into a formal request.
237. The evidence of Commander Tim Tully of Victoria Police was that, given the number of police call outs, it would not, in any event, have been an efficient use of police resources to have police at the hotels at all times.³⁰⁵ I accept that the number of those call outs was relatively low and that some of the risks of poor behaviour anticipated by those setting up the program did not eventuate.
238. This meant that Victoria Police responded, when requested, to a limited number of call outs to the hotels and, essentially, assisted in the operation in ad hoc ways,³⁰⁶ consistent with the plan that came to be understood from the SCC meeting on 27 March 2020. In mid-April 2020, it convened a security forum after concerns were raised about fresh air breaks. The purpose was not to take control of security but to understand procedures in place to keep the public away.³⁰⁷ I note here that Victoria Police had powers to manage cordons, and could have done so, had a request been made.³⁰⁸
239. There was no evidence that consideration was given, at the time, to the benefits that Victoria Police may have provided to the Program by virtue of its characteristics as a workforce, rather than simply its ability to enforce compliance with quarantine directions.
240. It was likely that a constant police presence would have ensured an increased focus on health and safety on-site. The documentation the Inquiry received from Chief Commissioner Patton regarding arrangements at the 'Health Hotels' in Operation Soteria 2 shows the attention that has been paid to ensuring a safe workplace for those police members working there.³⁰⁹
241. As I described in the Interim Report, Chief Commissioner Patton said that a full risk assessment had been conducted for his members to work on the sites, which had led to the creation of detailed procedures to ensure member safety.³¹⁰ These procedures included a Senior Sergeant of Police taking the role of Safety Officer, briefings for all members, written instructions for different roles, the delineation of 'green' and 'red' zones on-site, and training for contamination events and specific locations for decontamination.
242. As a cohort, police would also have been a stable and disciplined workforce. In the event of an outbreak, they would not have had the types of vulnerabilities that plagued contact tracing efforts among the security guard cohort as set out in Chapter 9.

243. It is worth noting here that there was evidence of the considerable tensions that arose from time to time in the hotel quarantine sites and, at times, aggressive and threatening behaviour of some quarantined travellers towards staff and personnel working in the facilities.³¹¹ While the number of actual call outs to police seemed relatively low,³¹² it is not difficult to conclude that the presence of Victoria Police on-site at the quarantine facilities would have provided considerable comfort and reassurance to the personnel working there and have likely acted as a deterrent to the more aggressive types of behaviour that were reported to the Inquiry.
244. The reality is that these issues were not considered at the time. I can make no finding about whether a proper, accountable decision-making process for enforcement arrangements might have avoided the outbreaks at the Rydges and the Stamford. However, given all of the vulnerabilities of the nature of private security generally discussed above, I am satisfied that the features of a fully salaried, highly structured workforce with a strong industrial focus on workplace safety, such as Victoria Police, would have minimised the risk of such outbreaks occurring and made contact tracing an easier job in the wake of any outbreaks. It is on that basis I made recommendation 20, that the Chief Commissioner of Police be requested to provide a 24/7 police presence on-site at each quarantine facility.³¹³

6.12 Conclusions

245. I have already recommended, in the Interim Report, a different model of enforcement in any future facility-based quarantine program. I do so again here. I made that recommendation because the evidence was that, ultimately, the frontline of enforcement in a quarantine program was not a static guarding function and therefore not a function for private security to perform.
246. There was not a basis to conclude anything other than the overwhelming majority of security guards who worked in the Hotel Quarantine Program did so honestly and with goodwill. No doubt, none of those workers went to work to get infected with COVID-19. As Mr Gupta said, they were frontline workers and they were performing an essential service and putting themselves at risk in doing so.
247. The problems I have identified in this chapter are systemic governmental failings. They are not criticisms of individuals and should not be taken as such.

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

248. It likely would have come as a considerable surprise to many that public money of this magnitude and contracts of this size and significance did not appear to have had the direct oversight of the Minister. It ought to have had direct input and oversight from Mr Phemister³¹⁴ and Minister Pakula. Mr Phemister said that he briefed Minister Pakula very rarely.³¹⁵ Minister Pakula said that it was not 'typical for ministers to be necessarily apprised of the details or even the fact of contracts that are being entered into' for an operation.³¹⁶
249. Putting to one side the issue as to proper public governance models generally, to accept that senior levels of government would not need to be involved in such operational matters is to view the Hotel Quarantine Program as an ordinary operation, when it was anything but ordinary.
250. Although it was not known in early April 2020 how long the Hotel Quarantine Program would run, it ought to have been apparent that the costs of security would be extensive and that the importance of security to the success of the Program was critical.

251. Outsourcing such a critical function warranted closer scrutiny from senior public servants and the Minister. Those who negotiated the terms of the contracts and those who supervised them were doing so without any clear understanding of how security fit into the broader Hotel Quarantine Program and had no expertise in security issues. They had no access to advice from those who had been party to the decision to use security and limited visibility over the services being performed.
252. The Minister should have been informed of security arrangements (See: Ministerial Briefing: Chapter 8).
253. It was not appreciated by the DJPR staff involved in the informal engagement of the security contractors that the workforce they were engaging would be a frontline service exposed to, and expected to manage, the risks posed by returned travellers who had contracted COVID-19. DJPR did not have any requisite experience or knowledge to make that assessment. Having regard to the role of DJPR, the role of Working for Victoria and the deadline involved, the main focus in the recruitment of the security companies was clearly availability and job creation, particularly if it could serve broader policy objectives.

Failings in the procurement process

254. The process by which the security guards were selected was not appropriate or sufficiently rigorous. It was made in haste and without any risk assessment, led by staff that did not have the requisite experience and knowledge needed, and without any public health oversight or input. The speed with which security had to be contracted is some explanation, though not a sufficient explanation, for why the initial contact was made in the way it was.
255. While I do not make a finding that the procurement decisions set out above can be directly causally linked to the problems that emerged at the Rydges and Stamford Plaza hotels, I do find that there were failures of proper procurement practice on the part of DJPR.
256. The first such failure was not using the State Purchase Contract when making initial arrangements for security over the weekend of 28 to 29 March 2020. Those involved in the WhatsApp chat were not aware of the State Purchase Contract arrangements for security services or the existence of publicly available details of security services providers that were regularly used by the Government by way of the State Purchase Contract arrangements. Those involved were also unaware of the applicable critical incident procurement policy and protocols and that an exemption from the State Purchase Contract was not needed.
257. At the time Ms Currie first made contact with Unified and Wilson she had no knowledge of how long the need for security would last or what it would cost. She is not to be criticised for making the quick decision to engage Unified in circumstances where time was of the essence. But the processes used by DJPR do warrant criticism. Ms Currie ought to have been furnished with details of the State Purchase Contract so that she could approach representatives of companies that had been assessed as competent and suitable for government work.
258. Procurement policies are there for a reason. The existence of procurement policies, in general, and the State Purchase Contract, specifically, reflect principles of value for money, as well as accountability, suitability and capacity to properly provide services, transparency and probity.³¹⁷ These contracts for security services represented tens of millions of dollars; it stands to reason that decisions made to spend public money on these providers should have been consistent with practices that are based on general procurement principles. That should have involved reliance on existing State Purchase Contract arrangements, as far as possible.
259. While it is true that there was a critical incident procurement policy that provided DJPR with the flexibility to source services outside of the State Purchasing Contract Panel, it does not follow that proper procurement practices and decision-making are irrelevant. Indeed, I note here that Hayley Baxter, from DTF, provided evidence that the Victorian Government Purchasing Board's communication to departmental procurement teams was that, wherever possible, state purchase contracts should continue to be used during the pandemic.³¹⁸

- 260. The second failure was in contracting longer term with Unified despite advice that it was preferable to use those who were part of the State Purchase Contract.
- 261. Those tasked with procuring security services for the Hotel Quarantine Program should have heeded the specific procurement advice they were given as to the risks imposed by informally engaging a non-panel firm to provide quarantine security. They should have considered whether Unified was suitable to remain a service provider in light of their knowledge of the State Purchase Contract arrangement.
- 262. The third failure was in not making evidence-based decisions about the allocation of work between the three contractors with which contracts were signed.
- 263. Even allowing for the use of Unified in the short term, it was a failure of government decision-making to contract for what became very significant sums of money with a firm that had previously been refused admission to the State Purchase Contract panel and, then, to allocate so much work to that company.
- 264. There was a preference within DJPR for Unified. The preference appears to have been based on what was seen as a willingness for Unified to do the work asked of it.

The role of private security

- 265. The role played by security was ill-defined from the beginning and was, ultimately, a role not suited to the cohort of guards who were engaged without close monitoring and extensive and continued training.
- 266. The role of security guards changed over time, from 'static guarding' at the outset, to facilitating fresh air breaks later on. The expanded roles increased the risk of security guards being infected through contact with potentially infected guests and through contact with possibly contaminated surfaces.
- 267. The introduction of those additional functions should have occurred following a proper re-evaluation of the infection control measures in place and an assessment of the increased risks to staff that they posed. No such assessment occurred, because (at least) no person or agency regarded themselves as responsible and accountable for the decision. Responsibility for revisiting the scope of the duties to be performed by security guards lay with DJPR as the contract manager. DJPR did not see that to be the case.
- 268. The situation was compounded by the positions taken by DJPR and DHHS about who was accountable for these contracted workers in circumstances where neither agency considered itself 'in charge' of the Program on-site.

Contract development and management

- 269. DJPR should not have been responsible for contract management throughout the Hotel Quarantine Program. DHHS was the appropriate body to manage those contracts and should have done so when it assumed the role of control agency and overall responsibility for the Hotel Quarantine Program.
- 270. The contracts should have clearly stated that security guards were subject to the direction of DHHS in supporting their enforcement functions.
- 271. Explicit provision in the contracts would have provided greater clarity and certainty as to who was in charge of security services personnel, which may have led to a greater focus on the Government supervising the work of security services personnel.

272. It was not appropriate that the contracts placed responsibility for training and supervision in relation to PPE and infection prevention and control on the contractors in the manner they did. That should have been a responsibility that remained with the Victorian Government, as architect of the Hotel Quarantine Program.
273. The contractual requirement for security services personnel to complete the Commonwealth Government Department of Health's COVID-19 online training module was an inappropriate mechanism to properly mitigate the risk of COVID-19 transmission in a hotel quarantine context. Commendable as it was to require training to be undertaken as a precondition to engagement in the Program, it was a failure in preparing those contracts that the content of such training was not based on advice specific as to the risks at hotel quarantine sites. COVID-19-related training should have been specifically tailored for non-health professionals working in a quarantine requirement. That it was not, and that it was potentially confusing, meant that it was even more important that contractual requirements as to PPE and training were clear, specific and relevant.
274. Not having clear and consistent training and PPE requirements among the contractors led to each having different levels of knowledge and sophistication when it came to the use of PPE; at one end of the spectrum, Wilson had a significant suite of policies, practices and supports to mitigate the risk of virus transmission, at the other, Unified was particularly reliant on DHHS to provide training and information.

Subcontracting security services

275. The heavy reliance on subcontracting posed a significant risk to the success of the Hotel Quarantine Program in terms of the quality and competence of security guards actually recruited. Nevertheless, DJPR did not have adequate oversight of the use of subcontractors in the Hotel Quarantine Program. That was due, in part, to DJPR not being aware of the extent to which the head contractors would rely on subcontracting.
276. DJPR should have been more vigilant and proactive in requiring the security service providers to seek written prior approval, as per their respective contracts. But so, too, should the security services providers have complied with their subcontracting obligations at the required time. The consequence of this was that DJPR did not give proper oversight to those performing security services.
277. It was a significant deficiency that DJPR was not in a position to know the extent to which Wilson, MSS and Unified actually engaged in subcontracting throughout the duration of the Hotel Quarantine Program, let alone be confident as to who was providing the services and whether they were properly equipped to do so.

Private security guards should not have been engaged in the circumstances

278. Security guards were not the appropriate cohort to provide security services in the Hotel Quarantine Program without close monitoring and extensive and continued training by those with the requisite expertise. That level of monitoring and training did not occur.
279. Consideration was not given to the appropriateness or implications of using a largely casualised workforce in an environment where staff had a high likelihood of being exposed to the highly infectious COVID-19. This, of course, had flow on impacts in terms of the spread of the virus.
280. That is not to say that staff, whether those who contracted security providers or the security staff themselves, acted in bad faith. However, greater consideration ought to have been given to the environment in which staff were working and to prior infection control knowledge and training.

281. As an industry, casually employed security guards were particularly vulnerable on the basis of a lack of job security, lack of appropriate training and knowledge in safety and workplace rights, and susceptible to imbalance of power resulting from the need to source and maintain work. These vulnerabilities had previously been identified by the Government; with that knowledge, they should not have been selected to provide the services they did without having addressed those vulnerabilities.
282. A fully salaried, highly structured workforce with a strong industrial focus on workplace safety, such as Victoria Police, would have been a more appropriate cohort, which would have minimised the risk of such outbreaks occurring and made contact tracing an easier job in the wake of any outbreaks.
283. As highlighted in the Interim Report, a future model of hotel quarantine should use a security cohort that, at least:
- A. makes every effort to ensure that on-site personnel does not work in other environments³¹⁹
 - B. so far as possible, is engaged on a salaried basis and appropriately remunerated³²⁰
 - C. is appropriately trained in infection control requirements and should understand personal protective equipment usage, physical distancing and hand hygiene³²¹
 - D. is subject to ongoing monitoring and supervision by personnel with expertise in infection prevention and control, including with respect to individual behaviour, use of personal protective equipment and cleaning practices³²²
 - E. has been given role clarity by the Quarantine Governing Body,³²³ and that the Site Manager ensures that they understand their roles and responsibilities.³²⁴

6.13 Recommendations

Recommendations 17, 18, 22, 23 and 25–29 of the Interim Report, adopted in this Final Report, apply directly to this chapter:

On-site role clarity

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

Dedicated personnel

- 22. Accepting the need to bring in expertise, every effort must be made to ensure that all personnel working at the facility are not working across multiple quarantine sites and not working in other forms of employment.
- 23. To achieve the aims of Recommendation 20 (that the Chief Commissioner of Police be requested to provide a 24/7 police presence on-site at each quarantine facility), every effort should be made to have personnel working at quarantine facilities salaried employees with terms and conditions that address the possible need to self-isolate in the event of an infection or possible infection, or close contact exposure, together with all necessary supports, including the need to relocate if necessary and have a managed return to work.

Training and workplace culture

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

Acquisition and use of PPE

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

Endnotes

- 1 Exhibit HQI0032_P Witness statement of Ms Claire Febey, 10 [39]; Transcript of day 9 hearing 27 August 2020, 401–402.
- 2 Exhibit HQI0184_RP Witness statement of Mr Simon Phemister, 14 [69].
- 3 Exhibit HQI0036_RP Witness statement of Ms Katrina Currie, 1 [3].
- 4 Transcript of day 8 hearing 27 August 2020, 439.
- 5 Exhibit HQI0036_RP Witness statement of Ms Katrina Currie, 3 [11]; Exhibit HQI0037_RP Annexures to witness statement of Ms Katrina Currie, DJP.104.008.6765.
- 6 Exhibit HQI0036_RP Witness statement of Ms Katrina Currie, 4 [13]; Exhibit HQI0037_RP Annexures to witness statement of Ms Katrina Currie, DJP.105.003.6258.
- 7 Transcript of day 8 hearing 27 August 2020, 440.
- 8 Transcript of day 22 hearing 22 September 2020, 1829.
- 9 Exhibit HQI0184_RP Witness statement of Mr Simon Phemister, 14 [71]; Exhibit HQI0185_RP Annexures to witness statement of Mr Simon Phemister, DJP.101.002.1076.
- 10 Exhibit HQI0036_RP Witness statement of Ms Katrina Currie, 4–5 [14].
- 11 Ibid 2 [8]–[9]; Transcript of day 8 hearing 27 August 2020, 439.
- 12 Exhibit HQI0036_RP Witness statement of Ms Katrina Currie, 4 [14].
- 13 Ibid 7–8 [26].
- 14 Exhibit HQI0182_RP Working for Vic messages re good security companies.
- 15 Ibid DJP.361.002.0003, DJP.361.002.0006.
- 16 Transcript of day 8 hearing 27 August 2020, 442.
- 17 See Exhibit HQI0036_RP Witness statement of Ms Katrina Currie, 8 [27].
- 18 Exhibit HQI0183_P Buying for Victoria webpage re security services; Transcript of day 22 hearing 22 September 2020, 1833–1844.
- 19 Exhibit HQI0036_RP Witness statement of Ms Katrina Currie, 7–8 [26]–[27].
- 20 Ibid 8–9 [28].
- 21 Ibid 9 [29]–[30]; Transcript of day 8 hearing 27 August 2020, 442.
- 22 Exhibit HQI0037_RP Annexures to witness statement of Ms Katrina Currie, DJP.108.004.5000, DJP.108.004.4999.
- 23 Exhibit HQI0036_RP Witness statement of Ms Katrina Currie, 10 [34].
- 24 Ibid 11–12 [36]–[40]; Exhibit HQI0037_RP Annexures to witness statement of Ms Katrina Currie, DJP.104.008.6756, DJP.105.004.3210.
- 25 Exhibit HQI0036_RP Witness statement of Ms Katrina Currie, 11–12 [36]–[40].
- 26 Ibid 7 [23]; Exhibit HQI0037_RP Annexures to witness statement of Ms Katrina Currie, DJP.108.006.0912; Transcript of day 8 hearing 27 August 2020, 446–447.
- 27 Exhibit HQI0036_RP Witness statement of Ms Katrina Currie, 11 [36]–[37].
- 28 Transcript of day 12 hearing 3 September 2020, 847–849; Exhibit HQI0069_RP Witness statement of Mr David Millward adopted by Mr Nigel Coppick, 6 [39]–[40].
- 29 Transcript of day 12 hearing 3 September 2020, 848; Exhibit HQI0071_RP Witness statement of Mr Mo Nagi, 1 [5]–[7].
- 30 Exhibit HQI0071_RP Witness statement of Mr Mo Nagi 3 [23].
- 31 Exhibit HQI0059_RP Witness statement of ‘Principal Policy Officer’, 3 [10], [12]; Exhibit HQI0036_RP Witness statement of Ms Katrina Currie, 13–14 [46].
- 32 Exhibit HQI0060_RP Annexures to witness statement of ‘Principal Policy Officer’, DJP.110.001.2996
- 33 Ibid DJP.110.003.7155.
- 34 Exhibit HQI0037_RP Annexures to witness statement of Ms Katrina Currie, DJP.108.005.5137.
- 35 Exhibit HQI0036_RP Witness statement of Ms Katrina Currie, 13 [45]; Transcript of day 8 hearing 27 August 2020, 452–453.
- 36 Exhibit HQI0037_RP Annexures to witness statement of Ms Katrina Currie, DJP.108.005.5136.
- 37 Submission 04 Department of Jobs, Precincts and Regions, 18 [64].
- 38 Exhibit HQI0037_RP Annexures to witness statement of Ms Katrina Currie, DJP.125.002.8161.
- 39 Ibid DJP.156.001.8404.
- 40 Transcript of day 8 hearing 27 August 2020, 458–459.
- 41 Exhibit HQI0182_RP Working with Vic messages re good security companies, DJP.361.002.0008.
- 42 Exhibit HQI0060_RP Annexures to witness statement of ‘Principal Policy Officer’, DJP.110.001.5268.
- 43 Exhibit HQI0037_RP Annexures to witness statement of Ms Katrina Currie, DJP.125.002.8162.

- 44 Transcript of day 8 hearing 27 August 2020, 456.
- 45 Exhibit HQI0060_RP Annexures to witness statement of 'Principal Policy Officer', DJP:110.003.7238.
- 46 Transcript of day 12 hearing 3 September 2020, 849.
- 47 Ibid 846; Exhibit HQI0069_RP Witness statement of Mr David Millward adopted by Mr Nigel Coppick, 3 [21].
- 48 Exhibit HQI0071_RP Witness statement of Mr Mo Nagi, 6 [49]–[52]; Transcript of day 12 hearing 3 September 2020, 857.
- 49 Exhibit HQI0037_RP Annexures to witness statement of Ms Katrina Currie, DJP:105.005.3836.
- 50 Exhibit HQI0184_RP Witness statement of Mr Simon Phemister, 23–25 [115].
- 51 Exhibit HQI00059_RP Witness statement of Principal Policy Officer, 5 [19]; Transcript of day 22 hearing 22 September 2020, 1837–38, 1845; Exhibit HQI0184_RP Witness statement of Mr Simon Phemister, 16 [80].
- 52 Transcript of day 8 hearing 27 August 2020, 497.
- 53 Exhibit HQI0184_RP Witness statement of Mr Simon Phemister, 23–25 [115]
- 54 Ibid.
- 55 See Exhibit HQI0071_RP Witness statement of Mr Mo Nagi, 14–15 [116]; Exhibit HQI0072_RP Annexures to witness statement of Mr Mo Nagi, USG.0001.0001.2192; Exhibit HQI0067_RP Witness statement of Mr Sam Krikelis, 15–17 [128]–[146].
- 56 Exhibit HQI0072_RP Annexures to witness statement of Mr Mo Nagi, USG.0001.0001.3407.
- 57 Exhibit HQI0184_RP Witness statement of Mr Simon Phemister, 23–25 [115].
- 58 Exhibit HQI0061_RP Witness statement of Mr Gregory Watson, 8 [38]; Transcript of day 11 hearing 2 September 2020, 792.
- 59 Exhibit HQI0065_RP Witness statement of Mr Jamie Adams, 1–2 [10]; Exhibit HQI0061_RP Witness statement of Mr Gregory Watson, 6 [27].
- 60 Transcript of day 22 hearing 22 September 2020, 1841.
- 61 See Exhibit HQI0051_RP Witness statement of Mr Sorav 'Sam' Aggarwal, 10 [51]; Exhibit HQI0053_RP Witness statement of Mr Ishu Gupta, 8 [34]; Exhibit HQI0052_RP Witness statement of Mr Mina Attalah, 8 [34]; Exhibit HQI0056_RP Witness statement of Mr Darko Sinadinov, 7–8 [37].
- 62 Exhibit HQI0051_RP Witness statement of Mr Sorav 'Sam' Aggarwal, 1 [7], 2 [11].
- 63 Ibid 3 [17].
- 64 Transcript of day 12 hearing 3 September 2020, 865.
- 65 Exhibit HQI0051_RP Witness statement of Mr Sorav 'Sam' Aggarwal, 4 [23]; Transcript of day 11 hearing 2 September 2020, 708.
- 66 Exhibit HQI0069_RP Witness statement of Mr David Millward adopted by Mr Nigel Coppick, 13–14 [79].
- 67 Exhibit HQI0051_RP Witness statement of Mr Sorav 'Sam' Aggarwal, 15 [81].
- 68 Transcript of day 9 hearing 28 August 2020, 591; Exhibit HQI0069_RP Witness statement of Mr David Millward, 13 [79], 19 [119].
- 69 Exhibit HQI0036_RP Witness statement of Ms Katrina Currie, 4 [14].
- 70 Exhibit HQI0032_RP Witness statement of Ms Claire Febey, 11 [43]–[44].
- 71 Exhibit HQI0148_RP Transcript of audio recording of SCC Operation Soteria meeting 27 March 2020, 22.
- 72 Exhibit HQI0036_RP Witness statement of Ms Katrina Currie, 5–6 [18]
- 73 Transcript of day 11 hearing 2 September 2020, 786.
- 74 Transcript of day 12 hearing 3 September 2020, 815.
- 75 Exhibit HQI0069_RP Witness statement of Mr David Millward adopted by Mr Nigel Coppick, 7 [50].
- 76 Exhibit HQI0062_RP Annexures to witness statement of Mr Gregory Watson, WILS.0001.0001.8812; Exhibit HQI0061_RP Witness statement of Mr Gregory Watson, 21 [93].
- 77 Transcript of day 11 hearing 2 September 2020, 790.
- 78 Ibid 791–792.
- 79 Exhibit HQI0065_RP Witness statement of Mr Jamie Adams, 11 [91]–[92].
- 80 Transcript of day 12 hearing 3 September 2020, 817–818.
- 81 Exhibit HQI0185_RP Annexures to witness statement of Mr Simon Phemister, DJP:105.003.1082–1083.
- 82 Ibid DJP:105.003.1358–1359.
- 83 Ibid DJP:105.003.0825–0825.
- 84 Transcript of day 11 hearing 2 September 2020, 799–800.
- 85 Exhibit HQI0061_RP Witness statement of Mr Gregory Watson, 14 [70]–[71].
- 86 Transcript of day 12 hearing 3 September 2020, 818, 853.
- 87 Transcript of day 11 hearing 2 September 2020, 787–789.
- 88 Ibid 787.
- 89 Ibid 788–789.
- 90 Transcript of day 12 hearing 3 September 2020, 819.
- 91 Ibid 857.

- 92 Ibid 818, 853; Exhibit HQI0071_RP Witness statement of Mr Mo Nagi, 3 [22], 4 [30]; Exhibit HQI0069_RP Witness statement of Mr David Millward adopted by Mr Nigel Coppick, 6 [41]; Exhibit HQI0061_RP Witness statement of Mr Gregory Watson, 18 [77]; Exhibit HQI0065_RP Witness statement of Mr Jamie Adams, 6 [50].
- 93 Transcript of day 6 hearing 20 August 2020, 292; Transcript of day 13 hearing 4 September 2020, 941.
- 94 Transcript of day 13 hearing 4 September 2020, 995.
- 95 Exhibit HQI0071_RP Witness statement of Mr Mo Nagi, 3 [23]; Exhibit HQI0069_RP Witness statement of Mr David Millward adopted by Mr Nigel Coppick, 8 [53]–[54].
- 96 Exhibit HQI0185_RP Annexures to witness statement of Mr Simon Phemister, DJP:105.003.0824, DJP:105.003.1357, DJP:105.003.1082.
- 97 Exhibit HQI0039_RP Annexures to witness statement of Ms Gönül Serbest, DJP:110.001.4976; Transcript of day 8 hearing 27 August 2020, 500–501.
- 98 Transcript of day 8 hearing 27 August 2020, 501.
- 99 Ibid 496–497.
- 100 Exhibit HQI0069_RP Witness statement of Mr David Millward adopted by Mr Nigel Coppick, 4 [29].
- 101 Exhibit HQI0184_RP Witness statement of Mr Simon Phemister, 21–22 [104].
- 102 Exhibit HQI0065_RP Witness statement of Mr Jamie Adams, 10 [80]; Exhibit HQI0085_RP Annexures to witness Statement of Mr Simon Phemister, DJP:105.003.1020 (MSS Contract).
- 103 Exhibit HQI0067_RP Witness statement of Mr Sam Krikelis, 2 [14].
- 104 Exhibit HQI0085_RP Annexures to witness Statement of Mr Simon Phemister, DJP:105.003.1296 (Wilson Contract).
- 105 Exhibit HQI0061_RP- Witness statement Greg Watson, 21 [93].
- 106 Exhibit HQI0059_RP Witness statement of ‘Principal Policy Officer’, 7 [28].
- 107 Exhibit HQI0085_RP Annexures to witness Statement of Mr Simon Phemister, DJP:105.003.0817, DJP:105.003.0793 (Unified Contract).
- 108 Exhibit HQI0069_RP Witness statement of Mr David Millward adopted by Mr Nigel Coppick, 5 [32].
- 109 Exhibit HQI0059_RP Witness statement of ‘Principal Policy Officer’, 6 [23].
- 110 Unified Contract, Annexure A; MSS Contract, Sch 3, Part 2; Wilson Contract, Sch 3, Part 2.
- 111 Exhibit HQI0059_RP Witness statement of ‘Principal Policy Officer’, 8 [31].
- 112 Wilson Contract, Sch 3, Part 2.1; MSS Contract, Sch 3, Part 2.1; Unified Contract, cl 2.1.
- 113 Exhibit HQI0059_RP Witness statement of ‘Principal Policy Officer’, 8 [31].
- 114 Wilson Contract, Sch 3, Part 2.1; MSS Agreement for Professional Services, Sch 3, Part 2.1; Unified Contract, cl. 2.1, Schedule 1 – Agreement Details.
- 115 Exhibit HQI0059_RP Witness statement of ‘Principal Policy Officer’, 14 [57(c)].
- 116 Exhibit HQI0060(1)_RP Annexures to witness statement of ‘Principal Policy Officer’, DJP:110.002.8419.
- 117 Transcript of day 8 hearing 27 August 2020, 501.
- 118 Wilson Contract, cl 3.4(a)(i); MSS Contract, cl 3.4(a)(i); Unified Contract, cl 2.2(a).
- 119 Wilson Contract, cl 3.4(a)(ii); MSS Contract, cl 3.4(a)(ii).
- 120 Unified Contract, cl 2.2(c).
- 121 Unified Contract, cl 2.2(d).
- 122 Exhibit HQI0061_RP Witness statement of Mr Gregory Watson, 28–29 [114].
- 123 Wilson Contract, Sch 3, Part 2, cl 3; MSS Contract, Sch 2, Part 2, cl 3; Unified Contract, cl 7.1.
- 124 Wilson Contract, cl 15.1(a) (as amended); MSS Contract, cl 15.1(a) (as amended); Unified Contract, cl 18.1(a).
- 125 Wilson Contract, Sch 3, Part 2, cl 2; MSS Contract, Sch 3, Part 2, cl 2;.
- 126 Unified Contract, cl 6.2(d).
- 127 Wilson Contract, Sch 3, Part 2, cl 3(a); MSS Contract, Sch 3, Part 2, cl 3(a); Unified Contract, cl 7.2(a).
- 128 Wilson Contract, Sch 3, Part 2, cl 3(b); MSS Contract, Sch 3, Part 2, cl 3; Unified Contract, cl 7.2(b).
- 129 Wilson Contract, Sch 3, Part 2, cl 3(c); MSS Contract, Sch 3, Part 2, cl 3; Unified Contract, cl 7.2(c).
- 130 Exhibit HQI0059_RP Witness Statement of ‘Principal Policy Officer’, 5 [20], 6–7 [24].
- 131 Transcript of day 12 hearing 3 September 2020, 862–863.
- 132 Ibid 822.
- 133 Ibid 863.
- 134 Exhibit HQI0061_RP Witness statement of Mr Gregory Watson, 18–19 [78].
- 135 Exhibit HQI0033(1)_RP Annexures to Witness Statement of Ms Claire Febey, DJP:102.001.3600.
- 136 Ibid.
- 137 Exhibit HQI0184_RP Witness Statement of Mr Simon Phemister, 30 [137], Exhibit HQI0185(1)_RP Annexures to the witness Statement of Mr Simon Phemister, DJP:102.001.3600.
- 138 Submission 03 Department of Health and Human Services, 27–29 [149]–[155].
- 139 Ibid 17 [91], [93]–[94].
- 140 Ibid 17 [94].

- 141 Ibid 15 [80].
- 142 Submission 04 Department of Jobs, Precincts and Regions, 31 [112].
- 143 Ibid 31 [112]–[113].
- 144 Ibid 31 [111].
- 145 Ibid 32–33 [116], [118].
- 146 Ibid 34 [121]–[122].
- 147 Exhibit HQI0036_RP Witness statement of Ms Katrina Currie, 11 [37].
- 148 Transcript of day 3 hearing 17 August 2020, 47.
- 149 Ibid 48.
- 150 Ibid 47.
- 151 Ibid.
- 152 Exhibit HQI0070_RP Annexures to witness statement of Mr David Millward, USG.0001.0001.2955.
- 153 Exhibit HQI0069_RP Witness statement of Mr David Millward adopted by Mr Nigel Coppick, 11 [72].
- 154 Transcript of day 12 hearing 3 September 2020, 821.
- 155 Exhibit HQI0061_RP Witness statement of Mr Gregory Watson, 34 [129(a)].
- 156 Ibid 41 [153].
- 157 Ibid 41 [152].
- 158 Ibid 39–40 [145]–[150].
- 159 Transcript of day 11 hearing 2 September 2020, 791.
- 160 Exhibit HQI0061_RP Witness Statement of Mr Gregory Watson, 43 [164(c)].
- 161 Exhibit HQI0065_RP Witness Statement of Mr Jamie Adams, 18 [131]–[132].
- 162 Transcript of day 12 hearing 3 September 2020, 820.
- 163 Ibid 820–821.
- 164 Exhibit HQI0065_RP Witness statement of Mr Jamie Adams, 12 [97].
- 165 Exhibit HQI0060(1)_RP Annexures to witness statement of ‘Principal Policy Officer’, DJP:105.003.1358–1359, DJP:105.003.1083–1084.
- 166 Exhibit HQI0061_RP Witness statement of Mr Greg Watson, 23–24 [98]–[99]; Exhibit HQI0065_RP Witness statement of Mr Jamie Adams, 7 [54], 8 [63]–[66], 12 [96].
- 167 Transcript of day 12 hearing 3 September 2020, 860–861.
- 168 Ibid 862.
- 169 Exhibit HQI0080_RP First witness statement of Ms Rachaele May, 8 [39]
- 170 Exhibit HQI0135_RP Witness statement of Ms Merrin Bamert, 12 [36].
- 171 Exhibit HQI0024_RP Witness statement of ‘Security 1’, 2 [14]–[15].
- 172 Ibid.
- 173 Ibid 2 [16].
- 174 Exhibit HQI0027_P Witness statement of Mr Kaan Ofli, 4 [23].
- 175 Exhibit HQI0020_P Witness statement of Ms Lilliana Ratcliff, 9 [69]–[72].
- 176 Exhibit HQI0014_RP Witness statement of Mr Michael Tait, 9 [78].
- 177 Ibid 9 [78]–[81].
- 178 Exhibit HQI0184_RP Witness statement of Mr Simon Phemister, 13–14 [68].
- 179 Transcript of day 12 hearing, 3 September 2020, 862.
- 180 Exhibit HQI0067_RP Witness statement of Mr Sam Krikelis, 8 [55] (emphasis in original).
- 181 Ibid.
- 182 Transcript of day 12 hearing 3 September 2020, 863.
- 183 Exhibit HQI0061_RP Witness statement of Mr Greg Watson, 37 [140].
- 184 Transcript of day 13 hearing 4 September 2020, 915.
- 185 Transcript of day 8 hearing 27 August 2020, 427; Transcript of day 11 hearing 2 September 2020, 795; Transcript of day 12 hearing 3 September 2020, 821, 863.
- 186 Transcript of day 23 hearing, 23 September 2020, 2011, 2012; Transcript of day 24 hearing, 24 September 2020, 2081.
- 187 Exhibit HQI0049_RP Witness statement of Mr Unni Menon, 10 [37]. Exhibit HQI0186_RP First witness statement of Ms Kym Peake, 34 [173]; See Exhibit HQI0046_RP Annexures to witness statement of Mr Rosswyn Menezes, RYD.0001.0001.0011; Exhibit HQI0048_RP Annexures to witness statement of Mr Karl Unterfrauner, STAM.0001.0001.0248.
- 188 Exhibit HQI0144_P First witness statement of Commissioner Andrew Crisp 22 [55]; Exhibit HQI0061_RP Witness statement of Mr Gregory Watson, 22 [95]; Exhibit HQI0065_RP Witness statement of Mr Jamie Adams, 15 [109]; Exhibit HQI0069_RP Witness statement of Mr David Millward adopted by Mr Nigel Coppick, 13–14.
- 189 Transcript of day 12 hearing 3 September 2020, 822.
- 190 Exhibit HQI0185_RP Annexures to witness statement Mr Simon Phemister, DJP:105.003.1296.

- 191 Exhibit HQI0032_RP Witness Statement of Ms Clare Febey, 23 [98].
- 192 Exhibit HQI0071_RP Witness Statement of Mo Nagi, 12 [97].
- 193 Exhibit HQI0059_RP Witness Statement of the 'Principal Policy Officer', 14 [56].
- 194 Ibid 14 [57].
- 195 Ibid 15 [60].
- 196 Transcript of day 16 hearing 11 September 2020, 1285–1286.
- 197 Exhibit HQI0059_RP Witness statement of 'Principal Policy Officer', 1–2 [4].
- 198 Ibid 17 [72], 18 [74].
- 199 'Returned Traveller 4', Information provided to the Inquiry via the Intake and Assessment team between 15 July to 3 December 2020.
- 200 Exhibit HQI0059_RP Witness statement of 'Principal Policy Officer', 18 [77].
- 201 Ibid.
- 202 Ibid 19 [80].
- 203 Ibid 20 [81].
- 204 Ibid 19 [80], 20 [81].
- 205 Ibid 20 [83].
- 206 Ibid 20 [84]–[85].
- 207 Ibid 20–21 [86].
- 208 Ibid 20 [85].
- 209 Ibid 21 [89].
- 210 Ibid.
- 211 Transcript of day 9 hearing 28 August 2020, 587–588; Transcript of day 12 hearing 3 September 2020, 823–824, 832.
- 212 Exhibit HQI0059_RP Witness Statement of the 'Principal Policy Officer', 20 [86].
- 213 See Exhibit HQI0066_RP Annexures to Witness Statement of Mr Jamie Adams, MSSS.0001.0009.0002_0022 as an example of the requirements of subcontracting under a Purchase Order Contract.
- 214 See Exhibit HQI0060_RP Annexures to Witness Statement of 'Principal Policy Officer', DJP:110.004.1405 as an example of a Notice of Intent.
- 215 Exhibit HQI0185_RP Annexures to Witness statement Mr Simon Phemister, DJP:105.003.1321–1323.
- 216 Exhibit HQI0061_RP Witness Statement of Mr Greg Watson, 29 [116].
- 217 Ibid 27 [109].
- 218 Ibid 28–29 [114].
- 219 Transcript of day 11 hearing 2 September 2020, 794.
- 220 Transcript of day 12 hearing 3 September 2020, 826.
- 221 Exhibit HQI0065_RP Witness Statement of Mr Jamie Adams, 16 [117].
- 222 Exhibit HQI0059_RP Witness Statement of 'Principal Policy Officer', 13 [51].
- 223 Exhibit HQI0065_RP Witness Statement of Mr Jamie Adams, 15 [109].
- 224 Exhibit HQI0059_RP Witness Statement of 'Principal Policy Officer', 13 [53].
- 225 Ibid.
- 226 Transcript of day 12 hearing 3 September 2020, 850.
- 227 Exhibit HQI0069_RP Witness statement of Mr David Millward adopted by Mr Nigel Coppick, 12–13 [78]–[79].
- 228 Ibid, 14 [83], 15 [85].
- 229 Exhibit HQI0059_RP Witness statement of 'Principal Policy Officer', 12 [46].
- 230 Ibid.
- 231 Transcript of day 22 hearing 22 September 2020, 1847.
- 232 Transcript of day 8 hearing 27 August 2020, 472.
- 233 Exhibit HQI0059_RP Witness statement of 'Principal Policy Officer', 13 [53].
- 234 Transcript of day 8 hearing 27 August 2020, 450–451.
- 235 Submission 04 Department of Jobs, Precincts and Regions, 1–2 [3], 17 [61(f)(iii)].
- 236 Exhibit HQI0036_RP Witness statement of Ms Katrina Currie, 9–10 [32]; Transcript of day 8 hearing 27 August 2020, 450.
- 237 Transcript of Hearing day 22 hearing 22 September 2020, 1847.
- 238 Ibid.
- 239 Exhibit HQI0185(1)_RP Annexures to Witness statement Mr Simon Phemister, DJP:104.004.8163.
- 240 Ibid DJP:105.003.1358–1359.
- 241 Exhibit HQI0069_RP Witness statement of Mr David Millward adopted by Mr Nigel Coppick, 12 [74].
- 242 Exhibit HQI0059_RP Witness statement of 'Principal Policy Officer', 12 [46].
- 243 Exhibit HQI0051_RP Witness statement of Mr Sorav 'Sam' Aggarwal, 4 [23].
- 244 Exhibit HQI0053_RP Witness statement of Mr Ishu Gupta, 3 [17].

- 245 HQI0061_RP Witness statement of Mr Gregory Watson, 14 [70]; Exhibit HQI0173_RP First witness statement of former Chief Commissioner Graham Ashton, 6 [3.4].
- 246 Transcript of day 17 hearing 15 September 2020, 1380.
- 247 See Exhibit HQI0060_RP Annexures to witness statement of 'Principal Policy Officer', DJP.110.003.7238 as discussed above at paragraph 31 of this chapter.
- 248 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>>.
- 249 Emergency Powers, Public Health and COVID-19 <https://www.parliament.vic.gov.au/publications/research-papers/download/36-research-papers/13962-emergency-powers-public-health-and-covid-19#_ftn322>
- 250 Transcript of day 6 hearing 21 August 2020, 286–287.
- 251 Transcript of day 8 hearing 27 August 2020, 461, 463.
- 252 Ibid 477–481.
- 253 Exhibit HQI0051_RP Witness statement of Mr Sorav 'Sam' Aggarwal, 10 [46]–[48].
- 254 Exhibit HQI0052_RP Witness statement of Mr Mina Attalah, 7 [31].
- 255 Transcript day 11 hearing 2 September 2020, 715.
- 256 Ibid.
- 257 Exhibit HQI0031_RP Witness statement of 'Security 16', 2 [13]
- 258 'Security Firm 2', Information provided to the Inquiry via the Intake and Assessment team between 15 July to 3 December 2020.
- 259 Transcript of day 25 hearing 25 September 2020, 2145.
- 260 Ibid.
- 261 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>>; Transcript of day 25 hearing, 25 September 2020, 2145.
- 262 Review of Victoria's Private Security Industry – Victoria's Private Security Industry: Issues Paper for consultation Police Policy and Strategy (15 June 2020) 25 <<https://engage.vic.gov.au/private-security-review-2020>>.
- 263 Ibid.
- 264 Ibid 30, 31; Transcript of day 25 hearing, 25 September 2020, 2146.
- 265 Review of Victoria's Private Security Industry – Victoria's Private Security Industry: Issues Paper for consultation Police Policy and Strategy (15 June 2020) 33 <<https://engage.vic.gov.au/private-security-review-2020>>; Transcript of day 25 hearing 25 September 2020, 2146.
- 266 Review of Victoria's Private Security Industry – Victoria's Private Security Industry: Issues Paper for consultation Police Policy and Strategy (15 June 2020) 33 <<https://engage.vic.gov.au/private-security-review-2020>>; Transcript of day 25 hearing 25 September 2020, 2147.
- 267 Exhibit HQI0097_RP Witness statement of Dr Clare Looker, 21 [95].
- 268 Ibid.
- 269 Ibid.
- 270 Transcript of day 18 hearing 16 September 2020, 1494.
- 271 Ibid 1494–1495.
- 272 Transcript of day 11 hearing 2 September 2020, 713–714.
- 273 'Security Guard 2', Information provided to the Inquiry via the Intake and Assessment team between 15 July to 3 December 2020.
- 274 Transcript of day 18 hearing 16 September 2020, 1494–1495.
- 275 'Security Guard 5', Information provided to the Inquiry via the Intake and Assessment team between 15 July to 3 December 2020.
- 276 See Transcript of day 11 hearing 2 September 2020, 734.
- 277 Exhibit HQI0178_RP Annexures to first witness statement of Mr Chris Eccles, DPC.0012.0001.0470, DPC.0001.0001.6552.
- 278 Transcript of day 11 hearing 2 September 2020, 732.
- 279 Ibid 733.
- 280 Ibid.
- 281 Ibid 734.
- 282 Ibid 733.
- 283 Ibid 734.
- 284 Submission 07 MSS Security Pty Ltd, 23 [93].
- 285 Transcript of day 26 hearing 28 September 2020, 2215–2216.
- 286 Submission 07 MSS Security Pty Ltd, 23 [93].
- 287 Submission 12 Wilson Security Pty Ltd, 16–17 [72]–[75], 19 [81].
- 288 Ibid 16 [72].

- 289 Ibid 17–18 [74]–[75].
- 290 Exhibit HQI0001_P Witness Statement of Professor Lindsay Grayson, 14-15 [61]–[65].
- 291 Board of Inquiry into the COVID-19 Hotel Quarantine Program (Interim Report, 6 November 2020) 13, 15, 27–53 <<https://www.quarantineinquiry.vic.gov.au/reports>>.
- 292 Ibid 33 [31].
- 293 Ibid.
- 294 Ibid 34 [36].
- 295 Ibid 57 [28].
- 296 Ibid 56 [14].
- 297 Ibid 56 [17].
- 298 Exhibit HQI0215_RP Initial Responses from Parties, DOJ.516.001.0006-0007 (DJCS' initial response); Exhibit HQI0178_RP Annexures to first witness statement of Mr Chris Eccles, DPC.0012.0001.0536.
- 299 Transcript day 18 hearing 16 September 2020, 1494.
- 300 Ibid.
- 301 Ibid.
- 302 Exhibit HQI0032_P Witness statement of Claire Febey, 13–14 [56]–[57].
- 303 Ibid 13 [52], 14 [57].
- 304 Transcript of day 19 hearing 17 September 2020, 1652.
- 305 Transcript of day 13 hearing 4 September 2020, 939.
- 306 Exhibit HQI0169_RP Witness statement of Chief Commissioner Shane Patton APM, 7 [3.14].
- 307 Transcript of day 13 hearing 4 September 2020, 939-942.
- 308 Ibid 942–943.
- 309 Exhibit HQI0170 _RP Attachments to the witness statement of Chief Commissioner Shane Patton APM.
- 310 Board of Inquiry into the COVID-19 Hotel Quarantine Program (Interim Report, 6 November 2020) 32 [27] <<https://www.quarantineinquiry.vic.gov.au/reports>>.
- 311 Transcript of day 6 hearing 20 August 2020, 272. Transcript of day 13 hearing 4 September 2020, 966.
- 312 Transcript of day 13 hearing 4 September 2020, 938.
- 313 Board of Inquiry into the COVID-19 Hotel Quarantine Program (Interim Report, 6 November 2020) 33, 34, 56, 57 <<https://www.quarantineinquiry.vic.gov.au/reports>>.
- 314 Exhibit HQI0185_RP Attachments to Witness Statement of Mr Simon Phemister, DJP.107.006.4577.
- 315 Transcript of day 22 hearing 22 September 2020, 1812.
- 316 Transcript of day 23 hearing 23 September 2020, 1929.
- 317 See Exhibit HQI0073_P Witness statement of Ms Hayley Baxter, 4 [15], 8–9 [28(c)], 12 [47].
- 318 Ibid 20 [79].
- 319 Board of Inquiry into the COVID-19 Hotel Quarantine Program (Interim Report, 6 November 2020) 33 [31] <<https://www.quarantineinquiry.vic.gov.au/reports>>.
- 320 Ibid.
- 321 Ibid 34 [36].
- 322 Ibid 57 [28].
- 323 Ibid 56 [14].
- 324 Ibid 56 [17].

CHAPTER 7

Use of hotels and cleaners

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

7.1 Decision to ‘stand up’ hotels for the Hotel Quarantine Program

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

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

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

7. Mr Phemister was confident that around 5,000 rooms would be available 36 hours after the call.⁹ As a result of that call, Mr Phemister understood that he would start to put together an ‘end-to-end’ program of work to support the operation;¹⁰ that is, from the moment someone was seated on an aeroplane to exiting the hotel after their two-week stay, and everything in between,¹¹ although I note Mr Eccles did not purport to commission DJPR to undertake the whole Program.¹²
8. Mr Phemister saw this call as ‘effectively a head-start’ for DJPR to commence work on the Program, including acquiring hotel stock.¹³ Mr Eccles stated that it was likely that he advised the Premier and the Premier’s Chief of Staff, Lissie Ratcliff, of what he was doing when stepping out of the National Cabinet meeting to telephone Mr Phemister.¹⁴ However, there was nothing in the evidence to suggest that Mr Eccles was instructed or directed to place that call. In fact, it was the evidence of Mr Eccles that it was he who decided to place this call to Mr Phemister.¹⁵ During the course of his press conference at about 3.00pm that afternoon, on 27 March 2020,¹⁶ the Premier stated that returning travellers would be quarantined at hotels and that ‘5,000 rooms [were] basically on standby now’.¹⁷
9. Ultimately, only 20 of those hotels were actually used as part of the Hotel Quarantine Program.¹⁸ However, it was that call as between these two departmental heads that commenced the hotel procurement process.
10. Although it was the evidence of Mr Eccles that it was his decision to call Mr Phemister and get the hotel procurement going, and that he was not directed by the Premier to do this, equally, by the following day, the Premier had embraced the proposal to use hotels.

7.2 Procurement of hotels

11. Following his call with Mr Eccles on the afternoon of 27 March 2020, Mr Phemister spoke with Unni Menon, Executive Director, Aviation Strategy and Services, at DJPR.¹⁹ Mr Phemister requested that Mr Menon begin work immediately so as to ascertain the availability of hotels for use in the Hotel Quarantine Program. This included determining the capacity of hotels to provide meals, security services and cleaning services.²⁰
12. Since around 22 March 2020, Mr Menon had been leading DJPR’s efforts to assist DHHS in identifying and securing hotel stock for vulnerable persons requiring accommodation in order to self-isolate.²¹ As part of these efforts, Mr Menon had run an ‘expression of interest’ processes through the Victorian Tourism Industry Council, the Australian Hotel Association and the Accommodation Association of Australia.²² Consequently, by 27 March 2020, Mr Menon had a significant amount of information about which hotels across Victoria were available and willing to participate in the Program.
13. In order to identify appropriate accommodation for the purposes of the Hotel Quarantine Program, Mr Menon and his team speedily commenced work to review the information obtained through the earlier expression of interest processes.²³ Mr Menon’s team sought feedback from the State Control Centre (SCC) team as to their preference from a mandatory quarantine perspective; he said SCC feedback was a preference for hotels to be located within the CBD.²⁴ Mr Menon understood the reason given for hotels in the Melbourne CBD was their proximity to major testing centres, major hospitals and to be confined in a geographical area for security and safety.²⁵
14. Mr Menon and his team began by contacting various hotels in the Melbourne CBD in order to ascertain the security, cleaning and catering capacity of each.²⁶

15. Meanwhile, having already spoken to Mr Menon, Mr Phemister convened a meeting with Rob Holland, Director, Office of the Secretary; Cameron Nolan, Executive Director, Priority Projects Unit; and Claire Febey, Executive Director, Priority Projects Unit at DJPR.²⁷ Ms Febey was made project lead.²⁸ At that stage, based on his understanding of the discussion with Mr Eccles, Mr Phemister believed that DJPR had lead responsibility for delivering the Hotel Quarantine Program. He believed, at the time, that other departments would hold responsibility for components of the Program within their areas of expertise, but that DJPR would ‘bring it all together’.²⁹
16. Early in the morning on 28 March 2020, Mr Menon circulated the spreadsheet he had created the day before, setting out the hotels that were available in the short term, as well as their cleaning, catering and security arrangements.³⁰ Around that time, the template for the contractual agreement for the provision of accommodation was drafted and provided to Mr Menon for completion.³¹
17. It appears that Mr Menon then sent an email to Mr Phemister requesting authorisation to execute the contracts with hotels.³² Mr Phemister replied that afternoon to convey his approval.³³ Mr Menon was, thereby, able to execute the formal agreements with hotels on behalf of DJPR, which he did.³⁴
18. Thus, it was that DJPR made the initial decisions about which hotel sites to use. According to Mr Menon, these decisions were informed by feedback from the team within the SCC, the views of key personnel within DJPR and discussions with the various hotels.³⁵ It was by this process the first hotels were selected and implemented within the Program.³⁶ It does not appear on the evidence that DHHS was specifically engaged in hotel selection at that stage. Notwithstanding the evidence of Mr Phemister that DHHS was consulted, Mr Menon did not identify any DHHS consultation at that point. State Controller — Health at the Department of Health and Human Services (DHHS), Jason Helps, in outlining to Ms Febey that a transition to DHHS must happen, stated that it would be ‘now be vital’ that DHHS made the operational decisions about which hotels to use and when.³⁷

Change of ‘lead agency’

19. On the morning of 28 March 2020, Mr Eccles informed Mr Phemister that Emergency Management Commissioner Andrew Crisp would have the responsibility for coordinating the Hotel Quarantine Program and that DHHS would be the control agency in respect of the program.³⁸ It was agreed that DJPR should transition various roles and functions over to DHHS.³⁹ (See chapters 5 and 8 for more detail).
20. DJPR’s position was that, upon DHHS becoming control agency, its role was as support agency effectively working under the direction of, and managing contracts to assist, DHHS as the department in control of the Program. DHHS maintained that it was not in charge of the overall Program and had responsibility only for those parts of the Program that related to the health and wellbeing of those in detention. Throughout the Inquiry and in closing submissions, DHHS, through its witnesses up to and including the former Minister Jenny Mikakos, maintained a description of its role as one of ‘shared accountability’. The impact of this is discussed at length in Chapter 8.
21. By Sunday 29 March 2020, Mr Helps emailed Ms Febey of DJPR to confirm his desire that DJPR ‘continue to provide the valuable work in procurement of hotels’, but went on to confirm that DHHS was the **control agency** (emphasis added).⁴⁰
22. Mr Menon and his team, thereafter, sought and relied upon the specific requirements and preferences expressed by DHHS representatives, as well as any feedback that had been received from the relevant DJPR personnel.⁴¹ According to Mr Menon, the views of DHHS on this matter were critical.⁴² He stated that DHHS had the ultimate call regarding the selection or renewal of hotels for use in the Program.⁴³

23. Some witnesses for DHHS appeared to have taken a different view as to its role in the selection of hotels. Merrin Bamert, the then Deputy Commander — Hotels at DHHS, gave evidence that, following her initial concerns about suitability of hotels, DHHS was able to have ‘more input’ regarding future contractual engagements, including by providing a checklist of ‘must-haves’ for contractual engagements and ‘trying to encourage the selection of hotels with fresh air options where possible’.⁴⁴ While Ms Bamert’s evidence indicated that DHHS had input into these decisions, it did not indicate that DHHS had ultimate responsibility. Indeed, DHHS submitted that selection of hotels was a matter for DJPR ‘as the entity with responsibility and knowledge of the relevant hotels and their suitability’.⁴⁵
24. The one exception to this was the Brady Hotel, which was selected to replace Rydges and to accommodate COVID-positive guests. DHHS selected and contracted the Brady Hotel, without the involvement of DJPR,⁴⁶ with it ultimately being stood up on 17 June 2020.⁴⁷
25. Mr Menon explained his understanding of the criteria applied by DHHS in determining whether a hotel was appropriate for use in the Program. This included room types and configurations, access to natural ventilation (windows or balconies), whether there were controlled areas for recreation, layout for check-in/out and access to lifts.⁴⁸
26. Mr Menon also gave evidence that he was not aware of any specific documentation from DHHS concerning assessment of prospective hotels from an infection control point of view prior to giving approval to engage them.⁴⁹

Hotels as quarantine facilities

27. The starting point on the issue of the selection of hotels was that there were no specific quarantine facilities able to be identified in Victoria at the time of the National Cabinet decision. The evidence of Pam Williams, DHHS COVID-19 Accommodation Commander, was that there were no apparent viable alternatives to the use of hotels for the purposes of the Hotel Quarantine Program. Ms Williams explained that ‘there are no specific quarantine facilities that we could have accessed’.⁵⁰ According to Ms Williams, while the Commonwealth had some designated quarantine facilities, Victoria did not have any such purpose-built facilities.⁵¹
28. Hotels provided the necessary capacity and availability given the then expected scale of the Program. While precise numbers of returning travellers were not known at that early stage, the evidence of the Premier was that he had been informed that thousands of rooms would be required.⁵²
29. As a result of the limitations that had been placed on travel and tourism due to the COVID-19 pandemic, the Premier knew that there were many hotel rooms available at that time,⁵³ thus, they would be generally available for occupation by those to be quarantined pursuant to the Program.
30. The use of hotels was also seen by the Premier as providing a significant financial and employment boost to the State’s pandemic-affected economy; specifically, a direct injection of work into the hotel and tourism sectors. As the Premier stated, in his press conference on 27 March 2020, and is described more fully in Chapter 5, the Hotel Quarantine Program was, in addition to being an appropriate health response, ‘also ... about working for Victoria and re-purposing people who have perhaps had their hours cut’.⁵⁴
31. It appeared that the suitability of hotels as quarantine facilities was considered mainly from a point of view of expediency, rather than their capability to minimise against the risk of infection transmission.
32. Hotels, it was said, could contain returned travellers within specific hotel rooms with access to their own bathroom, which could provide a measure against cross-contamination and the proliferation of infection.⁵⁵

33. But, as the Program unfolded, there were aspects of hotel facilities that provided challenges for infection prevention and control:
- the carpets and soft furnishings that made people in quarantine more comfortable may also have made it more difficult to clean surfaces⁵⁶
 - structurally, hotels were not designed for infection prevention and control; they do not typically have features, such as wide corridors and oversized lifts, that allow for physical distancing⁵⁷
 - handwashing stations and clinical waste disposal facilities were not readily available in a hotel environment⁵⁸
 - ventilation and air flow within hotels were not designed with a focus on infection prevention and control.⁵⁹
34. Despite efforts being made to source hotels with natural ventilation (windows/balconies), controlled areas for recreation and an appropriate layout for check-in/out and access to lifts, many of the hotels used in the Hotel Quarantine Program did not present as having suitable areas for access to fresh air without guests coming into contact with others. As Ms Williams observed, '[t]he fresh air breaks were difficult to implement safely and without transmission risk due to the limitations of many of the hotels (many did not have balconies, rooftops, or open areas that could be sectioned off from the public to reduce flight and transmission risk)'.⁶⁰
35. Ms Williams described what adaptations were made to ameliorate some of the challenges presented by the hotel environment in order to reduce transmission risks and support specific infection-control measures:
- [M]odifications were made to the physical set up of the hotels to reduce transmission risk. Hotel lobbies were cordoned off to encourage swift movement through the spaces. Hotels were encouraged to remove or limit soft furnishings. Lifts were assigned to 'clean' and 'dirty' purposes to reduce cross-infection. Staff on-site were separated into specific zones to prevent cross-infection.⁶¹
36. While such measures were conducive to reducing the risk of transmission, the physical features of hotels presented corresponding difficulties for the ability of staff to meet the health and wellbeing needs of those who were in quarantine. Hotels are set up so as to give guests privacy, and when those facilities are also used to ensure that potentially contaminated people do not come into contact with others, many guests may spend much, if not all, of their quarantine period without ever being seen by another person. The impact of this aspect of hotel quarantine on people's health and wellbeing is discussed in Chapter 12.2.

7.3 Contracts with hotels

37. As explained above, contracts were executed by DJPR with each participating hotel. Pursuant to those contracts (which were in substantially the same terms), the primary service that hotels were contracted to provide was the supply of rooms and meals to accommodate returned travellers.
38. The precise number of rooms to be supplied for the purposes of the Program varied between different hotels and at different times. Contractual arrangements were made with some hotels to supply the entire hotel for the Program, while others only agreed to supply a certain number of rooms or floors.⁶²
39. The decision as to whether a hotel would be contracted to provide the entire property or whether only certain floors or rooms depended on a number of factors, including the hotel's availability, the incoming demographics of returning travellers and the projected or anticipated demand in terms of hotel stock.⁶³

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

Catering

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

Provide three reasonable meals a day to each of the Department's Nominees. The preparation and service of food must be done in accordance with recommended health standards including in relation to COVID-19.⁶⁴

42. The evidence before the Inquiry was that there were a range of complaints from those in quarantine about the food provided by some of the hotels. These complaints included food quality, accommodation of dietary and religious requirements or preferences, religious requirements, quantity, the nutritional value of meals and a lack of variation in the food provided.⁶⁵
43. Witness Liliana Ratcliff noted that '[W]e were given the same breakfast each day. The other meals were mostly curries and pies. Once, we were given a salad, but otherwise there were very few vegetables only mushroom or pumpkin soup'. She further commented that '[I]t was possible to order Uber Eats. I started ordering food for me and my kids, because it was a way that we could have some control over a small part of our lives while we were in quarantine. From a mental health perspective, it was good for us to have that autonomy — to eat when we were hungry and to choose what we wanted to have'.⁶⁶
44. In some instances, the frustration expressed by witnesses was that, despite being asked about dietary requirements and giving this information on several occasions, the hotel catering was not apparently responsive to the information provided.⁶⁷
45. In response to this evidence, the hoteliers who gave evidence explained that they were mostly in circumstances where they were receiving large groups of people at very short notice with little or no information about dietary requirements being provided to them and, consequently, had little time to make the necessary arrangements for the incoming group.⁶⁸ According to some witnesses before the Inquiry, this issue of catering was a matter that had an impact on people's sense of wellbeing.⁶⁹ This matter is discussed further in Chapter 12.2 on psycho-social impacts of quarantine.

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

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

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

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

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

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

7.4 Contractual responsibility for risk management, worker safety and PPE

46. It was not contentious at any time during the Inquiry that training in how to work safely in the quarantine environment, including the provision and proper use of PPE, was a key element of infection prevention and control. What was contentious was who should provide that training, who did provide that training, what that training was, what that training should have been and the sufficiency of ‘episodic’ training sessions without the on-site embedded supervision and oversight of those with infection control expertise.
47. The form of contract prepared by DJPR made the hotel operators generally responsible for their staff training in workplace health and safety, risk management and the provision of PPE. The presence of such provisions was an acknowledgment of the central importance of infection prevention and control inside the quarantine hotels, and that worker safety on-site was an issue that needed to be addressed with training and the provision of PPE.

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

... be responsible for, ensuring that before its officers, employees, agents, contractors and sub-contractors perform the Services, they receive:

I. adequate training in security, workplace health and safety, customer service and risk management; and

II. are provided with personal protective equipment in accordance with the relevant public health standards, including but not limited to in relation to COVID-19.⁷⁰

49. Managers from a sample of hotels from the Program did not take issue with the contractual provisions contained in 2.1(h). Each of the hotel managers who gave evidence stated that they largely sourced their own information and support around specialist infection-control training and provision, and the use of PPE.⁷¹ The evidence established that each hotel, prior to its participation in the Program, had prepared for operating in a COVID-19 environment. Several hotels had quite detailed and structured policies and procedures in place around COVID-19 safe practices, which they used to train staff for the purposes of this Program.⁷²
50. For example, Stephen Ferrigno, General Manager at the Four Points by Sheraton Melbourne Docklands, gave evidence that its staff were required to do online training courses, including with respect to social distancing, hand sanitising, the use of PPE, public space cleanliness and cleaning, and what to do with a presumed or confirmed COVID-19 case on the property.⁷³ They were also tasked to complete the Australian Government Infection Control online training course.⁷⁴ Ram Mandyam, General Manager at the Travelodge Docklands, gave evidence of policies that covered self-isolation, sanitisation, use of PPE and signage.⁷⁵ Shaun D’Cruz, Executive Manager of Crown Melbourne Hotels, gave evidence of its staff being trained around social distancing and the use of PPE.⁷⁶
51. The PPE that each hotel provided to its staff varied. The evidence from the sample of hotels that gave evidence was that, generally, each supplied its own PPE to staff as per the hotel’s contractual obligations. Each of the hoteliers who gave evidence said that different levels of PPE were provided to hotel staff depending on the nature of contact that staff might have with guests.⁷⁷ At Travelodge, for example, the evidence was that the hotel provided staff with gloves, masks (N-95 and surgical), hairnets, sanitiser and PPE training.⁷⁸
52. At Crown, ‘standard PPE’ was supplied by DJPR to Crown staff, while all other PPE was supplied by Crown.⁷⁹ PPE was stationed throughout the hotel at various locations.⁸⁰ Staff were directed by Crown to wear standard PPE when working in designated areas.⁸¹ This changed to wearing masks at all times after the Victorian Government announced additional restrictions.⁸² All training on the use of PPE was provided by hotel management rather than people with expertise in infection prevention and control.⁸³
53. At the Four Points by Sheraton, the hotel initially provided staff with masks, gloves and safety glasses.⁸⁴ About 4–6 weeks into the Program, DHHS made PPE available for the Sheraton staff.⁸⁵ The hotel provided online and in-person training by managers and supervisors in relation to the use of PPE to staff. At some time after the Program commenced, the hotel was provided with documents from DHHS and DJPR in relation to the use of PPE. Again, the application of the training was supervised by hotel management and not by people who had expertise in infection prevention and control.⁸⁶
54. Understandably, the hotels that agreed to participate in the Hotel Quarantine Program were keen to have the business when the pandemic had such drastic impacts on the tourism industry. It was unsurprising they accepted obligations under their contracts to provide ‘adequate training’, ‘workplace health and safety’, ‘risk management’ and ‘personal protective equipment in accordance with the relevant public health standard, including but not limited to COVID-19’. Given the consequences of any failure to discharge these obligations, it was an entirely different matter as to whether it was prudent for the Government to allocate this obligation to hoteliers in the first place.

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

55. Self-evidently, the risk of infectious outbreaks as between those in quarantine, and to those working in the quarantine hotels, was an ever-present one on-site. Consequently, infection prevention and control (IPC) for those in quarantine and those working on the sites was an essential component of what the Hotel Quarantine Program was required to deliver.
56. IPC encompasses a wide range of issues in the context of hotels as quarantine facilities, including:
 - A. training for hotel workers, including in how to work safely by understanding the risks of infection and how to mitigate against those risks by engaging in practices such as maintaining safe distances, hand sanitising, understanding high-touch area risks and coughing and sneezing requirements
 - B. provision and use of PPE
 - C. cleaning requirements including methods and standards.

What expertise was available to hotels for IPC?

57. It was uncontentious that IPC was a recognised area of expertise. In the context of the COVID-19 pandemic, even those with such expertise have explained that understanding the nature and transmission of the virus was, and remains, a constantly evolving process.
58. DHHS accepted that it was its responsibility to provide guidance and advice on IPC issues, and asserted that it did do so.⁸⁷
59. More particularly, it was the position of DHHS that it was its role to provide the advice and guidance to DJPR and that DJPR was then responsible for passing it on and managing or overseeing compliance. DHHS took the position that it did not hold or manage the contracts with hotels and did not see it as its role to implement that advice and guidance and ensure it was done to the requisite standard.
60. DJPR's position was that although it held the contracts with the hotels, DJPR looked to DHHS for the necessary expertise and guidance in this area. This impasse made its contribution to what became a Gordian knot that developed in the early days of the Hotel Quarantine Program (See Chapter 8 for more detail).
61. At the time the Hotel Quarantine Program was set up, DHHS had one infection and prevention control consultant (IPC Consultant) at its disposal for the State of Victoria. That IPC Consultant stated that she had no formal role in the Hotel Quarantine Program.⁸⁸ The IPC Consultant's evidence was that she was not engaged with the Program,⁸⁹ had no knowledge of what PPE was provided to people working in hotel quarantine⁹⁰ and did not provide training at hotels about PPE, cleaning or other aspects of IPC other than providing guidance or advice or reviewing training materials from time to time.⁹¹
62. By early April 2020, the need for staff with IPC expertise was identified by DHHS as requests for assistance grew across the State.⁹² In early April 2020, the IPC Cell commenced with the IPC Consultant, two additional part-time consultants and an administrative assistant.⁹³ By mid-April 2020, the team had expanded to include an IPC Cell Strategy, Policy & Planning Lead and two more part-time IPC practitioners.⁹⁴ The number of IPC staff in the DHHS IPC Cell fluctuated thereafter.⁹⁵
63. Suffice to say, the evidence was that this very small team was handling general COVID-19 enquiries from across the State, rather than specifically focusing on the Hotel Quarantine Program. This would account for the slow and non-specific response that the Public Health Team inside DHHS was able to provide as the Hotel Quarantine Program commenced and developed.

64. The IPC Consultant explained that she answered questions from those working in the Hotel Quarantine Program from time to time in response to requests: ‘Often this advice was also provided as state-wide advice, that was then available to those managing the Hotel Quarantine Program’.⁹⁶
65. Her evidence was to the effect that various instances of ‘one-off’ training in the use of PPE were delivered at hotel sites for security staff in June.⁹⁷
66. On the suggestion of the IPC Consultant, DHHS engaged an outside consultant to provide IPC advice. As a result, Infection Prevention Australia was engaged in early April 2020.⁹⁸
67. There was no evidence before the Inquiry to suggest DHHS played a role in training hotel staff in infection prevention and control in any uniform, systematic or coordinated way. There were some examples of ad hoc training, like a short tutorial on infection prevention for all hotel staff at the Rydges on 11 April 2020, organised by DHHS.⁹⁹ No doubt, having such an inadequate capacity to provide that infection prevention control expertise from inside DHHS made its contribution to the lack of any cohesive approach to infection prevention and control in hotels.

Section 2 — Hotel cleaning contracts, oversight and vulnerabilities

7.5 The cleaning of quarantine hotels

The importance of cleaning

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

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

69. Cleaning requirements in the Hotel Quarantine Program needed to be informed by what was understood about modes of COVID-19 transmission. I have dealt with the evidence as to what is currently known about how the COVID-19 virus is transmitted in Chapter 2, but in the context of cleaning, the evidence about fomites was particularly relevant and worthy of briefly revisiting here.
70. As noted in Chapter 2, Professor Lindsay Grayson, Professor of Infectious Diseases at Austin Health, explained that the SARS-CoV-2 virus ‘can be transmitted through droplets, aerosols and fomites’.¹⁰⁰ Prof. Grayson provided the following explanation of fomite transmission:

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

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

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

72. Indeed, it was only when considering the Rydges outbreak, in late May 2020, that Dr Crouch first considered fomite transmission as a likely source of transmission.¹⁰³ He acknowledged, in light of the growing experience of the outbreaks that have since been managed, 'it does appear that fomite transmission plays a larger role than I would have given it credit at that point'.¹⁰⁴
73. It appeared, however, that others within DHHS were of a different view at an earlier stage as to the risk posed by fomite transmission. When asked as to her knowledge of the ways in which COVID-19 could be transmitted as of 1 May 2020, Dr Sarah McGuinness, an academic infectious diseases physician who was, at the time, Outbreaks Lead at DHHS, stated that her understanding would have reflected the World Health Organization (WHO) material current at the time.¹⁰⁵ In particular, Dr McGuinness made reference to the WHO guidance titled *Modes of transmission of virus causing COVID-19: implications for IPC precaution recommendations: scientific brief, 29 March 2020*.¹⁰⁶
74. That guidance provides as follows:

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

75. That same document also emphasised:

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

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

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

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

77. While the above section does not refer to airborne transmission, another section of that document states that '[a]irborne and contact precautions are now recommended in specific circumstances when undertaking aerosol generating procedures'.¹¹¹
78. Dr McGuinness stated that the document was consistent with the WHO position and, together, these documents reflected her understanding of the modes of transmission as of 1 May 2020.¹¹² As noted above, Dr McGuinness confirmed that the WHO guidance from late March 2020 was her source material as of 1 May 2020, among others.¹¹³

7.6 Contracts for cleaning of quarantine hotels

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

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

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

... ensure that each Room is thoroughly cleaned and disinfected at minimum:

- i. prior to the commencement of each Department's Nominee's stay; and
- ii. as soon as practicable following the conclusion of each Department Nominee's stay, to a standard consistent with the most recent recommended public health standards in respect of COVID-19.¹¹⁵

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

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

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

83. Each hotel used its own contracted cleaners/housekeepers (as per their regular operation) for the cleaning of rooms and common areas around the hotel. Evidence to the Inquiry was that some hotels provided training to their staff in relation to social distancing, the use of PPE and sanitation.¹¹⁸ Mr Ferrigno of the Four Points by Sheraton Melbourne Docklands, noted that staff were required to undertake specific COVID-19 cleaning training, including training on public space cleanliness and high touch cleaning, and touchless transactions.¹¹⁹
84. The regular hotel cleaners only cleaned rooms after the guests had departed (that is, there was no cleaning during the 14-day quarantine period).¹²⁰ During the quarantine period, essential cleaning items were required to be provided to guest rooms upon request (noting that no cleaning services were otherwise provided during this time).¹²¹
85. However, one returned traveller told the Intake and Assessment Team that he asked for a toilet brush and toilet cleaner during his stay. After three failed responses (he was offered dishwashing liquid, antiseptic wipes and then hair conditioner), he was advised that they had run out of cleaning equipment.¹²²
86. Representatives of the hotels who gave evidence at the hearings said they used subcontractors for their regular cleaning services. There was no evidence that these sub-contracted hotel cleaners were trained in any specific infection control procedures.¹²³

7.7 Procurement of commercial cleaning companies for ‘specialised cleaning’

87. DJPR was responsible for procuring and contracting the specialised commercial cleaning providers to perform COVID-positive cleans at quarantine hotels.¹²⁴
88. Rachaele May, Executive Director of Emergency Coordination and Resilience at DJPR, began substantively performing the procurement role after taking over from Ms Febey in mid-April.¹²⁵
89. Ms May was provided with the relevant quotes and sought to progress procurement.¹²⁶ As a preliminary step, she liaised with DHHS in an effort to understand its requirements in relation to the provision of commercial cleaning services.¹²⁷
90. Ms May gave evidence that she understood that DHHS did not have specific requirements about which cleaning contractor(s) were to be engaged.¹²⁸ As to methods and standards for cleaning, DJPR was advised by DHHS to direct the commercial cleaning contractors engaged to the relevant cleaning protocol,¹²⁹ which, at that time, was *Cleaning and disinfecting to reduce COVID-19 transmission, Tips for non-healthcare settings* (Cleaning Protocol).¹³⁰
91. One of the cleaning services that had provided a quote to DJPR was IKON Services Australia Pty Ltd (IKON), a commercial company that provides infectious cleaning services to a range of clients.¹³¹ In his evidence to the Inquiry, Michael Girgis, General Manager of IKON, said that he first became aware on 11 April 2020 that IKON had been requested to provide a quote for infectious cleaning services in respect of the Hotel Quarantine Program. It was Mr Girgis’ understanding that DJPR had initiated this contact and requested a quote.¹³²
92. On 13 April 2020, Ms May had a discussion with Mr Helps to express the view that IKON satisfied the requirements of the Cleaning Protocol and explained that rooms at the Crown hotels needed to be cleaned urgently so that further arrivals could be allocated later in the week. Mr Helps agreed with her assessment and advised Ms May to proceed and engage IKON.¹³³

93. Ms May approved the engagement of IKON and instructed that a contract be drafted for IKON's consideration.¹³⁴ Due to the urgency of the engagement, IKON commenced providing commercial cleaning services in the Program before having seen a contract. DJPR did, however, provide IKON with a copy of the Cleaning Protocol, in accordance with the direction from DHHS.¹³⁵
94. IKON was the only actual provider of commercial cleaning services to the Program prior to the outbreak at Rydges Hotel.¹³⁶
95. Mr Girgis gave evidence that his company provided specialised cleaning services including sanitising and disinfecting of rooms, and the use of a 'fogging' machine to ensure surfaces were free of bacteria and germs.¹³⁷ IKON used chlorine-based chemical (that is, bleach) to fog the rooms and a bleach and disinfectant to clean hard surfaces.¹³⁸ Rubbish and cutlery were removed in bio-waste bags. As requested, and on an ad hoc basis, IKON would also remove and bag linen from within those rooms.¹³⁹
96. Ms May understood that commercial cleaning service providers were in high demand at the time due to the COVID-19 pandemic. Of the five cleaning companies that were subsequently contacted by DJPR, only AHS Hospitality Pty Ltd (AHS) and AMC Commercial Cleaning (AMC) were available. After satisfying herself that the cleaning proposals of AHS and AMC met the requirements of the Cleaning Protocol, Ms May engaged both companies.¹⁴⁰
97. Ms May explained that IKON, AHS and AMC were each selected for the provision of commercial cleaning at the hotel quarantine sites because they satisfied the requirements prescribed by DHHS and they were available.¹⁴¹
98. The cleaning standards with which commercial cleaning contractors were required to comply also changed over time,¹⁴² as did the contractual terms addressing cleaning methods and standards, each of which varied between contractors, depending on the time of their engagement by DJPR.¹⁴³

Auditing of 'specialised cleaning'

99. The relevant commercial cleaning contracts imposed reporting obligations on the cleaners, but the form of those obligations also varied between different contractors. IKON was required to keep a record of the commercial cleaning it undertook, while AHS and AMC were required to provide DJPR with a report at the completion of each clean, attaching a cleaning certificate.¹⁴⁴
100. Mr Girgis described that, when other infectious cleans are undertaken by IKON, their client would (in every case) engage a separate organisation to conduct 'swab tests'. He explained that this is done as a form of auditing or checking to ensure the clean had been effective in eliminating pathogens. Mr Girgis did not believe such a 'swabbing' process occurred in respect of IKON's work in the Hotel Quarantine Program.¹⁴⁵

7.8 Cleaning standards and expert advice

101. As is clear, DJPR entered into the contracts with the hotels and the specialised commercial cleaning contractors. However, DJPR possessed no special expertise in infection control sufficient for it to direct or supervise the general hotel cleaners or the commercial cleaning contractors or assess the quality of their work.¹⁴⁶ Rather, DJPR asked DHHS to provide advice and guidance regarding infection prevention and control and appropriate cleaning methods so that DJPR could relay that information to the hotels and commercial cleaning contractors.
102. DHHS considered that DJPR was responsible for procuring commercial cleaning services.¹⁴⁷ Ms Williams saw DHHS's role as providing advice to cleaning contractors, but through DJPR as a conduit, on the basis that DJPR was the contract manager.¹⁴⁸

103. DHHS submitted that it provided the following by way of cleaning advice:
- A. First, its consultant prepared cleaning advice, *Cleaning and disinfecting to reduce COVID-19 transmission: Tips for non-healthcare settings* (March Cleaning Advice), which was publicly available on 20 March 2020.¹⁴⁹ (This advice was not specifically for hotels nor people working in a quarantine facility but, rather, a general advice that had been prepared for state-wide use. It was amended on 22 March 2020.)
 - B. Second, on 8 April 2020, DHHS emailed DJPR about cleaning requirements for rooms; specifically, those rooms that had been occupied by COVID-19 cases.¹⁵⁰ That email also provided the March Cleaning Advice and a document apparently directed to medical practitioners and those operating in a medical setting entitled, *COVID-19 Case and Contact Management Guidelines for Health Services and General Practitioners* (CCOM Guidelines).
 - C. Third, in response to requests for advice from DJPR, DHHS advised DJPR to refer cleaners to the March Cleaning Advice.¹⁵¹
 - D. Fourth, on 16 June 2020, DHHS issued a document, *Hotel Quarantine Response—Advice for cleaning requirements for hotels who are accommodating quarantined, close contacts and confirmed COVID-19 guests—Updated* (June Cleaning Advice).¹⁵²
104. The June Cleaning Advice was the first comprehensive, situation-specific cleaning advice tailored to the Hotel Quarantine Program environment. It was provided to DJPR on 17 June 2020 and DJPR directed it be provided to the cleaning contractors.¹⁵³ It is unclear whether the June Cleaning Advice was also provided to the hotel cleaners.
105. Ms May gave evidence that she considered DHHS was ultimately responsible for the cleaning function.¹⁵⁴ She did so on the basis that DHHS was the control agency, the only department with expertise in infection control and the only Department with a consistent site presence at hotels within the Program. Ms May saw DJPR's practical role to be responsible for procuring commercial cleaning contracts 'in accordance with the directions of DHHS', managing issues that were drawn to her attention directly with contractors, liaising with DHHS and commercial cleaning contractors and escalating issues for DHHS for resolution.¹⁵⁵
106. DJPR submitted that it had difficulties in getting DHHS to provide cleaning protocols tailored to the Hotel Quarantine Program environment and to respond to multiple and repeated escalations seeking tailored information and responses to specific questions about cleaning.¹⁵⁶
107. DHHS submitted that the June Cleaning Advice, provided to DJPR in mid-June, was essentially and substantially the same as that contained in the March Cleaning Advice.¹⁵⁷
108. In early April 2020, DJPR requested detailed advice from DHHS in relation to the general standard of cleaning for the hotels. Apart from a link to the generically available information referred to in paragraph 103, no further information was provided at that stage.¹⁵⁸ By mid-April, DJPR confirmed with DHHS that the Cleaning Protocol for the commercial contractors represented the standards expected of the cleaners in relation to cleaning COVID-19 positive rooms.¹⁵⁹
109. As set out at paragraph 104, on 17 June 2020, Ms May directed that the June Cleaning Advice be sent to the three commercial cleaning companies that DJPR had engaged at that time. IKON, AHS and AMC and the contractors were instructed that it must be followed.¹⁶⁰ On 28 June 2020, after the outbreaks at Rydges and the Stamford, DHHS reissued this second cleaning protocol, responding to comments and feedback from the hotels and others.¹⁶¹ Two days later, DHHS assumed control of all service contracts under the Program.¹⁶²
110. At the time of the outbreak at the Rydges Hotel in Carlton, there was no cleaning protocol specific for the Hotel Quarantine Program. DHHS was still relying on the generic cleaning advice issued on 20 March 2020 in relation to non-healthcare settings. The Program-specific cleaning protocol issued by DHHS on 16 June 2020, following agitation for such by DJPR, was released on the day the outbreak at the Stamford was identified.¹⁶³

111. The evidence demonstrates that DJPR was frustrated that DHHS did not provide tailored cleaning advice and protocols for the Hotel Quarantine Program in the initial phase of the operation. DJPR saw this as a concern and a problem that needed to be addressed.¹⁶⁴ In contrast, DHHS submitted that the March Cleaning Advice was applicable to the hotel environment and was sufficient and appropriate for the purposes of the program. DHHS did not share the same concern as DJPR. It should have.¹⁶⁵
112. DHHS submitted that it provided advice to DJPR about the standard of cleaning required, based on public health advice, and expected DJPR to be responsible for passing on that information to the hotels and cleaners.¹⁶⁶
113. As a result of the ad hoc nature of the information DJPR had received from DHHS around cleaning protocols, DJPR sought to consolidate all the information into one document for DHHS to consider. DHHS asked the Infection Control Consultant to review the document and also asked Ms May to approve the document. On 13 June 2020, Ms May declined, as DHHS was the control agency with responsibility for infection control and she did not consider herself to have the relevant expertise in infection control.¹⁶⁷
114. Given the scarcity of IPC expertise inside DHHS, it did not have the necessary capacity to provide advice tailored to the needs of quarantine hotels. I note here that the provision of expert advice and guidance is a separate issue to on site supervision and oversight which is discussed in more detail in Chapter 8.

Protocol for cleaning of common areas

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

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

116. DJPR, as the contracting agency, performed the role of arranging and scheduling the attendance of commercial cleaning contractors at the various hotel sites. It also provided directions as to the expected cleaning standards (as determined by DHHS). The DJPR site manager at each hotel would take requests from hotels for cleaning of vacated COVID-positive rooms, except in respect of Rydges (where there was no DJPR site presence). The DJPR site manager, or a member of the DJPR support team, would then arrange cleans directly with a representative of the commercial cleaning contractor.¹⁷⁰
117. There was evidence from DHHS witnesses that it did not accept its department as having responsibility in respect of the management and direction of cleaning contractors.¹⁷¹ However, other evidence indicated that DHHS did play a role in the management and direction of commercial cleaning contractors, not only in relation to the creation of the policy documents as to the cleaning standards required but also, at least in the case of the Rydges Hotel on 12 April 2020, in the provision of training on cleaning standards.¹⁷²

118. DHHS's evidence was that it was not responsible for supervising cleaning as part of IPC measures. Kym Peake, the then Secretary to DHHS, gave evidence that public health advice, including with respect to cleaning, would be translated into policies and guidelines by those at the Emergency Operations Centre.¹⁷³ Dr Annaliese van Diemen, Public Health Commander (and therefore having a formal position within Operation Soteria), gave evidence that, although her team had responsibility for the availability of IPC advice and guidance in hotels, it was not accountable for determining whether it was appropriately implemented.¹⁷⁴
119. That DHHS did not proactively take an oversight and implementation role in respect of appropriate IPC cleaning was especially significant. DHHS took the view that its role was to provide policies to DJPR as the contractors with hotels and cleaning companies and that it was for DJPR to oversee the implementation of those contracts. DHHS accepted that it was the department vested with specific public health expertise and knowledge, including, critically, in relation to the ways in which the virus could be transmitted.¹⁷⁵ Given the centrality of appropriate cleaning to any effective system of infection control, this created vulnerabilities within the program. Chapter 9 provides further details as to how inappropriate cleaning practices at the Rydges likely contributed to the outbreak.

Infection prevention and control and on-site supervision

120. In Chapter 2 of this Report, a number of conclusions drawn from the scientific evidence presented to the Inquiry were set out in relation to the fundamental safety features required to underpin any efficacious quarantine program. One of those fundamental safety features is expert advice, input and ongoing supervision and oversight of IPC.
121. Consistent with the evidence to the Inquiry, it was uncontroversial that IPC, including cleaning services, was a crucial aspect of a successful quarantine program.
122. Prof. Grayson described quarantine environments as 'self-evidently dangerous spaces' and emphasised that 'the rigour and processes in place need to reflect and reinforce this'.¹⁷⁶ Prof. Grayson highlighted the importance of on-site supervision of IPC measures. He was discussing the use of PPE but noted it was applicable to any safety training for infection control:

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

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

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

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

126. There were no IPC stationed at the hotel sites to give guidance, oversight or supervision on the range of risks to which hotel staff would be exposed and what they needed to do to mitigate those risks. That was a deficiency in the model.
127. Putting to one side the efficacy of the policies that were provided, the lack of an on-site presence with expertise in IPC, supervising, monitoring and overseeing the implementation of those policies was a demonstrable systemic flaw given the highly infectious nature of this virus and its risks of transmission, including by indirect surface (fomite) contact. This issue has been addressed in recommendations in Section 1 of the Interim Report and adopted as part of this Final Report at pages 38–49.

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

128. While many within DHHS saw DJPR's support role as being of great assistance,¹⁸³ the allocation of the contracting function to DJPR had the unintended effect of reducing the access of contractors to direct, timely and authoritative guidance and advice on cleaning practices.
129. Perhaps of more significance, DHHS held the view that as DJPR was the contracting department, it (DHHS) did not have any obligations in relation to the direction and management of contractors, even in respect of infection prevention and control.¹⁸⁴ That was so, despite the fact that DHHS had health and infection control responsibility in Operation Soteria, and that the cleaning (whether it was undertaken by hotels or commercial cleaners) was a clear component of any proper system of infection control.¹⁸⁵

130. DHHS submitted that Operation Soteria, and specifically the COVID-19 Accommodation Commander (a role held within DJPR), was responsible for ‘operationalizing [sic] the public health policies in each hotel’.¹⁸⁶ DHHS also submitted that ‘contracts between DJPR and hotels allocated responsibilities between them with respect to standard cleaning and for the commercial cleaning of COVID positive guest rooms’.¹⁸⁷ The difficulty with the first part of that submission rests on the use of the word ‘operationalising’. Its ordinary usage seems to be ‘putting into effect’, which carries an implication beyond sending through a piece of advice or a policy.
131. The requirements referred to in paragraph 130 were set out in clause 2.1 of the agreements with hotels. Under clause 2.1(d), the responsibility was on hotels to identify the most recent recommended public health standards in respect of COVID-19 for the cleaning of rooms used to accommodate people who were not known to have tested positive for COVID-19.¹⁸⁸ The onus was clearly on the hotels to identify those standards, for themselves, without guidance from DJPR or DHHS. The onus was clearly — and was clearly intended to be — on contractors to determine the standards. As Mr Menon said, ‘... first and foremost, it was the responsibility of the supplier to actually avail themselves of that relevant information’.¹⁸⁹
132. Similarly the agreements provided, at clause 2.1(h), that hotels:
- ... will be responsible for, ensuring that before its officers, employees, agents, contractors and sub-contractors perform the Services [which included cleaning] they receive:

 - i. adequate training in security, workplace health and safety, customer service and risk management; and
 - ii. are provided with personal protective equipment in accordance with the relevant public health standards, including but not limited to in relation to COVID-19.¹⁹⁰
133. As such, in respect of staff training, PPE supply and the cleaning of non-COVID guest rooms, hotel providers were largely left to determine these issues without guidance.
134. In respect of the training requirements within the commercial cleaning contracts, Ms May said that she asked for an approach to be taken in the commercial cleaning contracts similar to that adopted in the agreements for security services,¹⁹¹ that is, commercial cleaners would agree to provide their own training.¹⁹²
135. While the evidence shows, overwhelmingly, that all those working within the program acted in good faith and with good intentions, these providers simply did not have the expertise to adequately fulfil these obligations. That was evidenced and known to DHHS, certainly, following the outbreaks at the Rydges and Stamford Plaza hotels, where reviews found evidence of poor cleaning practices as well as poor training and education among some on-site personnel.¹⁹³
136. That most unsatisfactory situation led to DJPR with contract management responsibility but no expertise in IPC. DHHS led Operation Soteria. DHHS promulgated the relevant cleaning standards, which meant that DJPR was effectively acting as a conduit between DHHS and the cleaning providers as far as cleaning standards were concerned.¹⁹⁴ Like the situation that arose with the hotels, and indeed with security services providers discussed in Chapter 6, that made the administration of those contracts unwieldy and unnecessarily complicated, and not a safe system of IPC.
137. Consistent with DJPR’s contractual arrangements with security services providers, so, too, did the contracts with hotels and cleaning companies effectively impose the primary responsibilities for infection prevention and control on those private providers. That included obligations with respect to cleaning, staff training and the supply of PPE.¹⁹⁵ These were significant responsibilities to outsource, especially in the context of a government-led quarantine program.¹⁹⁶

138. By requiring all returned passengers to be detained in a hotel setting, the Government thereby concentrated, within the Program, a large number of potential carriers of the virus. The Government had a corresponding responsibility to take appropriate action to ensure the safest systems were in place to address the risk that accompanies the creation of suspected or known hot spots.
139. The Premier explained that he was, by the time he gave evidence, aware that the contracts signed by the hotels and cleaning companies sought to put the onus on those private operators to be responsible for IPC training and implementation. When it was put by Counsel Assisting, Ms Ellyard, that 'issues of infection control were too important to be left entirely to private contractors' the Premier answered: '... given what's at stake, given the seriousness and the infectivity of this virus ... I think that is a fair statement'.¹⁹⁷
140. This is, perhaps, an unsurprising concession. Given the focus of the Program and the engagement of contractors who were not specialised in the areas of IPC, shifting of a burden created, in part, by the Government to the contractors was inappropriate and ought not have occurred.
141. At odds with this concession from the Premier, DHHS submitted that the risks were not created or carried by the Hotel Quarantine Program but, rather, risks arose from COVID-19 itself and the entry into Victoria of travellers potentially infected with COVID-19.¹⁹⁸ What was required was a choice, it was submitted, as to how best to deal with the risk.¹⁹⁹
142. DHHS otherwise did not make submissions as to the contractual apportionment of responsibility for infection prevention and control measures, save to say that it considered the PPE and training requirements in the hotel contracts were 'reasonable and prudent' and consistent with hotels' pre-existing legal obligations.²⁰⁰
143. The DHHS submission did not recognise that if the Government mandates potentially infected people into the quarantine facility that it has created to avoid community transmission, it had then accepted the responsibility to take all necessary actions to keep the people in quarantine safe and minimise the risk of cross infection or community transmission out of the quarantine facility. Neither did the submission grapple with a reasonable and legitimate expectation of the Victorian community that its government, when faced with the threat of a highly contagious virus, would take whatever action it considered necessary to address it and then accept responsibility for the actions it took.
144. It was not unreasonable to impose a range of contractual obligations on a private contractor but, in circumstances where the Government is compelling people into a facility that carries such obvious risks, whatever other obligations exist, it too retained an obligation to maintain the highest standards of safety in that facility. Whatever the reason for those contractual provisions, it did not absolve the Government of its duty to ensure that appropriate safeguards were in place.

7.10 Conclusions

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

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

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

Procurement of hotels; contracting of hotels

147. It was beyond doubt that the organisation of the hotels and the cleaning companies involved a significant logistical undertaking. DJPR entered formal agreements with 29 hotels (only 20 hotels were ultimately used for the Program).²⁰¹ It engaged three professional cleaning companies for specialised cleaning, initially only for those rooms that had been used by people who were known to be COVID-positive.²⁰²
148. There is no controversy that those contracts between the State and the hotels and cleaning companies were prepared and executed, on behalf of the State, by DJPR.²⁰³ DJPR maintained the obligation of contract management throughout the period from March 2020 until July 2020, at which time primary control of the Hotel Quarantine Program transferred to the DJCS.²⁰⁴
149. Putting to one side the question of who had overall responsibility for the Program (which is discussed in detail at Chapter 8), while DJPR engaged the hotels and the contract cleaners (and established those contractual relationships between those services and the State), many aspects of the way in which those contracts were to be performed required substantive input from DHHS, specifically in the form of policies directed to IPC measures.²⁰⁵
150. In practical effect, this meant that, while DJPR had responsibility for management of the contracts, in a number of important respects, especially in relation to IPC measures, direction and management of those contractors was based on advice from DHHS. This resulted in a situation where those responsible for ensuring compliance with the contracts (DJPR) were not the ones with sufficient expertise to understand whether the contracts were being performed as they should. This was an unnecessarily complicated and unwieldy situation and not a safe system of infection prevention and control.
151. Important information directed to IPC — the cornerstone of this program — was merely transferred to the contractors via DJPR; as a result, its import may have been diluted or, even, lost.
152. Additionally, this contractual framework complicated and obscured what was the necessary and appropriate, albeit apparently lacking, ‘ongoing supervision and oversight’²⁰⁶ by DHHS of the operational aspects of the Hotel Quarantine Program.
153. Insofar as those aspects were being delivered, or at least were intended to be delivered, by the hotels and cleaners who had been engaged, it was apparent that the Public Health Team and the IPC expertise available to DHHS had little direct insight into how the Program was being administered and, indeed, no oversight.²⁰⁷ At most, DHHS submitted that ‘the Public Health Team had responsibility for the availability of IPC and PPE advice and guidance’.²⁰⁸
154. A number of witnesses (including Ms Peake and former Minister Mikakos) accepted that, while they were grateful to DJPR for establishing the contracts with hotels and cleaning providers that furnished the Program with the necessary facilities and ancillary – but no less necessary – cleaning professionals at an early stage, there was no legal or practical preclusion from the management of those contracts being transferred to DHHS after the establishment of those agreements and while the Program continued to run under the various iterations of Operation Soteria, with DHHS the designated control agency.²⁰⁹

155. The impact of fragmenting responsibilities in this way as between DJPR, DHHS and the private contractors added to or increased the vulnerabilities inherent within the Hotel Quarantine Program. The provision of policy advice and guidance on IPC measures, such as proper cleaning standards and methods, to DJPR, a department with no expertise in the area and, therefore, no ability to oversee the correct implementation of these requirements, was not a safe way to minimise the risk of infectious outbreaks in hotel quarantine sites.
156. Apparently, with a realisation as to the unwieldy nature of the Program, subsequently, from 3 July 2020, DHHS assumed responsibility for both the selection and contracting of all hotels in the Program.²¹⁰ Existing agreements with hotels were amended to reflect this transfer of responsibility from DJPR to DHHS on 3 July 2020.²¹¹
157. At a much earlier stage in the Program, DHHS and DJPR should have arranged for the transfer of responsibility for the administration of contracts to DHHS. This would have brought the department with public health expertise into a direct role in administering essential components of the Program and would have provided clear lines of accountability, responsibility and supervision of roles. It would also have meant those with the requisite public health expertise could be fully embedded in the operation of the Program, including the necessary on-site supervision. Importantly, given it was an unplanned and untested Program with high risks, one agency overseeing the Program would also have likely embedded a proper, ongoing review of the Program in its operation.
158. Decisions to contract with hotels were made with reliance on DHHS's requirements as to what hotels were suitable; despite this, DJPR (Mr Menon) did not receive any specific documents from DHHS regarding whether hotels were assessed from an infection control point of view. The key consideration for such an assessment should have been the extent to which infection control measures could be successfully implemented.

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

159. IPC measures are essential to a quarantine program. It is necessary to have those with the expertise in IPC deliver that training. And nothing short of constant reinforcement, supervision and oversight from those with the necessary expertise is what is required in such a highly infectious environment.
160. There were no IPC experts stationed at the hotel sites to give guidance, oversight or supervision on the range of risks to which hotel staff would be exposed and what they needed to do to mitigate those risks.
161. DHHS witnesses have made clear that knowledge about the virus and its modes of transmission was evolving.²¹² Dr Crouch gave evidence that:
- The understanding of COVID-19 continues to develop. As this has happened, so too has my understanding of the virus and its modes of transmission. I am not convinced that we yet fully understand how it is transmitted.
162. Given what Dr Crouch stated, it made it even more unsatisfactory that hoteliers were contracted to provide their own PPE, training and infection prevention and control. It was a wholly inadequate situation.

The importance of cleaning

163. There was inadequate focus in the design and implementation of the Hotel Quarantine Program on the need for specialised and rigorous cleaning to address the risk of virus transmission through environmental contact. Given that the guidance from the WHO in March 2020, specifically identified fomite transmission as a recognised method by which infection might occur, the Program should have been informed by the development of proper and authoritative guidance that dealt specifically with rigorous ‘environmental cleaning and disinfection’.
164. This was especially so given the movement of people in and out of the hotels; those in quarantine and the workers and staff and personnel on-site.

Procurement of commercial cleaning companies for ‘specialised cleaning’

165. The requirement that hotels undertake specialised cleans of COVID-positive rooms was flawed. It was based on a presumption that it would be known, upon rooms being vacated, which people in quarantine were COVID-positive and which people were not. Having regard to the symptomology of COVID-19 (see Chapter 2), because of the possibility that people infected with COVID-19 might be asymptomatic or might experience only mild symptoms that they may not recognise or may not report, and because testing was not initially universal nor ever compulsory, it was reasonably possible that a person’s COVID-positive status might not have been discovered. In such a case, a room that had held a person, potentially, at least, with COVID-19, would be cleaned by hotel staff or subcontractors rather than specialised cleaners.
166. Irrespective of the contracting arrangements and who carried out the cleaning, it was imperative that proper auditing checks were conducted with due care, particularly given the known risk of environmental transmission.²¹³ There is no evidence this was done.

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

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

Returned Traveller 12: ‘There were a lot of stains in the room ... It made me wonder if any checks had been done on the cleanliness of the rooms to see they were up to standard’.

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

Cleaning standards and quality control

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

168. It was necessary for advice that dealt specifically with hotels in the quarantine environment to have been provided early. It could not have been expected that DJPR officials engaging cleaning contractors had sufficient IPC knowledge to know whether generic guidance was appropriate in that specific context. Where DJPR had made requests of DHHS for tailored hotel quarantine advice and policies, those requests were reasonable.
169. The consequences of the 'split' DHHS and DJPR arrangement included delays in providing proper cleaning advice and services, hampering the ability of those within hotels to deal quickly with issues as they arose.

Oversight of specialised cleaning in quarantine hotels

170. Putting to one side the efficacy of the policies that were provided, as has already been noted, the lack of on-site presence of those with expertise in IPC, supervising, monitoring and overseeing the implementation of those policies was a systemic flaw given the highly infectious nature of this virus and its risks of transmission, including by surface (fomite) contact.
171. DHHS took over the management of all cleaning contracts (other than in relation to the Brady) in quarantine hotels from 1 July 2020.²¹⁴ Had DHHS taken over that contracting function earlier, it would likely have been more proactive in directing and managing hotels and cleaners in relation to IPC practices. The demarcation of roles that existed resulted in a diffusion of responsibility and led to an absence of appropriate oversight and leadership within the Program in respect of this central tenet of IPC.
172. From the outset of the Program, there should have been a fuller implementation of processes that adequately identified the known risks of transmission. Whether this arose due to the contractual arrangements or the division of responsibilities between DHHS as control agency and DJPR as the contracting party, or for some other reason, it is clear that this was an aspect of the program that was inadequate.
173. Further, the expertise to ensure proper IPC standards were embedded in the Program and maintained did not lie with the contracting agency. This was a structural problem that permeated the Program. DHHS should have been responsible for ensuring implementation of its own standards.

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

174. Chapter 6 sets out that it was not appropriate for the Government to place contractual responsibility for IPC on security services providers. I come to the same conclusion with respect to contracts with hotels and commercial cleaners, and I repeat those reasons here with respect to hotel and cleaning contracts.
175. That is, contracts entered into by DJPR on behalf of the State allocated to hotels and cleaners key responsibilities for worker safety, including the need to provide PPE and to manage IPC.

176. DJPR submitted that it was reasonable and appropriate for contractors to have responsibility for matters within their control, noting that under the *Occupational Health and Safety Act 2004 (Vic)*, contractors have a positive duty to control risks.²¹⁵ DJPR went further to submit that it would be inappropriate for the State to seek to assume contractors' own obligations with respect to their workforces because:
- A. obligations on contractors provide an extra layer of protection for workers²¹⁶
 - B. the State and contractors exercise a different level of control over relevant workers and workplaces: here, DJPR submits that contractors have particular roles with respect to on-site supervision arrangements, communication, disciplinary action and counselling²¹⁷
 - C. it is appropriate for the State to limit its risk through contracts²¹⁸
 - D. it was appropriate to require contractors to source their own PPE given the State's concern that it would be unable to source sufficient PPE.²¹⁹
177. DJPR submitted that its contracts did not purport to transfer to contractors, or diminish the State's IPC responsibilities, nor did the State seek to contract out of its obligations under the *Occupational Health and Safety Act 2004 (Vic)*.²²⁰
178. As I have said, earlier in Chapter 6, in the context of private security, this Inquiry is not the proper venue for rulings and findings with respect to duties owed by these contractors at employment, contract or tort law. Suffice to say, it was not appropriate for the Government to seek to impose the risk of transmission of COVID-19 onto the hotel and cleaning providers in the way in which these contracts purported to do. The Hotel Quarantine Program was not just a workplace or a private arrangement between employer and employee, or contractor and principal. It should not be seen solely through that lens. It was, fundamentally, a measure to protect the public from a significant public health threat.
179. There was simply too much at stake for the Government to have conferred such responsibilities on private service providers, whose ordinary roles were so far removed from IPC measures.
180. I note here that Rydges Hotels Ltd supported a finding that the Government assumed responsibility for the infection risks associated with the Hotel Quarantine Program.²²¹ It submitted that it was a matter for the Government as to where the Government should have placed contractual liability for PPE and infection control education,²²² but noted that it was the Government's responsibility to ensure effective IPC.²²³ I agree.
181. As I have said before, the weight of the expert evidence before the Inquiry from all of the health and medical witnesses is that the state of science and learning about the COVID-19 virus, its modes of transmission, its highly infectious nature, what forms of PPE should be used, and where and when, was changing, evolving and developing.²²⁴ Further, that state of learning was held not just in public health generally, but in infection control, more particularly, as a recognised field of expertise.
182. For either government department, be it DJPR through its contract provisions with hotels and cleaners or DHHS through its reliance on the contracting agency, to assume that hotels could or should have been making assessments about 'risk management' and what was 'adequate training' and 'relevant public health standards' for COVID-19 was completely inappropriate. There was no basis to assume that hotels would have had the specific expertise or experience in IPC and use of PPE to be making such assessments and, certainly, not to the degree required to contain this highly infectious virus or to the degree necessary to administer an effective and safe quarantine program.

183. The express provisions of the contracts placed primary responsibility for infection prevention control training and PPE supply and use on the contractors.²²⁵
184. In this regard, I repeat that it was the evidence of the Premier that it would ‘absolutely’ be a concern if the relevant departments ‘didn’t take an active role in ensuring that there was proper infection control and prevention measures in place’, in particular where the Government had assumed such risk by bringing members of the public into the hotels.²²⁶

7.11 Recommendations

185. The recommendations that emerge from the conclusions in this Chapter are in Section 1 of the Interim Report. Recommendations 1-39 in Section 1 of the Interim Report, and adopted into this Final Report, contain the features of the recommended model for a facility-based quarantine program.
186. Rather than replicating recommendations 1–39 here, these recommendations can be found at pages 38–49 of this Report.

Endnotes

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

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

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

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

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

DHHS as control agency

Introduction

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

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

2. As has been set out in Chapter 5, the Hotel Quarantine Program was set up over a weekend. Those with experience in developing complex health programs, such as Merrin Bamert, DHHS Agency Commander, Operation Soteria,² and Professor Euan Wallace, then Chief Executive Officer, Safer Care Victoria, stated that a program of this size and complexity would ordinarily have taken months to develop, with risk strategies in place.³ Ms Bamert noted, '[i]n this case, we had less than 48 hours to get the program up and running and in the first week, we had five hotels activated and 1,550 returning passengers'.⁴ In her evidence, Ms Williams quoted a higher number, stating that the number of returned travellers in the first week 'quickly reached over 2,000'.⁵
3. Given, as set out in Chapter 3, there was no pandemic plan for quarantining people in facilities, and the speed at which the Program was set up, operational policies and procedures for the Program were being finalised over the days and weeks following the commencement of the Program.⁶
4. Indeed, after the announcement at National Cabinet on 27 March 2020, all health agencies across the nation were having to grapple with contingency plans for the impact of COVID-19 on the healthcare sector while setting up their Hotel Quarantine Programs.

Structure of this Chapter

5. This Chapter examines the plans, structures, decision-making, management and governance of the Victorian Hotel Quarantine Program. It contains four sections:
 - A. Section 1 sets out some basic concepts of the Victorian emergency management framework relevant to this Inquiry. This has been done to put the role of DHHS in the Hotel Quarantine Program into the operational context in which it commenced.
 - B. Section 2 sets out how DHHS interpreted and performed its role and functions, and how it was structured in its work on the Hotel Quarantine Program relative to other Departments, the emergency management framework and internally.
 - C. Section 3 analyses how those interpretations, decisions and structures impacted the operation of the Hotel Quarantine Program.
 - D. Section 4 summarises my conclusions.

Section 8.1 — the emergency management framework

6. As set out in Chapter 5, while overall responsibility for the Program briefly lay with the Department of Jobs, Precincts and Regions (DJPR) on the first day of the Program, over the 24 hours that followed, governance structures for the Program were quickly reset to align with Victoria's emergency management framework. In order to examine how the Program unfolded, it is necessary to consider the foundational concepts of this emergency management framework, which informed the roles, actions and responsibilities constituting the Program.
7. Before doing so, it is relevant to note that parts of the emergency management framework discussed in this Chapter were replaced or superseded by the Victorian State Emergency Management Plan (SEMP) on 30 September 2020 and the *Emergency Management Legislation Amendment Act 2018* (Vic) (Amendment Act) on 1 December 2020. The changes, introduced by the SEMP and the Amendment Act, were not the subject of evidence to this Inquiry, noting that both the SEMP and Amendment Act commenced after the close of evidence. Accordingly, in what follows, I will address the emergency management framework, in the present tense, as it stood at the time of the Hotel Quarantine Program. Those engaged in emergency management reform should read the following and apply the findings and recommendations reached in this Chapter to the revised emergency management framework on this basis.

Foundational concepts

8. 'Emergency management' refers to the arrangements for, or in relation to, the mitigation of, response to and recovery from, emergencies.⁷ The emergency management framework in Victoria contains an extensive array of documents, manuals and plans that endeavour to address the range of emergencies that could emerge, and the operational structures to be implemented when responding to those various types of emergencies. According to former Emergency Management Commissioner, Craig Lapsley PSM, the creation of Emergency Management Victoria, being the central agency responsible for emergency management in Victoria, was an outcome of two catastrophic emergencies — Black Saturday in 2009 and the Victorian floods in 2010.⁸

9. The emergency management framework has a statutory basis. In Victoria, it is established by two main statutes: the *Emergency Management Act 2013* (Vic) (EM Act) and the *Emergency Management Act 1986* (Vic) (1986 Act).
10. The EM Act has several objectives.⁹ One of those objectives is of particular relevance to this Inquiry, being to establish efficient governance arrangements that, amongst other things, clarify the roles and responsibilities of agencies and facilitate cooperation between agencies.¹⁰

8.1.1 Functions of the Emergency Management Commissioner

11. One of the ways that the EM Act purports to achieve its aims is through establishing the office of the Emergency Management Commissioner.¹¹ The Emergency Management Commissioner has a number of functions, including:
 - A. the coordination of the activities of agencies having roles or responsibilities in relation to the response to Class 1 emergencies or Class 2 emergencies¹²
 - B. ensuring that control arrangements are in place during a Class 1 emergency or a Class 2 emergency and that the relevant agencies act in accordance with the state emergency response plan¹³
 - C. ensuring that the Minister for Emergency Services is provided with timely and up to date information in relation to the response to major emergencies¹⁴
 - D. being responsible for the preparation of the SEMP¹⁵

8.1.2 Classes of emergencies

12. Emergencies are categorised as ‘Class 1 emergencies’, ‘Class 2 emergencies’ or ‘Class 3 emergencies’.¹⁶
 - A. a Class 1 emergency is a major fire or any other major emergency for which the Metropolitan Fire and Emergency Services Board, the Country Fire Authority or the Victoria State Emergency Services Authority is the control agency under the SEMP
 - B. a Class 2 emergency is a major emergency other than a Class 1 emergency, a warlike act or act of terrorism (whether directed at Victoria or at any other State or Territory of the Commonwealth), hijack, siege or riot. A major public health emergency falls within this definition
 - C. a Class 3 emergency is a major emergency that *is a* warlike act or act of terrorism, hijack, siege or riot. A Class 3 emergency is often referred to as a ‘security emergency’.¹⁷
13. The COVID-19 pandemic, as a human disease emergency, was a Class 2 emergency under the emergency management framework.¹⁸

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

14. The EM Act provides the foundation for a range of plans to guide emergency activities.
15. The EM Act requires that the Emergency Management Commissioner arrange for the preparation of the State Emergency Response Plan (SERP).¹⁹ The SERP puts ‘meat on the bones’ of the framework of the EM Act.²⁰

THE STATE EMERGENCY RESPONSE PLAN

16. The SERP outlines the arrangements for a coordinated response to emergencies by all agencies with a role or responsibility in that emergency. The SERP contains provisions:
 - A. identifying, in relation to each form of emergency specified, the agency primarily responsible for responding to the emergency (the control agency)²¹
 - B. relating to the coordination of the activities of other agencies in support of a control agency in the event of the emergency (support agencies)²²
 - C. specifying the roles of the control and all support agencies in the event of an emergency²³
 - D. setting out provisions relating to consequence management²⁴
 - E. setting out the roles, responsibilities and process for appointing State Response Controller, Class 2 Emergency Controller and controllers under s. 39 of the EM Act.²⁵
17. The Inquiry received into evidence the Emergency Management Manual Victoria (EMMV),²⁶ a compendium of the principal policy and planning documents that set out the emergency management arrangements for Victoria. The EMMV sets out the SERP at Parts 3, 7 and 8,²⁷ and provides details about the roles that different organisations play in the emergency management arrangements for different classes of emergencies.

THE STATE HEALTH EMERGENCY RESPONSE PLAN

18. The EM Act also provides for the preparation of sub-plans to the SERP. The State Health Emergency Response Plan (SHERP) is a such a sub-plan.²⁸
19. When it comes to health emergencies, the SHERP is a critical document in the Victorian emergency management framework. The SHERP provides:

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

20. The emergency management framework encompasses plans at a high level, but also plans at different degrees of specificity, depending on the nature of the emergency. Aside from the SERP and the SHERP, there is a range of such plans that have been considered earlier in this Report at Chapter 3 (with respect to the state of emergency preparedness). I note them again here for completeness:
- A. The Victorian Health Management Plan for Pandemic Influenza.³⁰
 - B. The Victorian Action Plan for Pandemic Influenza.³¹
 - C. The COVID-19 Pandemic Plan for the Victorian Health Sector.³²
21. As set out in Chapter 3, none of these plans contemplate mass mandatory quarantine.

8.1.4 Control agency

22. A 'control agency' is defined, under the SERP, as the agency with the primary responsibility for responding to a specific form of emergency.³³
23. The EMMV (Part 7) lists control agencies for specific emergencies.³⁴
24. A control agency's responsibilities are set out in Part 3 of the EMMV.³⁵ Those responsibilities include:³⁶
- A. planning to deliver their responsibilities according to their Part 7 roles, including planning to resource those responsibilities through agency resources, support agency resources or contract or supply arrangements with private industry
 - B. preparing a sub-plan for the emergency when the arrangements for managing an emergency vary from the arrangements in the Response Plan
 - C. confirming the arrangements for the appointment of controllers for the specific form of emergency for which the agency is the control agency
 - D. responding to the form of emergency for which the agency is the control agency in accordance with the arrangements in the Response Plan or the relevant sub-plan
 - E. notifying the Emergency Management Commissioner of major emergencies or situations that may affect the capability of the agency to perform its role or responsibilities.
25. The EMMV lists control agencies for specific emergencies. Not surprisingly, given public health is squarely the responsibility of DHHS (particularly preventing the spread of communicable diseases),³⁷ DHHS is designated as the control agency for human disease emergencies.³⁸ Such emergencies are Class 2 emergencies under the EMMV.³⁹

Support agencies

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

Individual agencies perform specific tasks according to their role

27. The EMMV describes the activities and roles performed by the agencies involved in a response to an emergency. Part 3.2.1 of the EMMV distinguishes between the roles of coordinating, commanding or controlling functions in an emergency as set out below:
- A. Coordination** means bringing together agencies and resources to ensure effective response to, and recovery from, emergencies.
 - B. Command** means the internal direction of personnel and resources, operating vertically within an agency.
 - C. Control** means the overall direction of response activities in an emergency, operating horizontally across agencies.⁴²

Importance of control agency for emergency management

28. A control agency has the primary responsibility for responding to the specific emergency. This was explained by former Emergency Management Commissioner Lapsley to mean that the control agency is responsible for leading the response to the emergency, setting the strategic direction and developing and executing a management plan that involves all agencies supporting the response to the emergency.⁴³
29. Mr Lapsley explained why having a single control agency is important in an emergency response. He said:

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

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

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

Complex emergencies

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

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

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

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

33. The SHERP — being a sub-plan of the SERP — sets out how DHHS is to operationalise its SERP responsibilities within the EM Act framework.⁴⁸
34. Importantly, the SHERP sets out key roles where DHHS is the control agency for a health emergency, as follows:

Figure 8.1.1: Key roles for DHHS under the SHERP

<p>State Controller (DHHS as control) / State Health Incident Management Team Lead (DHHS as support)</p>	<p>As agency lead, the Secretary to DHHS appoints the State Controller (by instrument of appointment) to enable appropriate focus on managing health consequences according to the nature of the emergency:</p> <ul style="list-style-type: none"> • the Public Health Commander will be appointed State Controller for identified public health emergencies (most likely to occur in circumstances where a public health emergency is anticipated) • all other emergencies, including in the event of a rapid onset health emergency where the causation is unclear, the State Health Coordinator will be appointed as State Controller. <p>The State Controller is responsible for the following initial decisions and actions, in consultation with the appropriate internal and external stakeholders:</p> <ul style="list-style-type: none"> • verify the relevant response assessment (refer to Section 6.3.3) • determine the strategic objectives for response • determine the incident management model or activate pre-agreed plans for the initial response • establish incident management team(s) (as applicable) • ensure timely and appropriate public information and warnings are provided to the community • notify the EMC, support agencies and relevant health system service providers. <p>The State Controller may appoint a Deputy Controller.</p> <p>The State Controller should delegate their function on the State Health Incident Management Team (that is, Public Health Commander or State Health Coordinator) to a deputy or equivalent.</p>
<p>State Health Emergency Management Coordinator (SHEMC)</p>	<p>The SHEMC is an executive-level public administration function performed by DHHS and appointed by the Secretary of the department.</p> <p>The SHEMC is responsible for ensuring that appropriate appointments are made to state tier functions (the State Health Commander, State Health Coordinator and the Public Health Commander), as well as providing executive administrative support to ensure these functions operate effectively.</p> <p>While an instrument of appointment will determine whether the Public Health Commander or State Health Coordinator performs the function of State Controller, the SHEMC may advise the Secretary to DHHS who should fulfil the function of State Controller (with advice from the State Health Incident Management Team) according to the nature of the emergency and response, and consistent with the instrument of appointment.</p>

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

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

8.1.5 Controllers and Commanders

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

APPOINTMENT OF CONTROLLERS

36. The State Controller in any emergency sits above any particular incident and is responsible for the overall response to the emergency.⁵¹
37. As can be seen from the table above, in a Class 2 health emergency the SHERP provides for the Secretary to DHHS to appoint the State Controller (who, in the Hotel Quarantine Program, was referred to as the State Controller — Health) to enable appropriate focus on managing health consequences according to the nature of the health emergency.⁵² According to the table, where there is an identified public health emergency, the Public Health Commander is appointed the State Controller — Health.⁵³ The Public Health Commander is the role performed by the Chief Health Officer (CHO) or delegate.

38. How this appointment process occurred in the Hotel Quarantine Program, and who was ultimately appointed to the State Controller — Health role, are questions I address in some detail below, in sections 2 and 3 of this Chapter.
39. Once appointed under the SHERP, the State Controller — Health’s responsibilities include to:
 - A. lead and manage the response to a Class 2 emergency
 - B. establish a control structure for the Class 2 emergency as appropriate and monitor to ensure it suits the circumstances
 - C. support the Emergency Management Commissioner to identify current and emerging risks, or threats in regard to the Class 2 emergency, and implement proactive response strategies
 - D. support the Emergency Management Commissioner in the development of a state strategic plan for managing the Class 2 emergency.⁵⁴

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

40. The emergency management framework that I have outlined above (including the allocation of roles to the various offices) applies to a response to a major public health emergency, whether or not there is a declaration of a State of Emergency in place.⁵⁵
41. As I have set out in Chapter 1, the Minister for Health declared a State of Emergency in respect of the COVID-19 pandemic on 16 March 2020. This enabled the conferral of emergency powers on Authorised Officers, including the power to detain people.⁵⁶
42. This declaration, on 16 March 2020, was the first time that a State of Emergency had been declared under the *Public Health and Wellbeing Act 2008 (Vic)* (PHW Act) with respect to a Class 2 emergency.⁵⁷ It formed part of the legal arrangements for how DHHS administered and enforced the Hotel Quarantine Program.

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

43. It is against this backdrop, having regard to the emergency management framework summarised above, that I now turn to the governance structures ultimately adopted, and the decisions made, by DHHS in its role as control agency within the Hotel Quarantine Program.
44. There was no controversy that the COVID-19 pandemic was a Class 2 health emergency or that this Class 2 health emergency meant that DHHS was the ‘control’ agency. How DHHS interpreted that role and its functions and responsibilities in the context of the Hotel Quarantine Program was, however, the subject of considerable dispute.

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

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

47. As discussed in Chapter 5, the Hotel Quarantine Program had two key objectives, albeit perhaps not clearly articulated, each of which was a health and human objective. The paramount purpose of the Hotel Quarantine Program, and the very reason for its existence, was to prevent the further spread of COVID-19 from returning overseas travellers into the Victorian community, thus protecting the health of all Victorians.⁵⁸ The secondary objective of the Program was to meet the health and other needs of those detained in quarantine.⁵⁹
48. Infection control, outbreak management, healthcare, welfare and human services are core to the work of DHHS. Kym Peake, former Secretary of DHHS, stated that the purpose of the Department is to provide policy advice to government and to ‘fund, regulate and deliver programs to enhance the safety, health and wellbeing of Victorians’.⁶⁰ Key responsibilities of the Department relate to public health and include preventing the spread of communicable diseases.⁶¹
49. In its ordinary operations, DHHS reports to five Ministers across the portfolios of Health, Ambulance Services, Housing, Disability, Ageing and Carers, Mental Health, Child Protection, and the Prevention of Family Violence.⁶² To say that its remit is expansive is, perhaps, to understate the position. Victoria’s CHO, Professor Brett Sutton, evocatively and aptly, described DHHS as a ‘rather large beast’.⁶³
50. In this regard, it is of note that, on 30 November 2020, the State Government announced a restructure of DHHS to separate the Department of Health (DoH) from the new Department of Families, Fairness and Housing (DFFH), effective as of 1 February 2021.⁶⁴

CONCEPT OF OPERATIONS

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

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

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

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

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

During an emergency, whether in control, support or coordinating, the department will convene a single body to inform decision-making by leadership roles irrespective of the type of hazard that has precipitated the emergency. For the purpose of the SHERP, the departmental incident management team fulfils the function, and will operate as the State Health Incident Management Team under SHERP when required.

The D-IMT [Department Incident Management Team] determines the strategic priorities for the department, and in some cases the health and human services and emergency management sectors, in responding to emergencies across all functions. The D-IMT provides guidance on required decision-making, across the span of strategic, tactical and operational decisions. The D-IMT provides direction for functional lead officers in the discharge of all key activities and activities for which the department is accountable.⁶⁸

54. The Concept of Operations provided that membership of the Departmental Incident Management Team or State Health Incident Management Team under the SHERP should include:⁶⁹
- State Health Coordinator
 - State Health and Human Services (Departmental) Commander
 - Public Health Commander
 - State Health Commander (as required)
 - Regional Commanders (as required)
 - Functional lead officers.
55. The Concept of Operations also provided the roles for DHHS at the State Control Centre (SCC) when acting as a control agency, as follows:

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

THE STATE HEALTH EMERGENCY RESPONSE PLAN

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

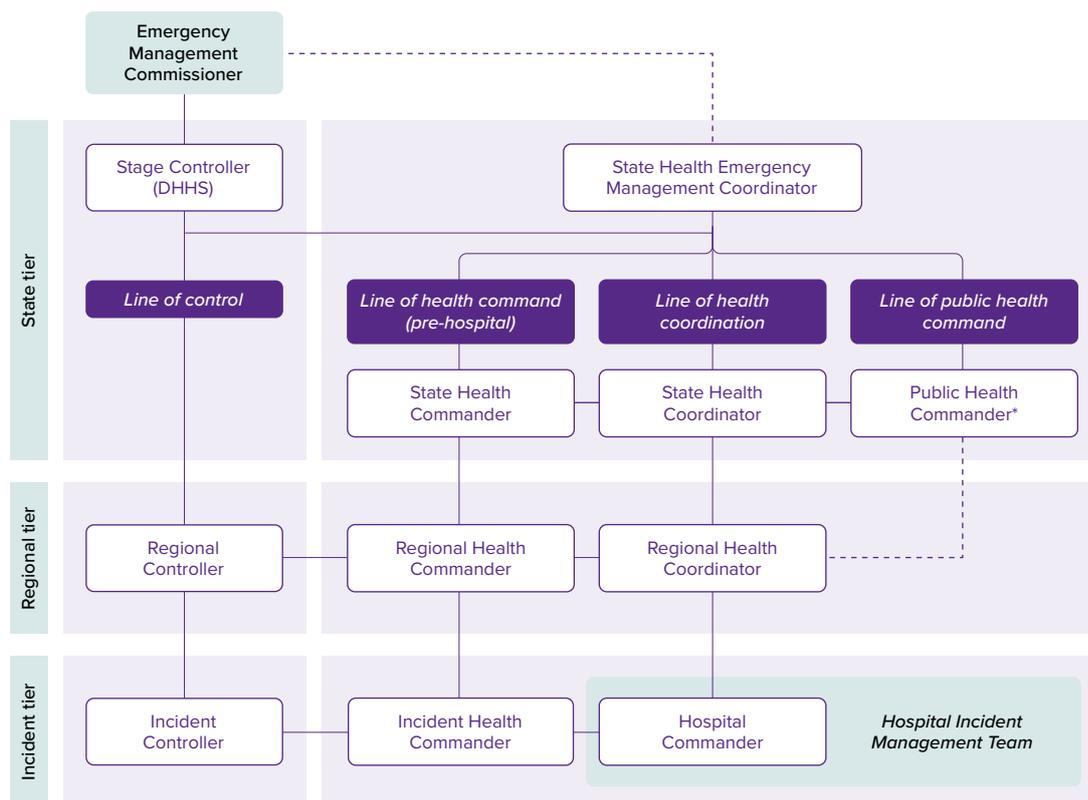
Under the EMMV Part 7 – Emergency Management Agency Roles, DHHS is the nominated control agency for specified health emergencies in Victoria (refer to Section 1).

DHHS is responsible for identifying unfolding or potential health emergencies, and escalating health emergency response arrangements outlined in this plan to ensure the health system can effectively respond and mitigate the adverse consequences for communities (refer to Section 6.3.3).

DHHS may activate the State Emergency Management Centre (located at DHHS) when considered necessary for the effective management of an emergency. To ensure an effective response to adverse health consequences for communities DHHS may also, in consultation with the EMC, request activation of the State Control Centre (SCC) to provide support to the State Controller. The SCC provides a range of services to assist with the coordination and control of emergencies and has well-established protocols for working across all government agencies and for providing information and warnings to the community.⁷¹

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

Figure 8.2.1: Reporting relationship for Class 2 health emergencies



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

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

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

58. The recognition that the COVID-19 pandemic was a Class 2 emergency led to the use of the emergency management framework in order to respond to the serious risk posed to the Victorian community. However, as the arrangements under the SHERP apply on a continuous basis and did not require 'activation',⁷² DHHS had already taken steps, from late January and into early February of 2020, to respond to the emerging COVID-19 pandemic emergency under the SHERP and in accordance with the Concept of Operations.
59. Ms Peake gave evidence that she and Melissa Skilbeck, Deputy Secretary Regulation, Health Protection and Emergency Management at DHHS (who also fulfilled the function of State Health Emergency Management Coordinator (SHEMC) under the SHERP),⁷³ met in late January 2020 to consider what action needed to be taken in respect to the COVID-19 pandemic.⁷⁴
60. On 20 January 2020, DHHS established an Incident Management Team to coordinate the public health and sector response to the COVID-19 pandemic emergency.⁷⁵ This was the same day that the Australian Health Protection Principal Committee (AHPPC) first met to discuss the national response to the pandemic.⁷⁶

61. Ms Peake stated that, on 1 February 2020, the same day that the AHPPC recommended that entry to Australia be limited for certain overseas arrivals due to the risk from COVID-19, she ‘and others’ were of the view that the COVID-19 outbreak met the definition of a ‘major emergency’ under the EM Act.⁷⁷ Not adopting the ‘normal’ course of appointing the CHO as the State Controller, Ms Peake appointed Andrea Spiteri as the Class 2 State Controller (later known as State Controller — Health) for the COVID-19 pandemic emergency.⁷⁸ Later, on 7 February 2020, Jason Helps was also appointed as State Controller — Health in response to the COVID-19 pandemic emergency.⁷⁹
62. On 2 February 2020, DHHS established a State Health Incident Management Team for the COVID-19 pandemic emergency.⁸⁰ Dr Finn Romanes, Deputy Public Health Commander, gave evidence that he performed the role of the Public Health Commander on initial establishment of the State Health Incident Management Team in February 2020, however, that role transitioned to Dr Annaliese van Diemen, as Deputy Chief Health Officer (DCHO) and Public Health Commander, in March 2020.⁸¹ Dr van Diemen also gave evidence that ‘on the declaration of a state of emergency on 16 March 2020, [she] became the [Public Health Commander] for the purposes of the SHERP’.⁸²
63. On 11 March 2020, the SCC was activated by the Emergency Management Commissioner, at the request of DHHS, to respond to the COVID-19 pandemic emergency.⁸³

8.2.3 Hotel Quarantine Program is commenced

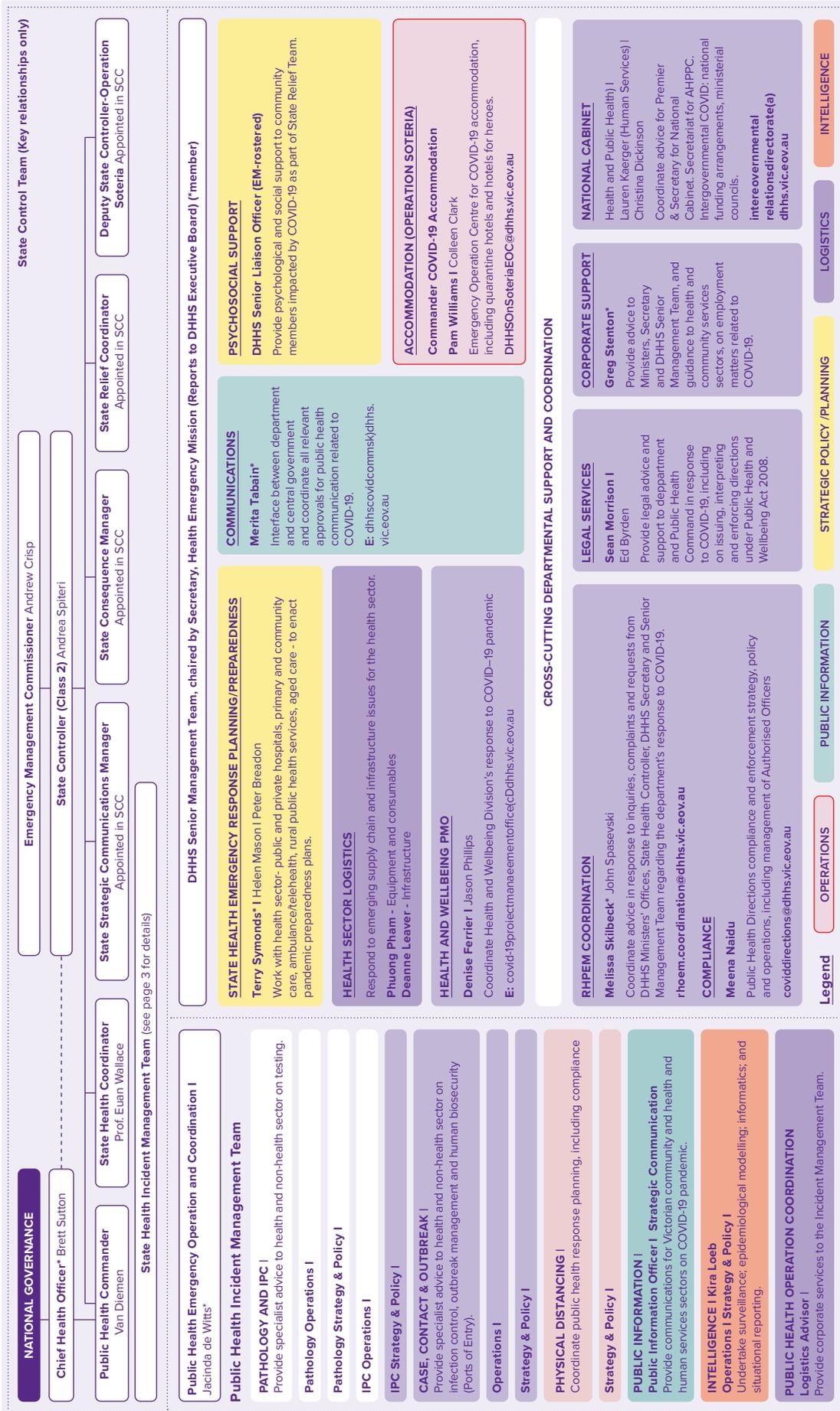
64. On 27 and 28 March 2020, those gathered at the SCC commenced implementing National Cabinet’s decision that all international arrivals be required to quarantine in a designated facility for 14 days.⁸⁴ It was revealed in the course of those SCC meetings that DJPR had been engaged by the then Secretary to the Department of Premier and Cabinet (DPC) to run the Program.⁸⁵
65. As of 27 March 2020, the two operating State Controllers — Health (Ms Spiteri and Mr Helps, both from DHHS) and the Deputy State Controllers (Christopher Eagle and Scott Falconer from the Department of Environment, Land, Water and Planning (DELWP)) were operating out of the SCC.⁸⁶
66. On 3 April 2020, Pam Williams commenced in the role of COVID-19 Accommodation Commander.⁸⁷ The role was renamed Commander, Operation Soteria from 1 May 2020, though the titles continued to be used interchangeably.⁸⁸ As Commander, Operation Soteria, Ms Williams reported to the State Controller — Health (Ms Spiteri and Mr Helps).⁸⁹
67. On 4 April 2020, DHHS established the Public Health Incident Management Team⁹⁰ — also referred to as ‘Public Health Command’.⁹¹ The structure was revised on about 8 April 2020 so as to better respond to the COVID-19 pandemic emergency.⁹² The Public Health Commander and the DCHO (Dr van Diemen) led the Public Health Incident Management Team and reported to the CHO. In addition, also reporting to the Public Health Commander were four Deputy Public Health Commanders presiding over the following teams:⁹³
- A. Pathology and Infection Prevention and Control (IPC)
 - B. Case, Contact and Outbreak Management
 - C. Strategy and Implementation
 - D. Intelligence.

68. On 7 April 2020, due to the complexity of DHHS's contribution to the COVID-19 pandemic emergency, Ms Peake made a decision to divide functional responsibilities as follows:⁹⁴
- A. the Regulation, Health Protection and Emergency Management Division, headed by Ms Skilbeck, was to be responsible for the emergency accommodation function (reporting through the Operation Soteria command structure) and enforcement and compliance functions. That division also retained responsibility for non-COVID-19 public health work
 - B. the COVID-19 Public Health Command Division (COVID-19 PHC Division)⁹⁵ was to be responsible for managing the state-wide response to the critical public health risks arising from COVID-19, including the provision of public health advice to DHHS and other government agencies, IPC, case contact and outbreak management, physical distancing, public information and intelligence.
69. On 8 April 2020, Jacinda de Witts commenced in the role of Deputy Secretary, COVID-19 PHC Division.⁹⁶ Her usual role was Deputy Secretary, Legal and Executive Services Division.⁹⁷

OPERATION SOTERIA MOVES OUT OF THE STATE CONTROL CENTRE

70. On 16 April 2020, Operation Soteria transitioned out of the SCC to a centre set up by DHHS in Fitzroy named the Emergency Operation Centre (EOC).⁹⁸ This move was a recognition that the Hotel Quarantine Program, known as Operation Soteria, needed to be run as a longer-term program rather than on an ongoing emergency footing. Ms Williams took on the role of leading Operation Soteria out of the EOC. This move was also in recognition of the realisation that Operation Soteria would be a significant and complex program and require specific attention.⁹⁹ It came to be the sole focus of Ms Williams's work.¹⁰⁰
71. On about 30 April 2020, Merrin Bamert was also appointed Operation Soteria Commander, sharing the role with Ms Williams on a rostered basis.¹⁰¹ Ms Bamert had previously held the role of Deputy Commander – Hotels.¹⁰²
72. DHHS provided details of its organisational structure in response to both the COVID-19 pandemic emergency and the Hotel Quarantine Program, as of 18 April 2020, as part of a response to the Victorian Ombudsman.¹⁰³ The overall governance structure for the COVID-19 health emergency at that time is represented in Figure 8.2.2:

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



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

Relevant decision-making structures external to DHHS

73. Pursuant to the *Public Administration Act 2004 (Vic)*, as the then Secretary of DHHS and Department Head, Ms Peake was responsible to the relevant portfolio Ministers for the general conduct and the effective, efficient and economical management of the functions of her department and its administrative offices.¹⁰⁴
74. As Secretary, Ms Peake described her ‘key accountabilities’ as being ‘to provide strategic leadership and stewardship of the Department and associated service systems, to ensure compliance with our legislative and regulatory responsibilities, and to advise portfolio Ministers on policy and service improvements to raise health and wellbeing outcomes’.¹⁰⁵ She agreed that the responsibility to advise portfolio ministers included the responsibility to keep the relevant Ministers informed of ‘significant issues’ within their portfolios.¹⁰⁶

CRISIS COUNCIL OF CABINET AND MISSION COORDINATION COMMITTEE

75. On 3 April 2020, DPC announced a new government and public service structure to respond to the COVID-19 pandemic emergency. This included the establishment of the Crisis Council of Cabinet (CCC) and the Mission Coordination Committee (MCC).¹⁰⁷ The CCC met for the first time on 6 April 2020.¹⁰⁸
76. The CCC comprised seven ministers, each with a portfolio directed to the coordination of the COVID-19 response.¹⁰⁹ The CCC was tasked with determining ‘all significant matters of policy, administration, budget and legislation required to respond to the COVID-19 pandemic crisis’.¹¹⁰
77. Departmental secretaries were given ‘Mission Lead’ roles and together formed the MCC.¹¹¹ Ms Peake was appointed to the role of Mission Lead Secretary — Health Emergency.¹¹² As such, she was to support the Minister for the Coordination of Health and Human Services, a role undertaken at the time by the Hon. Jenny Mikakos in addition to her role as Minister for Health.¹¹³ The Mission was tasked with ‘leadership of the health response to COVID-19’.¹¹⁴
78. Ms Peake was accountable directly to the Premier for delivery of that Mission.¹¹⁵ As explained in her evidence, in the ordinary course of events, Ms Peake was accountable primarily to the five Ministers of DHHS, and not directly to the Premier.¹¹⁶ Thus, her accountability as Mission Lead involved an extra line of reporting.
79. The Premier’s letter to Ms Peake of 3 April 2020 outlined the new government structures that were being put in place, as follows:

In this role you are accountable to me for the delivery of the missions. You will assist the new Crisis Council of Cabinet (CCC) which I have convened and new portfolio Ministers appointed to act as ‘Minister [sic] for the Coordination of the COVID-19 response. The CCC will determine all significant matters of policy, administration, budget and legislation required to respond to the COVID-19 pandemic crisis.

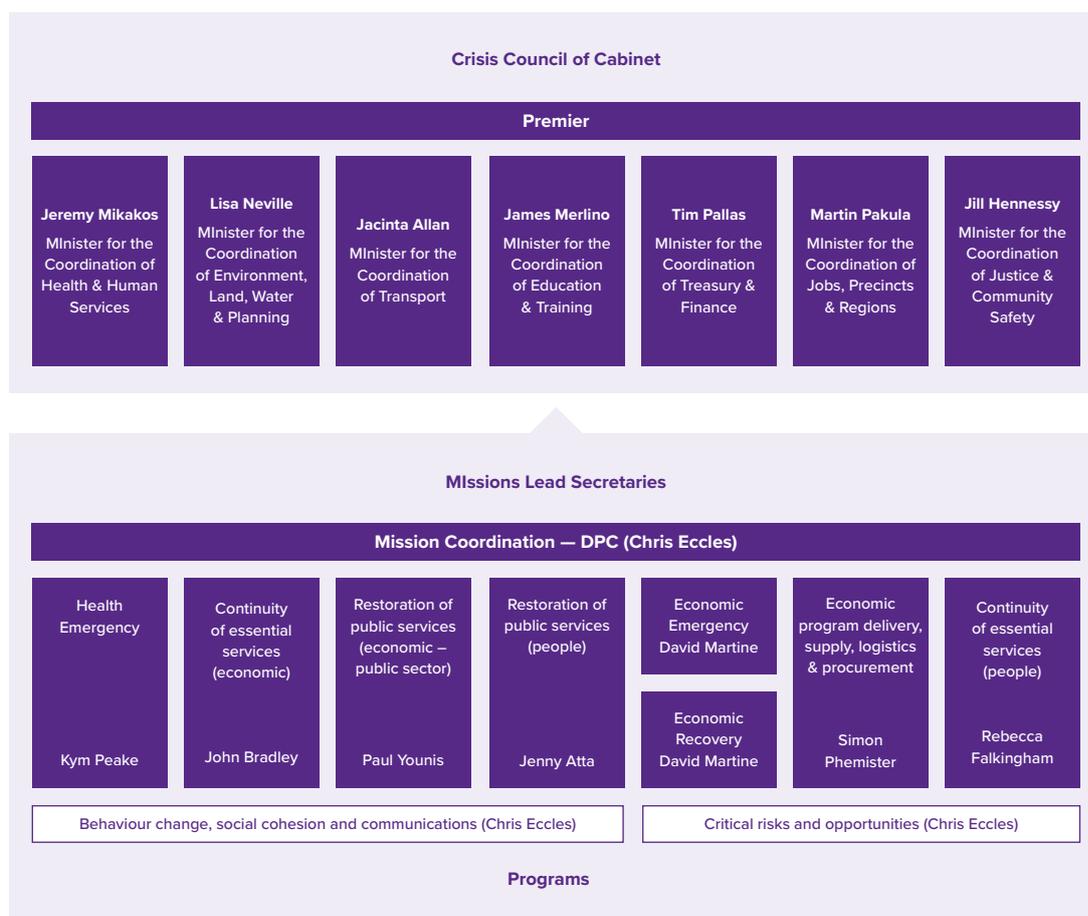
The new portfolio Ministers will comprise the CCC and report to me in developing and implementing the Victorian Government response, which will be structured around the core missions outlined in [Attachment A](#). I ask that you support the Minister for the Coordination of Health and Human Services - COVID-19 in this new portfolio.¹¹⁷

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

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

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

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

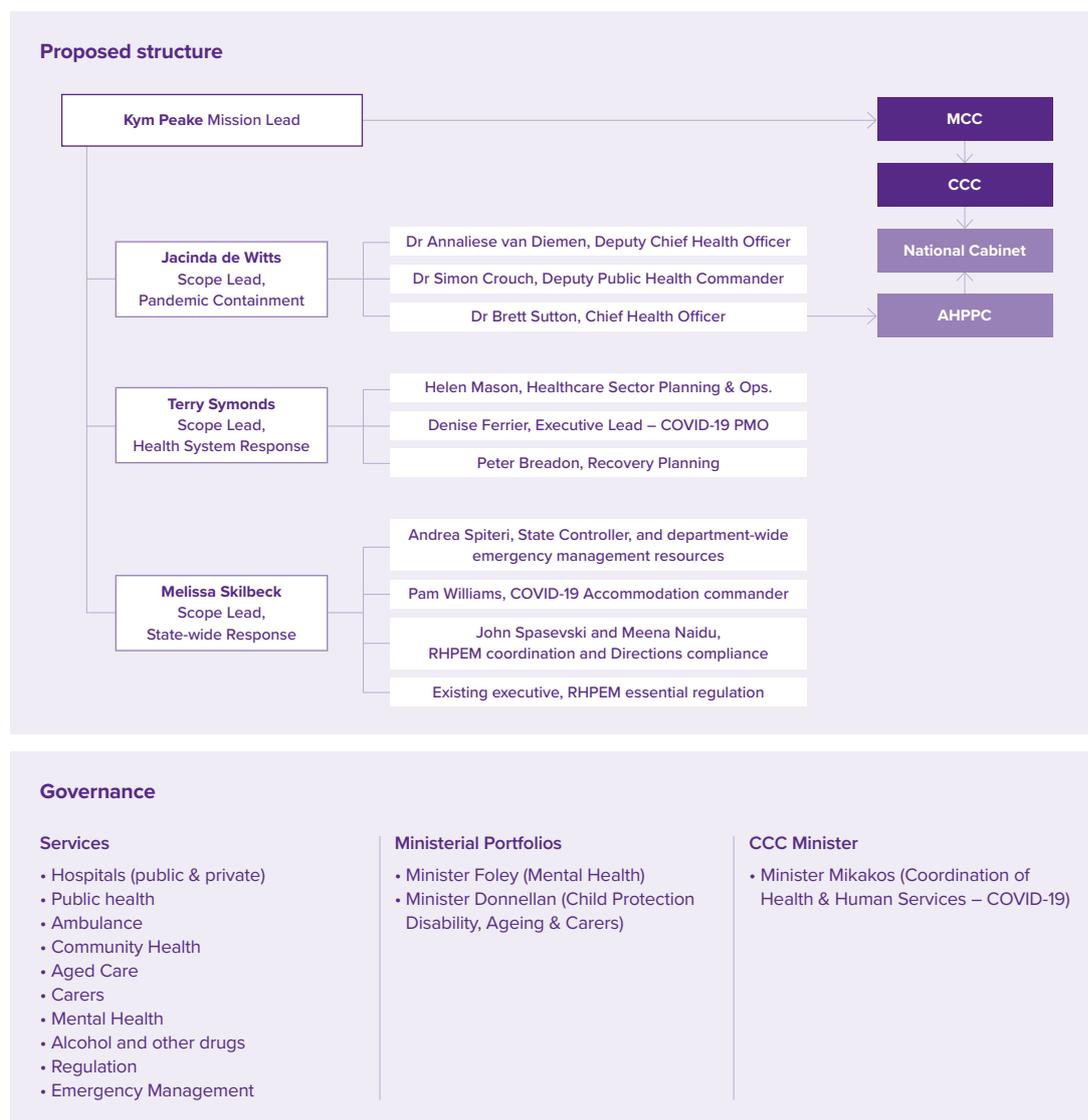


Source: Exhibit HQI0193_P Letter from the Hon Daniel Andrews MP to Ms Kym Peake.

82. By his letter to Ms Peake, the Premier designated two immediate tasks to her: first, that she establishes an implementation plan for the Mission; second, that she nominates an Associate Secretary to be responsible for the day-to-day administration of her Department.¹²⁰
83. Despite the direction from the Premier that she should divest herself of ongoing responsibilities as Secretary to DHHS, Ms Peake retained her day-to-day responsibilities for health¹²¹ and appointed a Deputy Secretary only for responsibility of the day-to-day management of the human services aspect of her usual role.¹²²

84. Even though this was a departure from what the Premier had requested of her expressly, and in writing, she did not raise it with the Premier directly.¹²³ Rather, Ms Peake explained that, following subsequent discussions at the Victorian Secretaries Board (VSB), she retained some of her day-to-day responsibilities because ‘health and public health were so intrinsically tied to the mission responsibilities’.¹²⁴ As Ms Peake was aware, there were no minutes or records of that discussion available.¹²⁵ Nor has the Inquiry received any such minutes or records. Nevertheless, Ms Peake explained to the Inquiry that she was satisfied that she ‘acquitted’ the Premier’s request by way of her discussions at the VSB meeting and with the then Secretary to DPC, Christopher Eccles.¹²⁶
85. Ms Peake confirmed that the Mission Implementation Plan that was created following the Premier’s request included a governance structure that was in place for some time prior to June 2020.¹²⁷ That structure was as outlined at Figure 8.2.4.

Figure 8.2.4: Mission structure and governance



Source: Exhibit HQI0194_RP Mission Implementation Plan.

86. This structure showed, and Ms Peake agreed,¹²⁸ that there was a direct reporting line into the MCC and the CCC from the emergency management framework through Ms Skilbeck. Separately, there was a reporting line into the CCC through Public Health Command from Ms de Witts.
87. In evidence, Ms Peake was also shown the State Governance Structure for the COVID-19 pandemic emergency, as contained in the State Operations Arrangements document as of 22 May 2020, as outlined in Figure 8.2.5.¹²⁹

88. Given the maze-like presentation of this document, when asked if people in charge understood the intersection of the CCC and MCC structures with the State Operational Arrangements, Ms Peake responded that, in the beginning of the pandemic, she did not think that, due to their emergency management background, staff would have expected there to be such an intersection between the emergency management frameworks and the whole-of-Government Cabinet structures. She explained that a lot of work was done to determine how that intersection would work but that, ultimately, and in her opinion, the arrangements were well defined and documented.¹³⁰
89. It was suggested by Ms Peake that the State Operations Arrangements governance structure was ‘an elaboration of the emergency management element [of the Mission Structure]’.¹³¹ When it was put to Ms Peake that the two structures had differing reporting lines, that is, that the State Controller — Health reported to the Emergency Management Commissioner under the emergency management framework and to Ms Skilbeck under the Mission Structure, Ms Peake said:

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

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

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

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

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

92. Prior to the COVID-19 pandemic emergency, Prof. Sutton headed up the Health Protection Branch, which sat in the Regulation Health Protection and Emergency Management Division.¹³⁴ The Health Protection Branch consisted of two DCHOs; the DCHO (Communicable Diseases), a role fulfilled by Dr van Diemen, and DCHO (Environment), a role fulfilled by Dr Angela Bone.¹³⁵ The communicable diseases team within the Health Protection Branch formed the basis of what would become the Public Health Command and, later, the COVID-19 Public Health Division.¹³⁶
93. As noted above, on 7 April 2020, Ms Peake divided functional responsibility for the COVID-19 pandemic response across two Divisions in DHHS. As a result, public health functions (in respect of the COVID-19 pandemic emergency) were taken out of the Regulation Health Protection and Emergency Management Division and formed the separate COVID-19 Public Health Command (PHC) Division, with a second reporting line from Ms de Witts to Ms Peake.¹³⁷ This was also reflected in the Mission Structure, where information regarding ‘pandemic containment’ came to the MCC through Ms de Witts and the COVID-19 PHC Division and information about the ‘state-wide response’ came to the MCC through Ms Skilbeck.¹³⁸ I discuss the DHHS COVID-19 PHC Division in more detail below, at Section 8.2.6.
94. Ordinarily, the CHO reported to Ms Skilbeck as Deputy Secretary, Regulation Health Protection and Emergency Management.¹³⁹ However, from about 8 April 2020, when Ms de Witts was seconded to assist the COVID-19 emergency response, the CHO had a dual reporting line to both her and to Ms Skilbeck.¹⁴⁰ Neither Ms Skilbeck nor Ms de Witts have a background in public health.¹⁴¹
95. During examination, Prof. Sutton explained that he continued to have a reporting line to Ms Skilbeck because his statutory obligations to protect the health and wellbeing of Victorians outside of the COVID-19 pandemic emergency continued and he remained accountable to Ms Skilbeck in respect of that work.¹⁴²
96. Prof. Sutton also gave evidence that, although he reported to Ms de Witts, she did not have a role in approving public health advice.¹⁴³ Prof. Sutton did not accept that Ms de Witts’s role was as a mere conduit for that advice but agreed that she was ‘a point of liaison for that advice into the Department’. He explained her role:

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

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

State Controllers — Health

99. As was noted above, Ms Peake, on the advice of Ms Skilbeck, did not adopt the 'normal' course of appointing the CHO, Prof. Sutton, as the State Controller — Health. Ms Peake appointed Ms Spiteri as State Controller — Health on 1 February 2020 and, on 7 February 2020, Mr Helps was also appointed as State Controller — Health.¹⁴⁵
100. The functions of the State Controller — Health in a Class 2 emergency are set out in paragraphs 35 to 39 above. In a Class 2 emergency, the first-listed responsibility for the State Controller — Health is to 'lead and manage the response to a Class 2 emergency'.¹⁴⁶
101. Mr Helps and Ms Spiteri gave evidence that the role of State Controller — Health did not operate in the Hotel Quarantine Program as would ordinarily be envisioned under the SERP and the SHERP. Mr Helps explained that critical decision-making for the emergency response was undertaken by National and/or State (Crisis) Cabinets.¹⁴⁷ He described these among the 'key control decision-makers' and said they, rightly, included decisions made by the CHO or the AHPPC, given their expertise in public health.¹⁴⁸
102. Mr Helps explained:

... the structure that we set up in Victoria meant that the Chief Health Officer and the Public Health Commander had absolute control of the public health emergency across the entire State, so they were the Incident Controllers for the emergency across the State.

The State Controller — Health role was to complement the public health response by managing the consequences, the broader community consequence, of that emergency. So, my role wasn't to effectively lead the decision-making in regards to public health or national or State policy in regards to the significant restrictions on civil liberties, on international trade, et cetera.¹⁴⁹

103. Mr Helps agreed in examination that, ordinarily, the EMMV envisaged a decision-making and leadership role for the State Controller. He stated that, in the context of Operation Soteria, the State Controller — Health could not fulfil that role. He added, however, that this was 'well known and well recognised'.¹⁵⁰
104. Ms Spiteri agreed that, ordinarily, the State Controller — Health would be vested with significant decision-making power under the EM Act, particularly in the context of an emergency such as a bushfire, which is generally a more localised emergency. However, due to the far-reaching nature of the decisions made (in the context of a pandemic), that decision-making was occurring elsewhere, namely at National and State Cabinet levels. She added, however, that there was still a decision-making element to the role.¹⁵¹
105. Ms Spiteri accepted that the State Controller — Health's principal responsibility in Operation Soteria was to be operationally accountable for the quarantine of returned travellers.¹⁵² In practice, this meant the State Controllers — Health were responsible for ensuring:¹⁵³

- A. there was an appropriate operations plan in place, with clear roles and responsibilities allocated for the Program
 - B. all necessary structures and governance arrangements were in place to manage the emergency, including the escalation and resolution of issues
 - C. environmental safety at the hotels. That meant ensuring public health guidance was provided to those in charge of the people on the ground, drawing on the expertise of the Public Health Command.
106. Ms Spiteri was at pains to emphasise that, while she and Mr Helps were in ‘direct control’ of ensuring that public health resources and advice, including PPE and relevant instructions, physical distancing guidance and behavioural expectations were provided to those working in the Program, it was a complex environment with many players:

The accountability for the hotel environment was ... it was a complex space. You had a hotel that was owned and managed by the hotel company. We were effectively ... and I think Ms Williams went to this the other day in her statement ... renting space in it, through the Department of Jobs, Precincts and Regions, DJPR. We had our own staff in that ... the Department of Health and Human Services had their own staff in that environment, so did DJPR, so did Victoria Police and so did a number of contracted companies as well. So overall the contribution to the safety of the environment was to ensure that there was guidance and instructions provided specifically to this emergency.

...

But every person working in that environment, from an occ. health and safety perspective, was responsible both for themselves and for complying with those instructions, and also their own organisations as a workplace were responsible as well (emphasis added).¹⁵⁴

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

Deputy State Controllers

108. The role of Deputy State Controller — Health was created on 29 March 2020.¹⁵⁷ It was filled by Mr Eagle and Mr Falconer, both of DELWP.¹⁵⁸ The role ceased on 1 May 2020, when Operation Soteria moved from the SCC to the EOC.¹⁵⁹
109. The Deputy State Controller — Health position was created specifically to enact the role of the Controller of Operation Soteria.¹⁶⁰ This position was in the ‘control line’, meaning that each agency with responsibilities designated under the *Operation Soteria Operations Plan* was thereby accountable to the Deputy State Controller — Health.¹⁶¹ However, notwithstanding the description of his role, Mr Eagle saw it differently and described his role as ‘a coordinator between the agencies and the State Controller — Health’.¹⁶² He agreed that the model deployed had a line of command whereby each agency had an Agency Commander at its head and those Agency Commanders would then escalate information through to him as the Deputy State Controller — Health.¹⁶³ He would then coordinate and escalate those issues to the State Controller — Health.¹⁶⁴

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

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

111. Mr Eagle said that the Deputy State Controller — Health role had no power delegated under any act, and all activities he undertook, or directions given, were on the direction of (and, thus, pursuant to the powers vested in) the State Controller — Health. No one reported to him and he was only there for information flow between Agency Commanders and the State Controller — Health.¹⁶⁸
112. Mr Eagle gave evidence that, during the course of the operation, it was common practice for conversations to occur, and directions to be given, directly between the DHHS State Agency Commander and the State Controller — Health or from other Agency Commanders directly to the State Controller — Health (leaving out the Deputy State Controller — Health). When asked if this made his role more difficult, Mr Eagle said that it did not. He said that this process made passing on information more efficient, without it being filtered through him.¹⁶⁹ Mr Eagle’s evidence demonstrated a disjunct between his title and the apparent intention of the role and any apparent role in the chain of command relating to a ‘health’ input beyond being a conduit for information to the State Controller — Health.
113. In any event, the role of Deputy State Controller — Health changed with the establishment of the EOC in mid-April. The Deputy State Controller — Health assisted in supporting the Commander, Operation Soteria (Ms Williams and Ms Bamert) in this transition, but Mr Eagle said he had little to do with the EOC because the position of Deputy State Controller — Health was discontinued once the transition to the EOC was completed.¹⁷⁰

8.2.5 Establishment of Emergency Operation Centre (EOC)

114. From the early days in Operation Soteria it was recognised that the Hotel Quarantine Program would be in place for likely up to 12–18 months.¹⁷¹ The emergency management response arrangements were not something designed to be maintained long-term, and it was determined that the Hotel Quarantine Program should transition from an emergency operation to a departmental program.¹⁷² Over the following weeks, a plan was created to transition the Program to be led by the DHHS COVID-19 Accommodation Commander, Ms Williams.¹⁷³
115. From 16–17 April 2020, the Hotel Quarantine Program operations team moved from the SCC to the DHHS office in Fitzroy, where the EOC was established for the purpose of running the Hotel Quarantine Program.¹⁷⁴
116. Both Ms Williams and Ms Bamert described the COVID-19 Accommodation Commander role as one of responsibility for the chain of command *within* DHHS, as it related to the department’s obligations to Operation Soteria.¹⁷⁵

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

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

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

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

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

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

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

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

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

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

Role of the Chief Health Officer in the Hotel Quarantine Program

124. For the purposes of a response to a Class 2 emergency, the SHERP envisaged that public health expertise would be embedded in the command structure of the health emergency response by appointment of the CHO to the role of State Controller. The non-appointment of Prof. Sutton as State Controller — Health, his views about that and the impact of it are dealt with from paragraph 254 below.
125. As CHO, Prof. Sutton was responsible for the Public Health Command structure, including the Public Health Incident Management Team.¹⁸⁵ In that role, he was vested with capacity to raise issues directly with the Minister for Health and the Secretary to DHHS.¹⁸⁶ However, it was Prof. Sutton's evidence, emphasised particularly in two affidavits produced following the close of the evidentiary hearings, that, despite those accountabilities, he and Public Health Command 'were not in day-to-day decision-making roles'¹⁸⁷ and, as such, were somewhat disenfranchised in the running of the Program.
126. Prof. Sutton gave evidence that one of his key areas of focus in the COVID-19 pandemic emergency response was in relation to his membership on the AHPPC and attendance at almost daily meetings of the AHPPC since mid-February 2020. In this capacity, he contributed to the nationwide response to the pandemic, including through the preparation of briefings and recommendations.¹⁸⁸
127. He described his other areas of responsibility in relation to the pandemic, more generally, as:¹⁸⁹
- A. playing a leading role in public communications in relation to the government-controlled measures (the directions and the enforceable requirements)
 - B. providing advice, taking into account AHPPC recommendations, on COVID-19 and appropriate mitigation measures and the matters they address in their public statements and in Victoria, by advising the Minister for Health, the Premier and the CCC on policy settings for key public health issues
 - C. making decisions on critical matters, normally raised with him by the DCHOs, usually where something was of high consequence and/or importance, or otherwise contentious or sensitive and therefore escalated to him.
128. Dr van Diemen gave evidence that, because the emergency response to the pandemic required the exercise of powers contained in the PHW Act, under which the CHO is the 'primary person', she continued to report to the CHO in her capacity as Public Health Commander because, 'it was made clear that [the CHO], regardless of whether he was the State Controller, would retain control over and ultimate responsibility for the public health response'.¹⁹⁰

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

129. Prof. Sutton gave evidence that the size and structure of the DHHS Public Health Team evolved over time due to the COVID-19 response.¹⁹¹
130. Dr van Diemen explained that the Public Health Incident Management Team is an emergency management structure that was ‘stood up’ in response to an incident.¹⁹² The Public Health Incident Management Team was stood up in respect of the COVID-19 pandemic emergency and as ‘the incident’ continued and multiplied, it became necessary for the structure of the Public Health Incident Management Team to develop into a more regular government structure.¹⁹³ That structure became the COVID-19 PHC Division.
131. Ms de Witts described the key functions of the COVID-19 PHC Division as follows:¹⁹⁴
- A. Case, Contact and Outbreak Management, which was responsible for undertaking contact tracing and responding to outbreaks
 - B. Intelligence, which was responsible for undertaking surveillance, epidemiological modelling, informatics and situational reporting
 - C. Physical Distancing, which was responsible for formulating the public health directions required to manage the virus (but not for compliance with those directions, which was managed by the Enforcement and Compliance branch within the Regulation, Health Protection and Emergency Management Division)
 - D. Pathology and IPC Policy, which was responsible for advising on testing issues, working with public and interstate laboratories and research institutions, setting overarching IPC policies for the State, providing cleaning and personal protective equipment (PPE) policies (available publicly on the department’s website) and providing specific advice on complex settings
 - E. Public Information, which was responsible for providing communications for the Victorian community and health and human services sectors on the COVID-19 pandemic (which included content input from the other teams as needed)
 - F. Public Health Operation Coordination, which was responsible for providing corporate services (such as finance support, HR support, procurement and rostering) to the Division.
132. Each of the Deputy Public Health Commanders reported to the Public Health Commander who, in turn, reported to the CHO.¹⁹⁵

Role of the Public Health Commander

133. Dr van Diemen's usual role was DCHO – Communicable Diseases. This role sits in the Health Protection Branch of DHHS.¹⁹⁶ In the context of the COVID-19 pandemic emergency, she was also the Public Health Commander (as described above). In each role, she was required to report to Prof. Sutton as CHO.¹⁹⁷
134. Dr van Diemen also had functions under the PHW Act, separate from her role as Public Health Commander and as DCHO. She was delegated a number of the CHO's powers pursuant to instruments of delegation and was also an Authorised Officer under the PHW Act.¹⁹⁸ It was in that latter capacity that she issued detention directions under the PHW Act, which gave the legal bases for the Hotel Quarantine Program. While Dr van Diemen signed the directions identifying her role as the DCHO, she explained in her evidence:

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

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

The Public Health Commander reports to the State Controller and is responsible for commanding the public health functions of a health emergency response (including investigating, eliminating or reducing a serious risk to public health).

Performing the function of Public Health Commander does not alter in any way the management, control and emergency powers of the Chief Health Officer under the PHW Act.

In performing this function, the Public Health Commander will liaise directly with the State Health Commander and State Health Coordinator.

For emergencies where the Public Health Commander is not appointed the State Controller, the Chief Health Officer's authority under the PHW Act remains unaffected, and their decisions on matters of public health should not be overridden by a State Controller.²⁰⁰

136. In final submissions, DHHS contended that, as the Public Health Commander led the Public Health Incident Management Team, Dr van Diemen '[sat] between the emergency and the Public Health Teams and provided direct input into decision-making as a member of the State Control Team'.²⁰¹
137. Somewhat at odds with that submission, Dr van Diemen gave evidence that, despite what is said in the SHERP, and despite the various governance structures placing the Public Health Commander in the State Control Team with a direct line of report to the State Controller — Health,²⁰² in practice she did not report to the State Controller — Health but reported to the CHO and, instead, fulfilled an advisory role to the State Controller — Health.²⁰³ She described her role as Public Health Commander in respect of the Hotel Quarantine Program as:

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

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

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

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

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

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

Infection Prevention and Control (IPC)

141. Dr Katherine Ong was the Deputy Public Health Commander Pathology and Infection, Prevention and Control. In early April 2020, Dr Ong established an Infection Prevention and Control Cell (IPC Cell) at the request of Dr van Diemen (as Public Health Commander).²⁰⁷ As I have described earlier, in Chapter 7, the IPC Cell was initially staffed by **one** DHHS IPC Consultant, along with two part-time IPC consultants. The IPC Cell expanded over time, with two additional part-time IPC consultants joining in mid-April 2020 and a further part-time consultant joining in mid-May 2020.²⁰⁸
142. However, Dr van Diemen gave evidence that, at the time of a request from Operation Soteria in early April 2020 to the 'infection control' team, that team consisted of one person.²⁰⁹ Later in her evidence Dr van Diemen explained:

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

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

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

144. DHHS, subsequently, engaged an external IPC consultant through Infection Prevention Australia to assist with providing IPC advice to the Hotel Quarantine Program.²¹³ The arrangement commenced around the time that the Rydges Hotel in Carlton was established as a 'hot hotel'.²¹⁴ Dr van Diemen gave evidence that the advice produced by Infection Prevention Australia was only looked over by DHHS's internal team but developed by the external person for the Hotel Quarantine Program.²¹⁵
145. Further discussion of the IPC advice and training that was implemented in the Hotel Quarantine Program and, in particular, in relation to the hot hotels, is contained in Chapter 9.

Case, Contact and Outbreak Management

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

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

147. According to the Outbreak Management Plan, the core members of an OMT included the Outbreak Lead, who reports to the Deputy Public Health Commander, CCOM (Dr Crouch and Dr Looker), the Case and Contact Management Lead and the Epidemiology Lead, who both report to the Outbreak Lead, and the DHHS Agency Commander who represented the State Controller — Health and an Outbreak Squad Coordinator.²¹⁸
148. Under the Outbreak Management Plan, an OMT is to be created in respect of each outbreak that occurs. Each OMT is led by an Outbreak Lead with responsibility for overseeing the outbreak response.²¹⁹ Dr Sarah McGuinness stated that she had the overall role of 'Outbreaks Lead', which is distinct from the role of Outbreak Lead for a specific outbreak, despite the near-identical title.²²⁰
149. Dr Crouch explained that Outbreak Squads were established by the Outbreak Squad Coordinator, if deemed necessary by the OMT.²²¹ The Outbreak Squad was the 'eyes and ears on the ground'.²²² It was required to report back to the OMT and provide advice on the ground, including in relation to IPC, PPE and cleaning.²²³
150. Dr Crouch stated that, while the Outbreak Lead for an OMT should be required to directly report to the Deputy Public Health Commander CCOM, it was decided that the Outbreak Squads would report directly to Ms de Witts, as Deputy Secretary, COVID-19 PHC Division and not via the Deputy Public Health Commander CCOM, who were also, separately, reporting at that time to Ms de Witts.²²⁴
151. A detailed discussion of the outbreaks that occurred at the Rydges and Stamford hotels is contained in Chapter 9.

Strategy and Implementation (Planning)

152. Dr Romanes was the Deputy Public Health Commander, Strategy and Implementation (also known as Deputy Public Health Commander – Planning).²²⁵ The responsibilities of the Deputy Public Health Commander – Planning included responsibility for the Physical Distancing Cell. The functions and role of the cell were to advise the Public Health Commander and to provide evidence and an informed policy rationale for decisions. The cell also prepared and consulted on policy and procedures.²²⁶
153. While Dr Romanes, as Deputy Public Health Commander – Planning, was not directly involved in Operation Soteria, Prof. Sutton described him as being engaged in advice on policy and guidance matters to Operation Soteria ‘more than most’.²²⁷ Dr Romanes’s statement includes a reference to this in his description of his role as Deputy Public Health Commander – Planning:

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

154. It seems that it was around this time (that is, mid-April 2020) when Dr Romanes’s active involvement (as described) lessened.²²⁹
155. Dr Romanes stated that his team’s role in the Hotel Quarantine Program was most active up until about 15 April 2020.²³⁰ In this period, his team developed a range of policies and procedures, including the draft *COVID-19 DHHS Physical Distancing and Public Health Compliance and Enforcement Plan*²³¹ and the *COVID-19 Interim Healthcare and Welfare Mandatory Quarantine plan* — a single policy addressing the healthcare and welfare of people in mandatory quarantine.²³²
156. However, like other members of Public Health Command, it was Dr Romanes’s evidence that he was not responsible for **implementing or overseeing** those procedures, and that work was to be carried out by the DHHS run EOC.²³³

8.2.7 On-site at Quarantine Hotels

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

DHHS TEAM LEADERS

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

159. Ms Williams gave evidence that many of the DHHS Team Leaders had worked in previous emergencies and, therefore, had some training.²³⁶ This included staff from within DHHS as well as those from other government departments.²³⁷ However, in her evidence, Ms Bamert conceded that Team Leaders were recruited from a range of backgrounds²³⁸ and that she had concerns about DHHS's capacity to provide 'suitably skilled' personnel.²³⁹
160. Ms Williams gave evidence about how public health advice was 'operationalised' in the Hotel Quarantine Program, explaining that EOC operational staff attended on-site at the hotels and worked with DHHS Team Leaders on the ground.²⁴⁰
161. While Ms Williams described the role of DHHS Team Leaders as being to coordinate and problem solve,²⁴¹ she also noted that significant reliance was placed on contractors operating in the Hotel Quarantine Program. She explained:

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

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

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

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

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

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

165. Murray Smith, who held the position Commander, COVID-19 Enforcement and Compliance, gave evidence that the DHHS Team Leaders were the ‘port of call for services provided by DHHS’ and that, for functions falling outside of those services, other Departments had site managers in the hotels.²⁵⁰
166. Jan Curtain of Your Nursing Agency said, in her evidence, that ‘DHHS would appoint a Team Leader for each shift who would be in charge of each hotel during that shift’.²⁵¹ Likewise, Eric Smith of SwingShift Nurses gave evidence that the DHHS Team Leaders had the ‘responsibility for ensuring health and safety risks were properly managed’.²⁵²
167. The evidence of Ms Williams and Ms Bamert was that DHHS Team Leaders performed a coordination function in the hotels but that should not be characterised as evidence that Team Leaders were ‘in charge’. Despite this, the perception of some other witnesses, who were on the ground in hotels and who were not DHHS employees, was that DHHS Team Leaders were in charge of the Program at the hotel sites.

AUTHORISED OFFICERS

168. Authorised Officers are common across the Victorian Public Sector. Agencies with regulatory functions often appoint officers as Authorised Officers to exercise compliance and enforcement functions under the legislation administered by those agencies.
169. Authorised Officers, for the purposes of the PHW Act, may be appointed by the Secretary to DHHS under s. 30(1) of that Act. Only public servants (that is, those people employed under Part 3 of the *Public Administration Act 2004*) may be appointed as Authorised Officers under s. 30(1), with s. 106(i) of the *Public Administration Act 2004* (Vic) expressly precluding police officers employed pursuant to the *Victoria Police Act 2013* (Vic) from the Act’s operation. Accordingly, members of Victoria Police are not eligible for appointment as Authorised Officers for the purposes of the PHW Act.²⁵³
170. Appointed Authorised Officers can exercise the general powers and functions conferred on them under Part 9 of the PHW Act. Those powers include entry, search and seizure powers that may be exercisable for certain limited purposes, including investigating whether there is a risk to public health or to manage or control a risk to public health,²⁵⁴ or to monitor compliance with the PHW Act or its regulations, or to investigate a possible contravention of the PHW Act.²⁵⁵
171. Authorised Officers may be further authorised to exercise specific powers in the case of a risk to public health. Section 189(1) of the PHW Act provides that, if the CHO believes it is necessary to do so to investigate, eliminate or reduce a risk to public health, the CHO may authorise Authorised Officers appointed by the Secretary (or a class or classes of authorised officers appointed by a specified Council or Councils) to exercise any of the public health risk powers. Those powers are set out at s. 190(1) of the PHW Act.
172. Under s. 199(2) of the PHW Act, the CHO may, for the purpose of eliminating or reducing the serious risk to public health, also authorise Authorised Officers appointed by the Secretary (or a class or classes of authorised officers appointed by a specified Council or Councils) to exercise any of the public health risk powers and ‘emergency powers’.
173. The ‘emergency powers’ are set out at s. 200(1) of the PHW Act. They are to:
- a. subject to this section, detain any person or group of persons in the emergency area for the period reasonably necessary to eliminate or reduce a serious risk to public health;
 - b. restrict the movement of any person or group of persons within the emergency area;
 - c. prevent any person or group of persons from entering the emergency area; and
 - d. give any other direction that the authorised officer considers is reasonably necessary to protect public health.

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

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

175. Section 203 sets out heavy penalties for a person who refuses or fails to comply with a direction given to a person or a requirement made of the person, in the exercise of a public health risk power or an emergency power; a person subject to a direction to quarantine, for example, may be fined up to almost \$20,000 for failing to comply with a direction.²⁵⁷
176. The fundamental role of the Authorised Officers in the Hotel Quarantine Program was to exercise those powers conferred on them by the PHW Act to give effect to the detention direction notice issued by the DCHO as an Authorised Officer. It was the detention direction notice issued by Dr van Dieman as an Authorised Officer that compelled people into detention in hotel quarantine, dealt with applications for temporary leave or exemption from quarantine and authorised the discharge of people at the end of their mandatory stay in quarantine.
177. Mr Cleaves described the role of the Authorised Officer as ‘to manage the compliance aspects of the Hotel Quarantine Program, that is to ensure compliance with the detention direction notices that have been issued to all of the incoming international passengers’.²⁵⁸ In his evidence, Mr Cleaves stated that the role of Authorised Officers was heavily focused on (amongst other things) understanding and interpreting detention direction notices, and making reasonable judgements about the appropriate ways to deal with instances of non-compliance.²⁵⁹
178. The roles of Authorised Officers, as described by Mr Smith and Mr Cleaves, were consistent with the role of Authorised Officers as described in DHHS policies issued to Authorised Officers. By 30 April 2020, around a month after Operation Soteria was established, the role of the Authorised Officer within hotels was set out in the *Annex 1 – COVID-19 Compliance Policy and Procedures–Detention and Authorisation* document (Annex 1).²⁶⁰
179. Annex 1 described the Authorised Officer’s role in terms of monitoring compliance as to ‘provide oversight and ensure compliance with the direction and detention notice’.²⁶¹ The specific roles and responsibilities in doing so included:²⁶²
- A. check that security are undertaking floor walks to encourage compliance and deter non-compliance
 - B. oversee and provide advice on compliance related issues (including to respond to requests from security to address compliance and to seek assistance from security or Victoria Police to support compliance efforts)
 - C. administer permission to leave and monitor compliance
 - D. raise any exemption requests with the Authorised Officer Team Leader in the first instance.
180. Annex 1 also gave specific guidance as to the scope of the role of the Authorised Officer. It said that Authorised Officers ‘should be aware that their role and scope is related to administration of, and compliance with, the direction and detention notice under the [PHW Act]’.²⁶³

COMMANDER COVID-19 ENFORCEMENT AND COMPLIANCE

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

182. In response to questions about the on-site role of Authorised Officers, Mr Smith gave evidence that his role was limited to exercising powers under s. 200(1) of the PHW Act, including serving detention notices on returning travellers, ensuring compliance with those notices, managing permissions and exemptions and, ultimately, approving people's release at the end of their detention.²⁶⁶ Mr Smith said that Authorised Officers had no role in supervising any other staff at the hotel, including security staff or in overseeing IPC or the use of PPE at the hotels.²⁶⁷ He advised that the person in charge of overseeing those functions generally was the Commander, Operation Soteria through the DHHS Team Leader,²⁶⁸ a role distinct, and in a separate line of command and reporting, from the roles of the Authorised Officers and Authorised Officers' Team Leader and, indeed, himself.
183. Claire Febey, Executive Director, Priority Projects at DJPR gave evidence that she thought that the work of overseeing security should have been under the direction of Authorised Officers as representatives of DHHS.²⁶⁹ Ms Febey explained that she held this view because the people in quarantine were being held on the legal authority of the Authorised Officers, as delegates under the PHW Act, with the role of security being to support those Authorised Officers in the exercise of the legal powers vested in them.²⁷⁰
184. Mr Smith's evidence was, however, that despite Authorised Officers operating as delegates of the DCHO, and despite what is set out in Annex 1 at paragraph 179, they played no part in the oversight of those people who were engaged in ensuring enforcement of that detention (namely, the security guards).²⁷¹ His evidence indicates that Authorised Officers played no part in ensuring the safety of the environment in which those people were detained, that is, ensuring compliance with IPC and PPE protocols.²⁷²

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

185. Having now discussed the manner in which DHHS interpreted, structured and performed its work in the Hotel Quarantine Program, this section focuses on how that approach ultimately impacted the operation of the Hotel Quarantine Program.
186. As noted in the introduction to this Chapter, there is no doubt that DHHS staff who worked within the Hotel Quarantine Program (whether in leadership positions or on the Program's frontlines or in providing advice and guidance) worked long hours, under enormous pressure, likely at a cost to their own wellbeing. I accept that individuals working within the Hotel Quarantine Program acted in good faith and with good intentions and performed their roles under immense pressure with stretched resources.
187. Notwithstanding this, there were significant systemic flaws and shortcomings within the DHHS response that affected the Program's capacity to achieve its objectives. These are the subject of this section.

8.3.1 The ‘control agency’ function and the Hotel Quarantine Program

188. As has been set out previously, within 24 hours of National Cabinet’s decision to direct all international arrivals into quarantine for 14 days, the Hotel Quarantine Program was being developed to align with Victoria’s emergency management framework. This decision was understandable at the time, given a public health emergency had been declared. As described in Section 8.1 of this Chapter, within Victoria’s emergency management framework different types of emergencies are given classifications that are intended to then direct that the agency with the recognised expertise to deal with that class of emergency becomes the designated **control** agency.
189. There was no controversy as to the classification of this emergency as a Class 2 public health emergency. Further, there was no controversy over which agency therefore became the ‘control agency’. It was DHHS as the agency responsible for public health in this State, as the name of that Department quite clearly contemplates, and the emergency management framework designates. Indeed, by the second iteration of the Operation Soteria Plan, developed on 28 March 2020, DHHS was designated as the control agency with operational command for each phase of the Program.²⁷³ Where the controversy lay was in the interpretation of what it meant to be the ‘**control** agency’.
190. DHHS accepted that it was the control agency for the overall response to the COVID-19 pandemic. DHHS appeared to accept that its responsibilities included the control of the identified hazard, which, in the context of the pandemic response, was the virus.²⁷⁴ However, the precise functions and responsibilities of DHHS as control agency in the context of the Hotel Quarantine Program were matters of deep disagreement before the Inquiry.

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

191. A theme of the evidence from DHHS witnesses (from the Minister through to the executive and into the frontlines of the Operation) that emerged throughout the Inquiry was that their Department was not ‘in charge’ or ‘in control’ of the Hotel Quarantine Program overall, as their interpretation of being a ‘control agency’ should be seen through the lens of the Hotel Quarantine Program being a ‘complex’ emergency within the meaning of the emergency management framework. This, it was said, meant the role of DHHS was a ‘coordinator’ or ‘collaborator’ and not a ‘controller’. The senior executive, indeed, through to former Minister Mikakos, interpreted the concept of ‘control agency’ as meaning that DHHS had a ‘shared accountability’ with the range of other agencies participating in the delivery of the Hotel Quarantine Program. It had some responsibilities and accountabilities but was not in control of the Hotel Quarantine Program overall.²⁷⁵
192. The essence of the Departmental witnesses’ evidence was that the ‘control agency’ role required coordination of the multi-agency approach, as conceived in the concept of a ‘complex emergency’ that resulted in all agencies involved having a shared accountability for the overall delivery of the Program.²⁷⁶

193. Ms Peake gave evidence that the role of DHHS,²⁷⁷ as the control agency, was ‘to provide operational control by ensuring appropriate governance was in place, to facilitate sharing of intelligence, enable escalation and resolution of operational issues’.²⁷⁸ She said that DHHS’s role was to bring together all departments and agencies with defined roles and responsibilities as part of the Hotel Quarantine Program.²⁷⁹ She further stated that, as the control agency, DHHS worked to ‘coordinate the input of all relevant departments and agencies’.²⁸⁰
194. Ms Peake gave evidence that, although DHHS was the control agency in emergency management terms, this was classified in emergency management terms as a ‘complex emergency’, stating:

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

195. When pressed on the EMMV language of the need, even in a complex emergency, for there to be a single agency responsible for the collaborative response, Ms Peake responded that DHHS ‘As the control agency, was responsible for determining for each of the operations that it was clear, the scope was clear, the roles and responsibilities was clear and the governance was clear, yes, that is my evidence’.²⁸²
196. Ms Skilbeck gave evidence the effect of which was that the term ‘control agency’ caused confusion. She explained:
- The key role in the control agency in something as big as this particular emergency, ‘control agency’ becomes something of a misnomer where really most of the activity is coordinating across the array of agencies and departments that have come together to respond as fulsomely as the Victorian public sector can to this emergency. So, it is both control in a very specific sense of the word, the public health response to a novel coronavirus; and the coordination role ... little c ‘coordination’, to make the distinction, because I think ‘Coordination’ is defined in the SERP as well ... but coordination across the many agencies that have come to support the response.²⁸³
197. The understanding proffered by Ms Skilbeck was consistent with that of former Minister for Health Mikakos, who expressed a view that control agency was a ‘highly misunderstood’ term and the fact that DHHS was the control agency ‘doesn’t mean that DHHS had control as such’. Former Minister Mikakos said ‘I think the best way to understand it is a coordination role. And the Hotel Quarantine Program was a multi-agency response with shared accountability. There were many Departments and agencies involve’.²⁸⁴
198. Former Minister Mikakos, consistent with Ms Peake’s evidence, identified two roles for DHHS in the Hotel Quarantine Program, which were to (a) provide the legal framework for the detention notices that compelled people into quarantine and (b) to provide for the health and wellbeing of those people in quarantine.²⁸⁵
199. This view that DHHS did not have overall responsibility for the Hotel Quarantine Program was echoed by those Departmental employees working closer to the frontlines of the Program. As noted above, when Ms Williams was asked during her evidence who was ‘in charge’ of the hotel sites in the Program, her response was that the terminology ‘in charge’ was ‘somewhat loaded’ in the context of the Inquiry.²⁸⁶

200. The framing, interpretation and impact of the term ‘multi-agency’ response was consistent through the DHHS management witnesses. The two appointed State Controllers — Health, Mr Helps and Ms Spiteri, gave evidence about their understanding of the emergency management language of ‘command’, ‘coordination’ and ‘control’. Mr Helps noted that ‘there was a lot of coordination in the role’²⁸⁷ as did Ms Spiteri, who stated, when describing her role as State Controller that it ‘became one of overall co-ordination of the implementation of both Chief Health Officer and government decisions and directions across government agencies, through the operational arrangement for COVID-19, using the structures and resources of the State Control Centre’.²⁸⁸
201. At odds with this evidence and the position taken by DHHS throughout the Inquiry is the position taken by Mr Helps on the first weekend of the Program’s commencement, when he made plain to Ms Febey from DJPR that he was the State Controller, and DHHS was the control agency for the Program.
202. In the context of Mr Helps learning that DJPR had been assigned the initial lead on 27 March 2020, Mr Helps was firm in clarifying with Ms Febey that DHHS should instead be the lead department. Ms Febey’s evidence to the Inquiry was that, when she discussed DHHS’s role as control agency with Mr Helps on 29 March 2020 at the SCC, he ‘emphasised that DHHS was the control agency and needed to be in charge as it was accountable for the Program’.²⁸⁹ In the below follow-up email from Mr Helps to Ms Febey on 29 March 2020 with the subject line ‘DJPR-DHHS role clarity’, Mr Helps stated that: ‘[a]s the Control Agency, DHHS has overall responsibility for all activities undertaken in response to this emergency’.²⁹⁰

Dear Claire,

As you are aware The Department of Health and Human Services (DHHS) is the Control Agency for the COVID-19 Pandemic, and at this time I am the State Controller — Health appointed by the Control Agency under the Emergency Management Act. Prof Brett Sutton is the Chief Health Officer leading the Public Health response under the Public Health and Wellbeing Act.

As the Control Agency, DHHS has overall responsibility for all activities undertaken in response to this emergency. The response to the direction for all passengers returning to Victoria after 11.59 p.m. 28/03/20 requiring to be quarantined in approved accommodation is being led by Dep State Controller Chris Eagle as ‘Operation Soteria’.

As discussed today I am extremely grateful to the support DJPR have provided to date, your team have demonstrated flexibility, good planning and expertise which has contributed to making the first day as successful as it could be. I also look forward to your team continuing to support Operation Soteria.

It is important however that we clarify some roles and responsibilities and work on a transition plan over the next day or so. Chris Eagle will work with you on this. Many of the roles DJPR provided in the planning, and operationally today will need to transition to the Deputy State Controller and DHHS as the Control Agency. I would like to clarify that, at a minimum, I would request DJPR continue to provide the valuable work in procurement of hotels and the services required to support people under the direction to detain, I don’t underestimate the complexity of this task in the current environment. It will be vital that DHHS make the operational decisions in regard to which hotels we utilise and when, along with other decisions which require a risk assessment by the Chief Health Officer or delegated Authorised Officer.

It was a pleasure to discuss this with you today and I sense the value of working closely on this for both agencies.

Please contact me again if I can assist or if a resolution cannot be reached during the handover process.

Regards

Jason Helps

Deputy Director Emergency Operation and Capability | Emergency Management Branch

203. When Ms Peake appeared before the Inquiry, Ms Peake speculated as to an explanation for Mr Helps's statement, '[a]s the Control Agency, DHHS has overall responsibility for all activities undertaken in response to this emergency'. She said that she thought that what Mr Helps meant by it was that DHHS had 'overall responsibility for ensuring any operation through the State Control Centre was appropriately scoped, involved the right people and had appropriate operational governance within it'.²⁹¹
204. However, the plain meaning of Mr Helps's email, which was sent at the outset of the Hotel Quarantine Program, is consistent with the evidence of all of the other witnesses not aligned with DHHS, as set out below.
205. Notwithstanding the remainder of non-DHHS witnesses being at odds with this view, during the Inquiry and in closing submissions, DHHS sought to rely on the definition and acceptance of this situation as a 'complex emergency' to maintain its position that its role was to coordinate rather than be 'in charge' or 'in control' or the agency with the overall responsibility for the operation of the Hotel Quarantine Program.
206. In closing submissions, DHHS extracted the passage from Part 7.1 of the EMMV it relied on and referred to throughout the Inquiry, which I set out again as follows:
- There are complex emergencies where a shared accountability across a number of agencies occurs. In these cases, there is a need for a single agency to be responsible for the collaborative response of all the agencies. For the purposes of consistency, the term control agency will be used to describe this lead agency role.²⁹²
207. DHHS submitted that no one agency could respond alone to such a complex emergency and that this 'does not reflect the reality of emergency management'.²⁹³
208. A few observations are noteworthy with respect to this submission.
209. First, it appears from this submission, that DHHS is referring to its role in the response to the entire pandemic state-wide rather than the operation of the Hotel Quarantine Program. The submission refers in a broad and sweeping way to the crisis structures of government and whole-of-government leadership and decision-making on overall directions for the COVID-19 response.²⁹⁴
210. Second, the DHHS submission refers to the other agencies involved in the delivery of the Hotel Quarantine Program, pointing out that agencies such as DJPR and private contractors all held their own responsibilities and accountabilities, ostensibly in support of the position that DHHS was a coordinator, rather than a controller of the Program that was in charge of, or responsible for, the Hotel Quarantine Program. The problem with this position is that the two concepts are not mutually exclusive. That agencies such as DJPR engaged in responding to the emergency are properly accountable for their actions is not in question. But that concept of accountability does not obviate the need for the control agency to be more than a mere coordinator. Indeed, the language DHHS seeks to rely upon seems plain enough: 'There is a need for a single agency to be responsible for the collaborative response of all agencies'.²⁹⁵

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

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

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

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

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

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

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

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

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

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

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

219. The Hon. Martin Pakula MP, Minister for Jobs, Precincts and Regions, gave evidence that, as control agency, DHHS was ‘in charge, if you like, and had overall responsibility’ and that it was the role of DJPR to assist DHHS.³⁰⁵
220. The Hon. Lisa Neville MP, Minister for Police and Emergency Services, said ‘I’m very clear about how these arrangements work. It was a Class 2 pandemic. In this case it was a health emergency, therefore the control agency was DHHS’.³⁰⁶
221. Similarly, Chief Commissioner of Victoria Police, Shane Patton, stated that ‘Victoria Police had only a supporting role in the HQP, which was in the control of DHHS’.³⁰⁷
222. The weight of the evidence is that, at all material times, DHHS had ‘overall responsibility’ for the Hotel Quarantine Program as (a) not only the government agency responsible for public health, but (b) also the government agency that had responsibility for the exercise of the statutory powers of detention that mandated the detention of people in quarantine and (c) the designated control agency in the emergency management framework in which the Program was set. The fact that it did not see itself as having this responsibility and did not accept this responsibility, either during its involvement in the Program or throughout this Inquiry, can be understood as being a progenitor of many problems that eventuated in the Hotel Quarantine Program.

‘Shared accountability’

223. Separate, although related to the concept of multi-agency collaboration, is the concept of ‘shared accountability’ upon which DHHS sought to place much weight. It is plain that this language comes from the language of ‘complex emergencies’ from the EMMV.³⁰⁸ In this ‘shared accountability’ model, DHHS sought to create a delineation between what it saw as its areas of responsibility, being (a) public health and wellbeing and (b) the statutory framework for the making of the detention orders. During the Inquiry, this position was particularly aimed at DJPR in the ‘shared accountability’ model but included the private contractors as well.
224. As has been stated several times already in this report, the evidence is uncontroversial that, in its first 24 hours, the Hotel Quarantine Program was initiated as a departmental operation run by DJPR.³⁰⁹ As a result, a number of the initial operational decisions were, in effect, inherited by DHHS when it became control agency under the transition on 28 and 29 March 2020 into the emergency management framework.³¹⁰
225. It is plain, as a matter of fact and practicality, in an emergency response such as the set up and operation of the Hotel Quarantine Program was, that no single agency will have all the resources, expertise and experience to respond alone. It is also plain that agencies that are given responsibilities to deliver aspects of the component parts of the Program, as was the case here, bear responsibility for that proper delivery.
226. The evidence of DHHS witnesses and former Minister Mikakos was that accountability was ‘shared’ between DHHS and other agencies.³¹¹ They explained that this model of ‘shared accountability’ was expressly provided for by the emergency management framework. In her first statement to the Inquiry, Ms Peake offered the observation that emergency management has reflected a general trend in the public sector toward ‘collaborative governance’.³¹²
227. The concept of ‘shared accountability’ is, indeed, expressly identified in the EMMV. However, what many DHHS witnesses failed to acknowledge in their invocation of the concept of ‘shared accountability’ was the necessity for designation of overall responsibility and the expressly stated requirement for a single agency to be the lead agency.³¹³
228. Senior figures within DHHS, including the former Minister, regarded the Department’s function as a control agency for the operation of the Hotel Quarantine Program as an exercise in ‘collaborative governance’, where the role was one of coordination and facilitation but not one in which it was functioning as the single agency with overall responsibility for the Program.

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

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

8.3.2 Support agency role: DJPR

230. Once it became apparent over that first weekend to Ms Febey of DJPR that DHHS was the lead Department, she understood that DJPR would act as a *support agency* to DHHS.³¹⁴ As noted above, the SERP defines a support agency as an agency that provides services, personnel or material support to the control agency.³¹⁵
231. Ms Febey gave evidence that it took a few days into the Program to clarify exactly what that supporting role meant in practice.³¹⁶ Ms Febey understood, in functional terms, that DJPR was:
- A. contracting hotels and other services
 - B. meeting day-to-day needs of people in quarantine
 - C. arranging food
 - D. implementing a call centre function for people in quarantine
 - E. providing logistical support on the ground; for example, around deliveries, Uber Eats, exercise, smoking, et cetera.³¹⁷
232. From that point onwards, Ms Febey understood, correctly in my view, that DJPR was required to act as a support agency to DHHS and was to work under its direction.³¹⁸ That DJPR did a substantial amount of work towards the Program did not change Ms Febey's view that DHHS was, from that point, the control agency.³¹⁹
233. When Ms May, of DJPR, took over from Ms Febey as DJPR Agency Commander, Ms May stated that she understood she was required to take direction from DHHS in relation to matters of policy and procedure and could only act on the directions of DHHS.³²⁰ Ms May described her role as Agency Commander of DJPR as also having responsibility for supporting the directions of the State Controller — Health via the DHHS Commander. Her evidence was that she was also required to establish a DJPR command structure, lead DJPR resources and ensure a timely flow of information to the DHHS Commander.³²¹ Ms May gave evidence that she did establish a command structure within DJPR, as required by the EMMV framework, and all DJPR staff on the Hotel Quarantine Program ultimately reported to her.³²²
234. Ms May gave evidence that she understood that Operation Soteria was run by its DHHS Commander, Ms Williams, and that she understood that DJPR would work under the direction of the DHHS Commander.³²³
235. Ms Williams saw it differently, saying she had no control or authority to direct others within the Operation, for example, DJPR, Authorised Officers or on-site medical staff.³²⁴ However, DHHS (through the former Secretary and Minister) accepted that it could have transferred conduct of the contracts for hotels, security guards and cleaning being held and managed by DJPR to itself at any time. To disavow its capacity to exercise all of the necessary powers to take control of the Program is an untenable position for this government agency to take in the face of such an important program.³²⁵

236. As Emergency Management Commissioner Crisp stated in his evidence when asked about the reason for drawing a distinction between a control agency and support agencies: '[i]t is always very important to know who is in control, who is running a particular operation'.³²⁶
237. In other words, in any emergency response, it is essential that there is clarity as to roles, chains of command and lines of control. The fact that there were conflicting views about what it meant for DHHS to be the 'control agency' is a matter of considerable concern. It is also of concern that it does not appear to have been identified and escalated as an issue by DHHS, through which it could have sought clarification as to its functions and role from the Emergency Management Commissioner, or through its Minister or the CCC.
238. It would not be hard to understand that DHHS staff may have felt exhausted and overwhelmed given the enormity and range of the Department's functions, tasks and responsibilities during the early months of the pandemic. However, as previously stated, the impact of DHHS not taking overall responsibility for the Hotel Quarantine Program, and endeavouring to reframe this responsibility as one in which it was but one part of a collaborative approach of all agencies, left the Program without a responsible, accountable supervisor. Coordination is one thing. Being accountable to ensure that the collaborative approach does not break down or that, by reason of the collaboration and involvement of multiple agencies, there are not governance or operational gaps in meeting the aims of an emergency response, is another.
239. In my view, the designation of DHHS as control agency vested it with clear responsibility to deliver that response with the collaboration of multiple support agencies responsible for the proper delivery of that support agency response, as was required, **and** to ensure that those agencies were working together so that the response fulfilled its aims. But that did not remove or vary the overall need and responsibility for the single agency, DHHS, to take control of the Program and exercise the necessary vigilance required to ensure its safe and proper operation shaped into a best practice model.
240. Accordingly, I do not accept the DHHS submission that it 'delivered on the appropriate role of the control agency in a complex emergency'.³²⁷ At a minimum, as control agency, DHHS was responsible for ensuring that the plans for the Operation, including division of responsibilities, chains of command and overall accountability, were understood by all operating within it. Evidence of this clear leadership role is documented in several iterations of the Operation Soteria plan and further evidenced by the leadership hierarchy of the Program, where all key roles were either filled with DHHS staff or staff appointed by DHHS.
241. Notwithstanding the language contained in the EMMV, while DHHS accepted it was the control agency, it sought to re-define what 'control agency' meant in the emergency management context. The impact of this was multilayered.
242. By mischaracterising or misinterpreting its role as the control agency, it left the Hotel Quarantine Program without a manager, without a leader and without what was critically needed for such a high-risk program: an agency to be in charge and take responsibility to ensure, to the best of its ability, that the Program was being operated to minimise the risks inherent in it.
243. That such a misinterpretation or mischaracterisation of the role and function of this central aspect of the response to a public health emergency could become so embedded in the minds of the senior management of DHHS — all the way through to the Minister — points to the obvious need to clarify the meaning and role of control agency, whether it be a complex emergency or not.
244. To ensure that such a situation does not emerge again, I make the following recommendation:

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

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

245. As part of its ordinary operations, one of the key responsibilities of DHHS is in preventing the spread of communicable diseases.³²⁸ Within the structure of Victoria's response to the pandemic, 'the department had responsibility for public health interventions to suppress the virus (including through investigation [and] management of public health risk'.³²⁹ As noted above, Ms Peake stated that DHHS 'was also responsible for stewardship of health and human service sector responses to the pandemic, including overseeing delivery of services that support the health and wellbeing of Victorians'.³³⁰
246. It is well understood and accepted that, throughout the relevant period in which the Hotel Quarantine Program was implemented, DHHS had responsibility not only for the Program, but for numerous other aspects of Victoria's response to the pandemic.³³¹ DHHS continued to attend to its broader public health functions throughout the Hotel Quarantine Program. I have been cognisant of that fact when assessing the roles, responsibilities and accountabilities of personnel and DHHS within the Hotel Quarantine Program including the DHHS Public Health Team.
247. I accept the submission advanced on behalf of DHHS that 'the hotel quarantine program was one part of a State-wide emergency response to the pandemic'.³³² However, this changes nothing, other than to confirm that the resources of DHHS were severely stretched. Further, Ms Peake gave evidence of the 'understanding, in late March 2020, that the major form of transmission of COVID-19 in Australia at that time was from returned travellers'.³³³
248. Because the major form of transmission, as understood at that time, was from returned travellers, the Hotel Quarantine Program was the State's most critical bulwark against the further spread of disease and the devastation feared by its proliferation. The purpose of the Program — to contain the spread of the virus — and the magnitude of the decision to deprive citizens of their liberty to achieve that aim, means that it had to be given primary focus in relation to its conception, development, resourcing, oversight and operation. There is evidence that the ability to properly resource the Hotel Quarantine Program with the health and medical expertise needed was compromised by not enough public health experts either employed by DHHS or available to DHHS to fulfil the necessary functions and demands of the Hotel Quarantine Program.³³⁴
249. As an example, as at early April, the evidence is that DHHS had only one IPC expert, employed by the Microbiological Diagnostic Unit Public Health Laboratory in a 'shared capacity' with the Department³³⁵ (noting that Dr van Diemen would later establish a new IPC Cell led by a public health physician and comprised of infection control consultants).³³⁶ As stated above, that person initially provided advice across Victoria in response to the pandemic. When that DHHS consultant had no capacity to respond to Operation Soteria requests for further specialised advice regarding the Hotel Quarantine Program, including in the context of establishing the Rydges Hotel in Carlton as a designated COVID-19 hotel, it was recommended that Operation Soteria engaged an outside consultant for advice. DHHS engaged Infection Prevention Australia as a contractor on a number of occasions.³³⁷ Similarly, DHHS engaged nursing agencies to provide nursing services and a newly created company to provide general medical practitioners.³³⁸ It is no criticism at all of DHHS that it engaged this assistance, particularly in response to not only the unprecedented pandemic to which it was responding but the unpredictable numbers and limited information on the health needs of those coming into Hotel Quarantine. These factors made it very difficult to plan for, particularly given there had been no contingency plans in place at the time the Hotel Quarantine Program was announced.

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

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

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

Engagement with medical experts outside DHHS

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

We believe that there was no shortage of experts in Victoria who could have assisted the government with establishing hotel quarantine – but somewhere along the line, the government didn't view engagement with these types of experts as being necessary.

Overall, there is not a culture within government and within the DHHS of meaningful engagement with stakeholders. There appears to be a lack of appropriate planning, collaboration and two-way communication between the DHHS and its external stakeholders. There need to be more genuine attempts to seek feedback, test assumptions and ideas, obtain input from experts, and collaborate in planning and understand the experience on the ground.³⁴¹

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

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

8.3.3 Not appointing Chief Health Officer as State Controller — Health

254. Related to the issue of ‘not enough public health experts to go around’ was the impact of the non-appointment of the CHO as State Controller — Health. As set out above, the default position in the SHERP for Victoria is that the CHO will be appointed as the State Controller — Health. As Secretary of DHHS, Ms Peake was aware of the presumption under the SHERP that the CHO is the presumed appointment.³⁴² As DHHS was the control agency for a Class 2 health emergency, Ms Peake had the authority to appoint a State Controller — Health and to depart from the normal course. She chose to depart from it. In February, Ms Peake was advised by Ms Skilbeck (an economist by training) to appoint someone other than the CHO, Prof. Sutton, as the State Controller — Health.³⁴³
255. Instead of the CHO, as previously stated, two executive members of DHHS were appointed to the role of State Controller — Health by the Secretary of DHHS in response to the COVID-19 pandemic.³⁴⁴ The first, Ms Spiteri, Executive Director of Emergency Management, DHHS, was appointed on 1 February 2020. The second, Mr Helps, Deputy Director of Emergency Operation and Capability, DHHS, was appointed on 7 February 2020.³⁴⁵ They performed the role of State Controller — Health according to a rostered arrangement.³⁴⁶ Both were very experienced in emergency management.
256. Ms Peake gave evidence that, despite the presumption in the SHERP that the CHO would fulfil the function of State Controller, this was not always the case and her decision not to appoint the CHO was due to:

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

257. In Ms Peake’s view, given the other duties of the CHO in response to the overall public health emergency, it was not practicable for him to take on the role of State Controller — Health.
258. Ms Skilbeck spoke about her reasons for making that recommendation. Ms Skilbeck explained that she viewed the Hotel Quarantine Program primarily as a significant logistics program that required logistical expertise rather than public health knowledge.³⁴⁸ She also referred to the other responsibilities falling to the CHO at the time.³⁴⁹
259. Shortly after Ms Spiteri’s appointment, Ms Skilbeck provided Ms Peake with a brief that documented her reasons for recommending the appointment of Ms Spiteri rather than Prof. Sutton as State Controller. In her brief, Ms Skilbeck explained as follows:

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

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

261. In reflecting on his not having been appointed State Controller — Health, Prof. Sutton said that the position of State Controller — Health would have given him a significant ‘line of sight’ perspective over operational elements for which he (as CHO) was accountable because it was his authority, pursuant to the PHW Act, which was the source of legal power for the Program. He said that it was important for him to have line of sight of the application of those controls and to have ‘situational awareness of those operational activities’.³⁵³ Moreover, in Prof. Sutton’s view, it would have been preferable to appoint ‘a public health physician with communicable disease experience and tropical medicine experience and [his] specific qualifications and experience’.³⁵⁴
262. In her evidence, Dr van Diemen (who was DCHO and Public Health Commander and the person who authorised the detention notices placing people in quarantine) stated that it would have been ‘perhaps more ideal’ to have someone who had a public health background and greater communicable disease focus as the State Controller.³⁵⁵ However, she said that she could understand the reasoning that was advanced for the appointments that were made, given the enormous demands on everybody’s time.³⁵⁶
263. As previously noted, Ms Skilbeck explained, in her evidence, that Ms Spiteri and Mr Helps were chosen, ‘[To] provide access to the needed state level logistics and communications support, rather than hazard (virus) control’.³⁵⁷
264. Emergency Management Commissioner Crisp was consulted by Ms Skilbeck about the proposed appointment. He stated that the rationale for the departure from the normal position was explained to him by Ms Skilbeck, and he agreed with that position. He did so on the basis that the CHO was too busy with other responsibilities.³⁵⁸
265. Both Ms Peake and Ms Skilbeck knew that Prof. Sutton did not agree that someone else should be appointed, and there was discussion between them about the disagreement.³⁵⁹ Despite that conversation, Ms Peake remained of the view that it was just not feasible that the CHO could perform the role of State Controller — Health, and doing so would have compromised his other functions.³⁶⁰
266. Both Prof. Sutton and Dr Romanes expressed their concerns that those in the leadership roles in the Hotel Quarantine Program were people without significant public health experience. It was the view of Dr Romanes that those appointed to senior leadership positions ‘did not have significant public health experience’ and that this resulted in the Hotel Quarantine Program being ‘characterised and managed predominantly as an accommodation or logistics program’.³⁶¹ In his evidence, Prof. Sutton agreed that he, too, had reservations about the lack of Public Health Command involvement in Operation Soteria.³⁶²
267. Ms Peake gave evidence that, by the time of her appearance before the Inquiry, she was aware of various statements made by DHHS staff, including the CHO, the DCHO/Public Health Commander and Dr Romanes, to the effect that if the CHO had been appointed State Controller, public health expertise may have been more embedded in the governance of the Hotel Quarantine Program.³⁶³ Her view was that it was important to reflect on the practical realities of the ‘bandwidth’ of public health at the time of the appointments, having regard to other DHHS tasks.³⁶⁴ She said that it had been, and remained, her view that it was not practicable for Prof. Sutton to execute his statutory obligations of CHO at the time and take on that facilitation of multiagency operations across government, and that the Public Health Command was established to ensure there was public health input into Operation Soteria and into other operations that were in train at the same time.³⁶⁵
268. Ms Spiteri stated that this was the first appointment of a State Controller for a Class 2 human disease pandemic in Victoria with ‘a remit to coordinate whole of Victorian Government planning and responses to the broader impacts and consequences of the pandemic’.³⁶⁶
269. Ms Spiteri referred to the detail of what is contained in the SERP that includes to lead and manage the response to a Class 2 emergency, establish a control structure for the Class 2 emergency as appropriate and monitor to ensure it suits the circumstances, and give directions to other incident controllers, if applicable.³⁶⁷

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

271. Ms Spiteri went on to state:

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

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

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

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

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

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

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

278. The impact of this decision (apparently) not to appoint the CHO as State Controller — Health meant that the senior person in this State with the recognised public health expertise necessary to oversee such a Program did not have any active oversight role in the Program. This deprived the Program of that expertise and created another fragmented line of reporting, accountability and opportunity lost for oversight of the Hotel Quarantine Program. Further, given the CHO and DCHO were accountable for the exercise of the statutory powers under the PHW Act, both of them considered it important that they should have visibility over the activities undertaken in respect of the exercise of those powers. This is a position that, in my view, is unarguably correct.
279. Both Prof. Sutton and Dr van Diemen raised their concerns about this internally, for example, with Prof. Wallace as evidenced by Prof. Sutton's email to Prof. Wallace dated 13 April 2020, extracted at paragraph 318 below.³⁷⁸ However, despite this concern, Prof. Sutton did not elevate the issue to the former Minister for Health with whom he met regularly.³⁷⁹

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

280. Adding to the apparent complexity of the governance of the Hotel Quarantine Program was another layer of either intersecting pathways or parallel lines, depending on the way it was viewed, created by the emergency management framework and the statutory role and powers of the CHO. It was said to emerge in this way.
281. The common emergency experience (for example, bushfires or floods) is that incident control is exercised in response to a geographical incident (for example, a particular fire ground). If there are multiple incidents (such as several different bushfires), each Incident Control Team will be supported by the Regional and State Controllers. It is an hierarchical system.³⁸⁰
282. According to Mr Helps, the COVID-19 emergency differed from that norm because the 'incident' encompassed the entire State. In his view, the 'Incident Control' function lay with the CHO by reason of his statutory powers and with the Public Health Commander by reason of the appointment under the emergency management framework. In his view, this meant, in practice, the Incident Management had the same 'footprint' as the State Control and was not within a traditional hierarchy.³⁸¹ According to Mr Helps, this meant there was no hierarchy between Incident Management and State Control.³⁸² The State Operational Arrangements COVID-19 described Incident Management, as it was applied to this emergency, in this way:

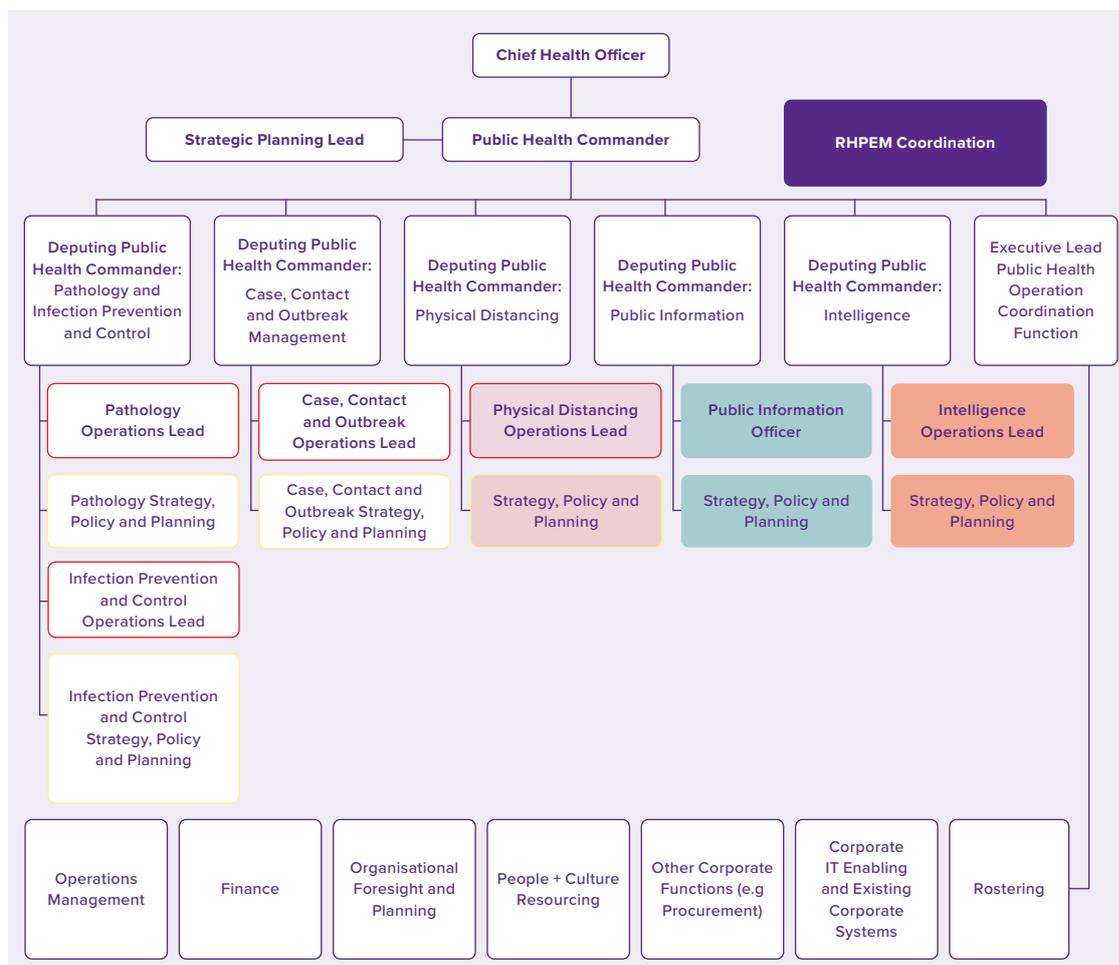
Incident Management for a state-wide Health Emergency will be managed by a single Incident Management Team (IMT) that brings together Public Health Command Operations (Case and Contact Management, Laboratories, Ports of Entry, Specialist Advice), Planning (Health Service, Public Health and other services), supported by Intelligence, Public Information. The incident footprint is the State of Victoria. The Incident Controller is the Public Health Commander.

The Public Health Commander reports to the Chief Health Officer, Victoria's health response is working in conjunction with other States and National response, with Governance arrangements at a National level leading key National policy.

The State Controller – Health, where appointed, will manage impacts of COVID-19 across the broader community that require the coordination of agencies in response to the consequences. It is difficult to predict precisely where or when specific COVID-19 impacts are going to occur, so it has been determined that a state level response is the best method to manage these emergencies.

Management of the impacts and consequences of COVID-19 on the affected community will be undertaken by emergency management agencies and government departments. This management of consequences requires agencies and government to work together in a coordinated way, therefore, a coordination centre (remote or in a facility) may be established, to facilitate identification and manage the response to the consequences rather than to control the emergency.³⁸³

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



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

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

284. This parallel structure added to the complexity of the COVID-19 pandemic emergency response and hence the Hotel Quarantine Program. The Public Health Commander under the SHERP leads the Incident Management Team. The role is to have oversight of the public health response to the health emergency. In this particular emergency, there was an operations aspect to the role (contact tracing, outbreak management, et cetera), a planning aspect (implementing and easing of restrictions, health planning), an intelligence aspect (epidemiology, data, surveillance) and a logistics function (human and physical resources to response to emergency).³⁸⁴
285. The SHERP contemplates the Public Health Commander reporting to the State Controller — Health, as it is presumed under the SHERP that the CHO will be the State Controller. However, because the CHO was not (apparently) appointed the State Controller, the Public Health Commander reported directly to the CHO, as he had ultimate responsibility for the public health response, not the State Controller.³⁸⁵ Although this was not in line with the emergency management arrangements, according to Dr van Diemen, this was ‘an agreed approach by everybody’.³⁸⁶
286. The Public Health Incident Management Team is part of the emergency management structure and sits under the Public Health Commander. The Public Health Incident Management Team was initiated in response to the declaration of the COVID-19 pandemic. As the pandemic developed, the Public Health Incident Management Team became larger and more multi-layered as it adjusted for the scale and requirements of the emergency across the entire State. It seems to have developed into a more permanent structure.³⁸⁷
287. The Public Health Incident Management Team provided advice to the State Controller — Health in relation to the health aspects of the COVID-19 response across the entire State. This was both in an informal capacity and a more formal setting by creating policies and guidance around general IPC, among other things across many different settings. This guidance was provided to those running the Hotel Quarantine Program but, largely, was not tailored to the Hotel Quarantine Program and its very particular and unique requirements. Much of the advice was directed to the broader population, including various industries, as part of the COVID-19 response as a whole.³⁸⁸ As such, the advice was often not particularly helpful as it was not engaged with the very particular circumstances in Hotel Quarantine.
288. Mr Helps’s conclusion that there was no hierarchical relationship between incident management and State Control, as there would be in a more ‘traditional’ emergency such as a bushfire or a flood, raises the question as to how appropriate the emergency management framework was to operate the Hotel Quarantine Program. I return to this question at 8.3.12

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

MISCHARACTERISATION OF THE PROGRAM

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

290. The views about its primary characterisation as a logistics or public health program largely split inside DHHS as between the emergency management division and the public health division. Dr Romanes saw Operation Soteria as ‘characterised and managed predominantly as an accommodation logistics program’ but that ‘public health consideration needed to be concurrently addressed’.³⁸⁹
291. Ms Bamert saw a real need for someone who was part of the Operation Soteria management team to have IPC expertise at that management level.³⁹⁰
292. In evidence, Dr van Diemen agreed that she, Prof. Sutton and Dr Romanes all expressed concern that there was an absence of health focus in the governance of the Hotel Quarantine Program.³⁹¹
293. Both Prof. Sutton and Dr Romanes expressed concerns that those in the leadership roles in the Hotel Quarantine Program were people without significant public health experience.³⁹² Dr Romanes offered the following view in his statement to the Inquiry:

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

294. Part of the evidence I relied upon in reaching a conclusion on this issue was based on the reality of the on-site presence at the hotels. DHHS Team Leaders appeared to be liaisons who were maintaining ‘representation’ of DHHS on-site for daily issues. The other DHHS presence on-site was the Authorised Officers, whose role was characterised as overseeing compliance with the detention directions.
295. The weight of the evidence was that the Program was characterised as a compliance and logistics exercise rather than a public health program. The conceptualisation of the Program in this way created tension within DHHS, and also meant that the necessary attention was not paid to the central risk of the Program and, ultimately, to the whole State, being the risk of outbreaks inside the hotels or into the community at large.
296. While the Hotel Quarantine Program was not in existence or even contemplated when the decision was made to (apparently) not appoint the CHO as State Controller — Health, the consequence for the Program was that, when it was brought under the control of the State Controllers — Health, it was also being brought under emergency management, rather than public health governance.
297. The essential rationale behind the designation of DHHS as the control agency in response to a health emergency was that public health expertise, rather than logistical support, was the unique function that was required at the helm in the SCC infrastructure. That was the purpose for which DHHS was designated as the control agency in the first place.
298. No system of IPC in the context of this pandemic was going to be perfect. It goes without saying that this virus can, and has, crossed over containment lines even in best-practice settings, such as hospitals and other healthcare settings. However, the starting point for a Program to minimise the risk of transmission events is one that sees itself as a public health program, not a logistics program, and therefore places those with the right expertise into lead positions.

8.3.6 Transfer of Operation Soteria to the Emergency Operation Centre

299. As noted above, at Section 8.2.5, in recognition that Operation Soteria needed to be placed into a longer-term programmatic footing rather than an ongoing emergency response, it was moved out of the SCC by mid-April and into a location in Fitzroy, the EOC. According to Ms Williams and Ms Bamert, this was done in the recognition that this would be a significant and complex program that was likely to be in place for 12–18 months.³⁹⁴ Further, it was understood and accepted that the emergency management structure was not one that was designed for long-term, sustained responses.³⁹⁵
300. Ms Williams observed that a ‘surge workforce’, appropriate for an emergency over a few weeks, was harder to sustain over months. Ms Williams further stated that people recruited in a surge workforce come from a range of backgrounds and work experience and have a significant turnover rate. Longer-term appointments allow for a team structure and proper training and supervision.³⁹⁶
301. Ms Williams reflected that ‘the extent and complexity of clinical needs in hotel quarantine was substantial; direct service provision by a public health service would have assisted in managing those needs, both at the hotel and when escalation to hospital care was necessary’.³⁹⁷ Ms Williams also reflected that approval of public health policy and transfer into implementation of policy around infection control and cleaning needed to happen much more quickly.³⁹⁸
302. Ms Williams pointed out that, at the start of the Program and observing what was happening overseas, hospitals were preparing for large numbers of COVID-19-positive patients. Once this pressure abated, Alfred Health assumed its role at the Brady Hotel in mid-June 2020.³⁹⁹
303. While I accept the concern about hospitals getting overwhelmed by patients being a reason for not moving to this clinical model earlier, it was actually in the wake of the two outbreaks from hotel quarantine that Alfred Health accepted the role at the Brady Hotel.⁴⁰⁰
304. Notwithstanding that transfer with the intention of moving the Program out of the emergency management framework, Ms Williams and Ms Bamert (who came into the SCC on 30 April 2020⁴⁰¹) continued with titles taken from the ‘chain of command’ emergency management structure: COVID-19 Accommodation Commanders and, ironically, DHHS named its new location as the ‘Emergency Operation Centre’.
305. The move away from the SCC with the intention of setting the Program onto a longer-term footing was sensible and correctly assessed as consistent with the needs of the Hotel Quarantine Program. That it remained entwined with the emergency management structure, and that DHHS did not take the opportunity to re-conceptualise what was needed in the wake of that transition, was an opportunity lost in mid-April.

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

306. Notwithstanding Ms Peake’s evidence that ‘there was a healthy and engaged relationship between the Public Health Command that was created to provide that input into all of the operations, including Operation Soteria’,⁴⁰² the evidence was completely at odds with this, in particular on the topic of the chain of command within DHHS.
307. There was considerable evidence, some that emerged after the close of the evidence and final submissions, of confusion and tension about who was in command of whom inside DHHS. The split that emerged was as between the emergency management personnel within DHHS and the public health witnesses. There was conflicting evidence about reporting lines and chains of command as between these two groups.
308. Mr Helps, State Controller — Health, stated that he believed his role in the Program was ‘very complex to navigate’ and that ‘[t]rying to coordinate across very different levels of governance (Public Health Command, Government and Emergency Management) was a constant challenge’.⁴⁰³ As explained above, in evidence, Mr Helps said that ‘my role wasn’t to effectively lead the decision-making in regards to public health or national or State policy’.⁴⁰⁴ Mr Helps said that it was ‘well known and well recognised’ that he was not able to fulfil the full suite of responsibilities that usually fell to the State Controller because those decisions were being made elsewhere by other people, including by the CHO.⁴⁰⁵ Ms Spiteri said that a lot of decisions were made by ‘other people in other places’.⁴⁰⁶ I accept from both Mr Helps and Ms Spiteri that their roles were vast and complex. That does not assist, however, in clarifying the chain of command inside DHHS.
309. In his affidavit of 4 November 2020, Mr Helps said that ‘the governance and responsibility of the Hotel Quarantine Program was with Public Health Command’.⁴⁰⁷
310. On the other hand, Prof. Sutton’s evidence to this Inquiry was that he understood the Operation Soteria Commander to be responsible for running the Hotel Quarantine Program.⁴⁰⁸ In his affidavit of 4 November 2020, he was emphatic that the Program was not under the overall control of the Public Health Command, stating: ‘I did not consider myself to be and was not the overall head of a chain of command in relation to Operation Soteria generally’.⁴⁰⁹ He stated that he was so divorced from the command arrangements that he was not even aware of the detail of the governance arrangements:
- [W]hile I do not know in detail how policy or oversight of people in detention was handled in the Hotel Quarantine Program, I was aware that there was another management structure, in Operation Soteria and under the State Controller and Operation Soteria Commander.⁴¹⁰
311. The account of the Public Health Team’s role that was offered by Braedon Hogan (DHHS Agency Commander) fell somewhere between those diametrically opposed positions: by affidavit, dated 3 November 2020, Mr Hogan stated that ‘there was involvement of the public health team in the decision-making process’.⁴¹¹

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

Just an important reminder: all policy and oversight of people in detention is being handled in a strict chain of command, from:

- Chief Health Officer to
- Deputy CHO (today — Simon Crouch) to
- Deputy Public Health Commander Planning (Finn Romanes) to
- Director Health Regulation and Reform (Meena Naidu) to
- Authorised Officers (under Noel Cleaves and some other managers).

It is important that all direction, policy, reporting and arrangements do not break this chain.⁴¹²

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

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

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

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

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

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

I understand that there is a bit of tension between PH and EM - everyone trying to do their best.

I have had a look at the health and wellbeing arrangements for the Operation - looks like there are some holes /opportunities for improvement.

I really wanted to get your view re: governance etc

I understand that the persons are detained under your order. Assuming this is correct, this brings with it a level of accountability/responsibility for the health and welfare of those detained. Is that a cause for concern to Annaliese, Finn etc?

Is that the main pressure point or is there something else?⁴¹⁹

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

I think the main point of tension is exactly that, Euan. Operation Soteria was – as an illustration – set up and put into place through EMV / State controller without even getting my approval or even input. Annaliese was similarly excluded. That, in and of itself, is astounding to us. It was seen as an almost wholly logistic exercise and had EM governance without an understanding of where accountability sat, or perhaps should sit.

The mandatory quarantine regimen was a policy recommendation of National Cabinet, for all jurisdictions to put into place under relevant legislation. For us, that means that the CHO nominates and authorises an authorised officer to write a direction. In this case, Annaliese wrote the direction so was effectively the ‘maker’ of the entire scheme and has responsibility in law for it.

I agree that everyone is trying to work constructively in this space. But there is clearly a disconnect with our EM colleagues, perhaps especially in EMV who understood their role as controller of the scheme and effectively excluded those with significant accountability. That is a source of unease - moral and legal!⁴²⁰

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

In essence, who is responsible for the quarantined detainees. there is not a consensus on this and lack of consensus/clarity fundamentally undermines governance and decisions.

The structure suggests that the Accommodation Commander reporting to State Controller is responsible. However, there is also an opinion that PH is ultimately responsible because the passengers are detained under their direction.⁴²¹

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

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

321. What was being raised at a senior level inside DHHS was a serious internal division of views about where the internal lines of command and responsibility lay, and the risks associated with the situation if left unaddressed.
322. Ms Williams stated that, as Operation Soteria Commander, she was ‘responsible for the day to day management of Operation Soteria command’.⁴²³ Ms Bamert (who was ‘twinned’ in the role with Ms Williams) similarly stated that, as Operation Soteria Commander, she was ‘responsible for the day to day management of Operation Soteria’ and that her ‘responsibilities were to operationalise the public health policy developed by the Chief Health Officer and Public Health Command as well as coordinate activities for which other agencies were responsible’.⁴²⁴

323. In an email to Safer Care Victoria, sent on 21 May 2020, Ms Bamert stated ‘I am not sure who you would say was in charge at that point’⁴²⁵ as at 11 April 2020. That was the date of the first incident investigated by Safer Care Victoria.⁴²⁶
324. While Ms Bamert sought to clarify, in evidence, that she was describing a lack of clarity in the governance arrangements as at 11 April 2020, and that that was a catalyst for the transition to the EOC,⁴²⁷ Mr Helps continued to express concerns about the governance arrangements as late as 17 May 2020, almost two months into the Program.⁴²⁸
325. In giving her view about the internal chain of command, Dr van Diemen stated that the State Controller – Health had oversight of the implementation of advice, guidance, policies and procedures issued by her as Public Health Commander.⁴²⁹ That view followed from her stated position that ‘[t]he hotel quarantine program was not a public health function but an emergency management function and response relating to a health emergency’.⁴³⁰ She was of the view that the implementation of health and welfare policies and protocols (promulgated by the Public Health Incident Management Team) would actually be performed by the Emergency Operation Command, which sat with Ms Williams.⁴³¹
326. Dr van Diemen reflected, in her statement, that fragmented responsibilities ‘were indicative of some inconsistencies in understandings between different staff and departments as to who was considered to be ultimately responsible for certain aspects of the program, including oversight of operations on the ground’.⁴³²
327. In his further affidavit of 12 November 2020, Prof. Sutton emphasised, consistent with his earlier email to Prof. Wallace, ‘that public health were not briefed and were not involved and did not have operational control of matters in respect of which we felt we had a moral and perhaps legal responsibility’.⁴³³ He further stated that ‘public health were not in day to day decision making roles’.⁴³⁴
328. The above evidence leads to the inevitable conclusion that senior DHHS employees did not share a joint or even consistent understanding of who was ‘in charge’ of the Hotel Quarantine Program as between the various teams inside DHHS. There were divergent views as to who fulfilled what functions and what their respective roles were within the Program. There were also differing views amounting to a fundamental disagreement inside DHHS as to who was reporting to whom inside which chain of command, and who was subordinate to whom.
329. This level of confusion and disagreement inside the DHHS chain of command invariably contributed to the ultimate position that no division inside DHHS saw itself as having the power or authority or ability to be responsible for the operation of the Hotel Quarantine Program. For such a high-risk program to be left in this situation was a catastrophe waiting to happen.

8.3.8 Liaison officer as link to respond to governance issues

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

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

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

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

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

334. Dr van Diemen said that she commenced pushing for the creation of a clinical lead position in late-April 2020.⁴⁴¹ However, by the time she made her statement in mid-September 2020, she remained unsure as to whether that role had ever been filled. At the time she ceased her involvement with the Program in July 2020, there was no clinical lead or liaison in place to her knowledge.⁴⁴²

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

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

336. Ms Bamert accepted that there were some delays in fulfilling the position of clinical governance lead, and this did not occur until the second week of June 2020.⁴⁴⁴ I take Ms Bamert’s evidence to refer to the Clinical Lead that Dr van Diemen was pressing for, noting that, as at the time of her statement, Dr van Diemen was unable to say whether such role had been filled. It is plain that there were some differences in the views of Ms Bamert (Commander, Operation Soteria) and Dr van Diemen (Public Health Commander) as to what roles, fulfilling which duties, were created and when.

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

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

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

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

340. It would appear, on the basis of the foregoing, that, from the perspective of those within the EOC responsible for running Operation Soteria, there was no dedicated 'Public Health Liaison' role in Operation Soteria prior to the later creation of the Clinical Liaison role. This is so, despite Prof. Sutton's evidence that agreement had been reached to create such a position, and despite the role actually appearing in the Organisational Structure for Operation Soteria.
341. Putting to one side the differing evidence as to whether that position was actually created, the chain of command issues appeared to require more than the creation of 'a link'. In an email sent by Dr Romanes on behalf of the CHO and DCHO, he called for an urgent review of the governance of Operation Soteria. By that email, those members of the Public Health Team demanded the urgent creation of a 'single plan' to guide the Program.⁴⁴⁹
342. Following the close of evidence on 25 September 2020, the Inquiry sought and received a further statement from Mr Helps in the form of a sworn affidavit and accompanying material. As noted above, Mr Helps stated that 'the governance and responsibility of the Hotel Quarantine Program was with Public Health Command. I believe that all other Department staff (including Emergency Management Command, EOC Command, Compliance and Enforcement, Health and Wellbeing and others) were operating subordinate to, and in support of Public Health Command'.⁴⁵⁰
343. DHHS submitted that public health leadership, advice and expertise was sought by, and operationalised in, Operation Soteria, including through the CHO and Public Health Commander relying on the evidence of Dr van Diemen, Ms de Witts and the Infection Control Consultant, as well as from Ms Williams and Ms Bamert.⁴⁵¹
344. The first issue to extract from this submission is the difference between the provision of guidance and advice and policy and the **implementation** of that guidance and advice and policy. Implementation requires more than passing on information; it implies the need for a system in place to ensure that this guidance and advice and policy is being adopted and used systematically, is fit for the purpose and is subject to monitoring and supervision.
345. The second issue of note with this submission is that it is not where the weight of the evidence lay. The Infection Control Consultant relied upon for this submission stated that she was not involved in the Hotel Quarantine Program apart from providing some advice from time-to-time. Ms Bamert, herself, saw the need to have public health embedded in the EOC⁴⁵² and Dr van Diemen described herself as remaining 'somewhat conflicted' over the removal of Prof. Sutton as the State Controller.⁴⁵³ The further problem with this submission is that it relied on the views of those not in the Public Health Team.
346. Witnesses from inside the Public Health Team expressed the view that they did not consider they had sufficient oversight of what was happening inside the Hotel Quarantine Program. There was clearly a distinction being drawn between providing advice and guidance to various issues as they arose, as opposed to being properly embedded into the design and operation of the Program with the 'on the ground oversight' of the Program.

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

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

348. Given all of the above, it comes as no surprise that there was confusion and misunderstanding on the ground as to who had what role and who was ‘in charge’ of the operation. Indeed, given the refusal of DHHS to see the Program as its responsibility to lead and manage, through its senior management, it effectively characterised the hotel quarantine sites as the bringing together of a range of agencies that all had accountabilities back up through their own management structures.
349. This difficulty with the conceptualisation of how hotel sites worked can be seen in the oral evidence of Ms Spiteri. She described the hotel site as a ‘complex space’.⁴⁵⁵ Ms Spiteri described the fact that a number of agencies and contractors were working in the space. Ms Spiteri summed up DHHS’s responsibility as one in which its overall ‘contribution to safety of the environment was to ensure that there was guidance and instructions provided specifically to this emergency. And what I mean by that is that the instructions around the public health aspects were provided into that environment’.⁴⁵⁶
350. Ms Spiteri went on to describe the space as follows: ‘You had a hotel that was owned and managed by a hotel company. DHHS were renting space in it through DJPR ... We had our own staff in that environment, so did DJPR, so did Victoria Police and so did a number of contracted companies as well’.⁴⁵⁷
351. Ms Spiteri saw DHHS’s responsibility as providing information about PPE and behaviour such as social distancing, with responsibility from an occupational health and safety perspective, lying with every person and their organisations.⁴⁵⁸
352. Ms Williams’s view was that ‘each agency undertook responsibility for their own staff and contractors, including to ensure their contractors were provided with training as to correct use of PPE’.⁴⁵⁹ According to Ms Williams, DHHS was responsible for providing training to its staff on-site (hotel Team Leaders and Authorised Officers) as to correct use of PPE and was also responsible for providing training to its contracted staff on-site (although she noted that ‘the Department’s contracted nursing and medical staff could be assumed to have familiarity with correct use of PPE’).⁴⁶⁰
353. DHHS Team Leaders present at quarantine hotels were there to ‘coordinate and problem solve’.⁴⁶¹ As set out above, Ms Williams explained that, if there was a problem with security, the Team Leader would raise it with security managers. If there was a problem with the hotel, the Team Leader would raise it with the hotel manager. If a problem needed to be escalated beyond security or hotel management, it would be escalated to DJPR.⁴⁶²
354. No one has sought to ascribe responsibility for managing IPC, welfare services or delivery of clinical care to the Department’s Team Leaders. There is no evidence to suggest that it was their role.⁴⁶³

355. Ms Spiteri's description of how the sites worked is echoed by the following observation of Nurse Jen about her experiences working on-site as a nurse at the Park Royal Hotel: '... things were siloed — there was a sense that everything was nobody's job. The [DHHS] staff were in charge, but nobody really reported to anyone'.⁴⁶⁴
356. There were Authorised Officers on-site at each hotel. The evidence revealed that the perception of the role of Authorised Officers on-site depended upon who was being asked. There was considerable evidence that many on-site personnel assumed that it was the Authorised Officers who were 'in charge' on-site, as they were the ones with the legal powers to detain and discharge people in quarantine and grant fresh air breaks and temporary leave.
357. Luke Ashford, an Authorised Officer on secondment to DHHS, gave evidence that he was not clear as to what the role of the Authorised Officer would be when he was first seconded to Hotel Quarantine from Parks Victoria.⁴⁶⁵ He was appointed as an Authorised Officer on 28 April 2020. At the time, his general idea was that Authorised Officers would be assisting Victoria Police to conduct door knocks and spot checks at homes.⁴⁶⁶ By 25 May 2020, when Mr Ashford started his first shift, he still did not have any formal idea of what he would be required to do in his role as an Authorised Officer.⁴⁶⁷ Mr Ashford's evidence was that he received no specialist training in respect of performing Authorised Officer duties for DHHS.⁴⁶⁸ His training related to the use of the COVID-19 app and equality and diversity training. He had no training on infection control.⁴⁶⁹ Mr Ashford did not receive any finalised documents or instructions as to his functions and role.⁴⁷⁰
358. Mr Cleaves said that Authorised Officers had no management or control over other aspects of the Hotel Quarantine Program; their role was heavily focused on the compliance aspects with the detention notices as they applied to the people under detention.⁴⁷¹
359. Further, Mr Cleaves's evidence was that Authorised Officers were discouraged from helping others with tasks unrelated to detention. He said:
- Over time it became clear that we needed to settle into what was described as our lane, and one of our Commanders would regularly use that phrase of 'stay in our lane', which we clearly understood to be focusing on the things for which we were accountable, which was the legal detention process, as I've mentioned a number of times.⁴⁷²
360. Arrangements for Authorised Officers at each hotel posed challenges for those in hotel quarantine. Rostering arrangements meant that, often, Authorised Officers would work at different hotels and not at the same hotel over a period, leading to a lack of continuity at each hotel. As new Authorised Officers came into a new hotel, they would be faced with different situations and different experiences.⁴⁷³ There were inconsistencies throughout hotels, particularly with handovers between shifts, in respect of walk-lists and temporary leave arrangements for compassionate leave.⁴⁷⁴
361. The evidence of Mr Cleaves was that Authorised Officers did not have operational control over security teams.⁴⁷⁵ Similarly, Mr Cleaves stated he did not recall personally giving direct instructions to security guards regarding operational matters such as cleaning or the appropriate use of PPE, except when carrying out a specific Authorised Officer function.⁴⁷⁶ He was clear that security did not report to Authorised Officers, nor did Authorised Officers supervise security or their teams.⁴⁷⁷
362. But they were not the views held by those providing security services at hotels. Evidence from security guards and security companies was that they saw Authorised Officers as 'in charge' at hotels. For example:
- A. The security guard known as Security 1 understood that Authorised Officers were in charge of quarantine at the site.⁴⁷⁸ Similarly, the security guard known as Security 2 understood that 'DHHS [was] the ultimate authority, as the Authorised Officer'.⁴⁷⁹
 - B. Greg Watson, from Wilson Security Pty Ltd, understood that Authorised Officers were in charge of the site, on the basis that they were mentioned in detention orders, mentioned as a point of escalation, and in correspondence where it is identified that the decision rested with Authorised Officers.⁴⁸⁰

- C. Jamie Adams, from MSS Security Pty Ltd, understood that each hotel would have an Authorised Officer and that security would report to them at a site on a day-to-day operational level.⁴⁸¹
- D. Mo Nagi, from Unified Security Group (Australia) Pty Ltd, gave evidence that he understood the responsibilities of Authorised Officers at hotels included dealing with guest issues and managing fresh air walks.⁴⁸² He saw Authorised Officers as the ‘overlay of any issues and concerns that were required where any authority needed to occur ...’⁴⁸³ Mr Nagi accepted that Authorised Officers could give directions to, or make requests of, security staff.⁴⁸⁴
- E. Ishu Gupta, one of the directors of The Security Hub Pty Ltd, was critical of Authorised Officers whom he saw as ‘running the program’ without necessarily having relevant training and knowledge or a background in health.⁴⁸⁵
- F. Commander Tim Tully of Victoria Police gave evidence that he observed that security guards would look to Authorised Officers for guidance on what could actually be undertaken in the hotel quarantine environment; however, his evidence was also that Authorised Officers were saying ‘well, we’re not in a position to empower you to do it’.⁴⁸⁶
363. It is understandable that many perceived that Authorised Officers were ‘in charge’ as they did represent the legal power to detain people in their rooms as well as grant fresh air breaks and leave and, ultimately, authorise the discharge of people from their mandatory quarantine period.
364. However, Authorised Officers on-site at the hotels had no role in overseeing IPC.⁴⁸⁷ Mr Smith (Commander of COVID-19 Enforcement and Compliance) espoused the view that the Commander of Operation Soteria had overall responsibility for IPC and that DHHS Team Leaders were their representatives on-site. It was his understanding that this included responsibility for PPE but only for DHHS staff — as opposed to the other staff — working at the hotels.⁴⁸⁸
365. The evidence as to the perceptions and confusion, in particular from non-DHHS people about who was ‘in charge’ on-site, was a completely understandable and human response to this situation. Putting to one side the question of having the right expertise on-site, at a minimum, such a challenging and dangerous environment that mandated people into a 14-day detention demanded that the control agency provide an on-site supervisor whose role it should have included monitoring safety on-site and understanding and intervening when risks and dangers emerged on-site.
366. In her statement, Ms Spiteri, when asked what could have been done differently, sensibly and helpfully stated that ‘[e]arlier strengthening of the role of rostering of the Department’s team leaders in hotels, as well as clearer communications about the roles of the Department’s team leaders, Authorised Officers and DJPR site managers, would have assisted all staff working in the quarantine hotels to understand who to report to for escalation and resolution. A clear, consistent and communicated unified command structure at each hotel, with consistent staffing of key management positions, could have ensured all staff working in quarantine hotels knew who was in charge of which aspects of the operation’.⁴⁸⁹ Ms Spiteri went on to explain that ‘The ongoing challenge to resource Departmental Team Leader and Authorised Officer roles, given the speed with which the program was initially stood up and then the pace of standing up new quarantine hotels, was a key factor in preventing this from occurring’.⁴⁹⁰
367. Setting up this Program, bringing all of the disparate agencies together and not having a coherent on-site supervising presence was always going to fall short of what best practice required of such a dangerous site. It was not enough to provide advice and guidance and policies to a disparate group of people and rely on the various agencies to oversee themselves. Each site needed a supervisory role to ensure that the site operated safely and according to best practice.

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

8.3.10 Clinical guidance and governance on-site

369. Having found that such a complex and dangerous site needed on-site supervision from the control agency, the next question was what skills and background people filling such roles should have had. The nature of the virus and constant and inherent dangers of transmission required nothing short of IPC expertise on-site, to embed best practice infection and control processes, oversee the induction and training of all personnel on-site, and maintain vigilant oversight and monitoring to minimise the risk of transmission of the virus.
370. As has been stated throughout this Report, the supply and use of PPE, cleaning procedures and IPC procedures are areas of expertise that cannot be left to chance, or, merely, to posters put up on-site or one-off pieces of training from time-to-time. Nothing short of constant on-site vigilance from those with the right expertise is what is required. For this reason, I have recommended that the Site Manager be responsible for IPC measures, including with respect to training and supervision arrangements.⁴⁹³
371. Dr van Diemen conceded that priority should have been given to ensuring there was oversight from clinically-trained personnel.⁴⁹⁴ She observed that ‘we all could have treated the hotel quarantine program more as a health program than a logistics or compliance exercise and viewed the overarching principles more from a health lens than occurred at the time, including standards of care and infection control’.⁴⁹⁵ She also reflected that, in line with a greater health focus, there could have been regular external auditing and reporting on adherence to standards.⁴⁹⁶
372. On this issue, it was the evidence of Mr Helps that there was no overall risk register created across the Program.⁴⁹⁷ Mr Helps noted that the risks and issues were such that they required immediate action and resolution. No argument can be taken with that, but it misses the value and importance of capturing what is happening at and across sites, and the value of having a central repository for this information to ensure that a risk addressed on one site is analysed and addressed to assess whether there may be a systems-wide issue to address. The maintenance of a risk register is a proper and necessary practice at each quarantine facility. It should be made available for the purposes of safety audits that should be undertaken by independent experts.⁴⁹⁸
373. Mr Helps was unaware if agencies working in the Program maintained a risk register,⁴⁹⁹ but whether they did or did not, the agency with overall site responsibility, DHHS, should have maintained such a register to enable the necessary system-wide overview.
374. Incorporated into the safe operation of sites should be regular safety audits, which would include inspection of the risk registers. This would have assisted in a more cohesive and Program-wide view of the emerging risks across the hotel sites.⁵⁰⁰
375. The evidence was that there was public health guidance provided from time-to-time⁵⁰¹ to Operation Soteria. This guidance, which the Public Health Team had input into, included PPE advice for healthcare workers, security staff and Authorised Officers, advice about cleaning requirements, and guidelines for the health and welfare of the detainees.⁵⁰²

376. A number of witnesses from DHHS gave evidence about the various policies and procedures relating to infection control and welfare that were drafted and disseminated. But the process was *ad hoc*, fragmented and reactive.
377. Advice in respect of cleaning provides a useful illustration. I have described cleaning policies in more detail in Chapter 7 of this Report. Suffice to say, there were several iterations of cleaning advice provided at different times, to different people and entities and on a variety of different topics.⁵⁰³ The process by which specific and tailored cleaning guidance was disseminated is an example. The document entitled *Cleaning and disinfecting to reduce COVID-19 transmission: Tips for non-healthcare settings* (dated 20 March 2020: pre-dating the set-up of Hotel Quarantine) was initially used as guidance for cleaning of quarantine hotels. According to that document '[t]he principles in this guide apply equally to domestic settings, office buildings, small retail businesses, social venues and all other non-healthcare settings'.⁵⁰⁴
378. By email, dated 2 April 2020, Ms Febey of DJPR wrote to the State Emergency Management Centre, asking for 'some advice which is more tailored to the context that we're operating in' and noting that quarantine hotels 'are running essentially health services'.⁵⁰⁵ However, as at 27 April 2020, cleaning contractors were still being directed to that document as guidance for the cleaning of quarantine hotels.⁵⁰⁶ Eventually, specific guidance was prepared that set out advice for cleaning requirements for hotels that were accommodating quarantined, close contacts and confirmed COVID-19 guests.⁵⁰⁷
379. Prof. Sutton explained that the Public Health Incident Management Team provided guidance and advice and policies to the Hotel Quarantine Program regarding the use of PPE and cleaning and other matters relevant to IPC but had no awareness of the level of compliance with those policies;⁵⁰⁸ that is, at least until the outbreaks occurred and were the subject of investigation and scrutiny. Dr van Diemen also said that her team's lack of operational oversight meant that the Public Health Command was not aware of significant IPC issues plaguing the Program until after the outbreaks.⁵⁰⁹ Indeed, the Public Health Team did not regard itself as responsible for the implementation or supervision of those policies on-site. That meant that there was no one on-site with the expertise to maintain the necessary vigilance and supervision required. That this gap in the Program existed was a serious danger inherent in the Program.
380. Certainly, public health expertise from within the Public Health Command was called upon during the Program. So, too, was external expertise from Infection Prevention Australia. However, from a control and governance perspective, that public health advice was developed and on-shared to other agencies and their contractors to implement. These other agencies and contractors did not have expertise in IPC.
381. There was no evidence presented of any overarching plan, oversight or accountability within the Program for IPC on-site. While there were obvious aspects of the Program designed to meet these ends, they were largely reactive and lacking in cohesion of plan and purpose. The evidence demonstrated that the need for overarching clinical governance was not identified in the initial planning and implementation of the Program. It was apparently not until after the first outbreak from Rydges that thought was given by DHHS senior management to instituting a system of a clinical governance framework with a clinical governance lead.⁵¹⁰ It had no real effect until the engagement of Alfred Health, on 27 June 2020, when it took over clinical governance and clinical leadership of the Program⁵¹¹ to provide 'streamlined clinical governance and oversight functions at the COVID Positive hotel with clinical staff and auxiliary and security staff all being drawn from individuals experienced in the IPC requirements of hospital environments'.⁵¹²
382. It is now clear that the expert guidance that was provided, by way of advice and policies, did not extend to the level of operational oversight that was essential to the minimising of risk to the operation of the Hotel Quarantine Program.

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

8.3.11 Ministerial briefings

384. During the course of the Inquiry, the issue of the briefing of Ministers by senior public servants arose on more than one occasion. In the DHHS context, Ms Peake acknowledged that, as Secretary to DHHS, she was accountable to her Ministers, including the Health Minister.⁵¹³ She was also accountable to the Premier in her role as Mission Lead — Secretary for the COVID-19 response.⁵¹⁴ In each role, she was specifically accountable for keeping those Ministers informed of significant issues within their portfolios.⁵¹⁵
385. In response to questions by Counsel Assisting about the set up and structure and lines of accountability for the Hotel Quarantine Program, former Minister Mikakos gave evidence that she was not consulted nor did she receive any advice as to the operational plan or the initial decisions taken in the setup of the Program.⁵¹⁶
386. Former Minister Mikakos agreed that DHHS's involvement in the Hotel Quarantine Program, even initially, was a substantial undertaking and a significant issue that fell within her portfolio.⁵¹⁷
387. Her evidence was that she did not 'approve' of the plan in the sense of signing off on it. She stated that she considered that to be the role of the Emergency Management Commissioner.⁵¹⁸
388. Similarly, the evidence of former Minister Mikakos was that she was not consulted or involved in the decision to move to the emergency management framework in which DHHS was the control agency for the Program.⁵¹⁹ Neither was she consulted with respect to the decision not to appoint the CHO as the State Controller — Health in the face of the looming COVID-19 pandemic, although, it was the former Minister's evidence that she would not expect to have been briefed on that issue.⁵²⁰
389. Former Minister Mikakos did, however, express 'surprise' that she was not delivered copies of Safer Care Victoria reports that investigated two serious incidents in the Hotel Quarantine Program.⁵²¹ The reports contained recommendations about a range of matters that should be addressed to improve safety for people being detained in quarantine hotels.⁵²²
390. While the Premier became aware of the control agency arrangements early on in the Hotel Quarantine Program, he could not point to a specific document or briefing as to precisely when he became so aware.⁵²³ He was aware, in general terms, of the concept of control agency and support agency for emergency management purposes, and the significance of those terms.⁵²⁴ He stated that he may have had some sense of departmental arrangements, but not much awareness as to the agencies involved. He thought that he would have had a briefing on the operational structure of the Program ahead of the announcements he made at his press conference on 28 March 2020, but could not recall the specifics.⁵²⁵ However, in the ordinary course of his duties, he said, he would not expect to see operational documents.⁵²⁶
391. DHHS submitted that 'there was very regular and appropriate briefing of Ministers, their offices, the Premier, his office and the Crisis Council of Cabinet on ... the operation of the hotel quarantine program'.⁵²⁷ This submission is at odds with aspects of the evidence of both the Premier and former Minister Mikakos.⁵²⁸

392. Another example of information that was significant to the operation of the Hotel Quarantine Program being provided to a senior public servant but not being passed on to a Minister can be found in an email exchange in early April 2020. That exchange was between Phil Gaetjens, Secretary to the Department of Prime Minister and Cabinet, and his Victorian counterpart, Mr Eccles.⁵²⁹ Mr Eccles gave evidence that he had asked the Commonwealth to assist with the cost of private security at hotels.⁵³⁰ Mr Gaetjens responded that NSW had been provided with support in the form of Australian Defence Force personnel and that the same support might be available to Victoria if it were to reconsider its model of operating the Hotel Quarantine Program.⁵³¹
393. Mr Eccles did not, so far as the documentary evidence reveals, respond, other than by return email to say ‘thanks’.⁵³² His oral evidence was that he could not recall taking any other action in response to this email.⁵³³ In its submissions, DPC accepted that the evidence established that Mr Eccles did not draw the contents of Mr Gaetjens’s email to the attention of the Premier. DPC further accepted that it was open to me to find that Mr Eccles should have drawn the contents of Mr Gaetjens’s email to the attention of the Premier, because its contents concerned a significant issue.⁵³⁴ These concessions are properly made. Apart from anything that has later been learned about the issues that arose with respect to the use of private security, their use in the Hotel Quarantine Program was at a cost of many millions to the public purse.
394. Similarly, Minister Pakula, as the Minister for DJPR, gave evidence that, while he received verbal briefings from time to time about the work of DJPR in the Hotel Quarantine Program, he only became aware of issues and concerns his department was having about such things as whether there should be a police presence at hotels or whether people should be allowed out of their rooms, as a result of evidence to this Inquiry.⁵³⁵ Further, his evidence was that he was not aware that contracts were going to be entered into for the provision of private security services or cleaning services, or how those contracts were constructed.⁵³⁶ Minister Pakula was unable to recall how he became aware that his department had entered into contracts with private security companies for the provision of services at quarantine hotels. He thought it may have been ‘from media reportage’ or ‘a conversation’.⁵³⁷ Minister Pakula thought it was ‘usual’ that he would not know about his department being engaged in these multimillion dollar contracts.⁵³⁸ Indeed, the estimate given from DPC for the amount spent by DJPR for its part in the Hotel Quarantine program was \$133.4 million to 30 June 2020.⁵³⁹
395. As can be seen from these examples taken from the evidence, the issue of the information that does or does not get passed on by senior public servants to Ministers responsible to Victorians for the operation of their portfolios came up in several significant ways across several departments. Ensuring that Ministers are thoroughly and properly briefed is part of our system of responsible government, in place to create checks and balances on bureaucratic decision-making. It is also in place to, thereby, confirm that the Minister for the department is performing the important function of maintaining oversight of his or her department’s actions for which he or she is answerable to the people of Victoria.
396. It is beyond the remit of this Inquiry to engage in an examination of the Westminster system of ministerial and public service lines of accountability and responsibility. However, the evidence on this issue that emerged in the Inquiry dictates that an appropriate agency or entity should undertake an examination of what has occurred to assess what action may be necessary in response. Given the role and responsibilities of the Public Sector Commissioner, as set out in the *Public Administration Act 2004* (Vic), I am satisfied that this is the appropriate place to direct a recommendation.

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

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

8.3.12 Appropriateness of EMMV and Class 2 emergency

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

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

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

8.4 — Summary of conclusions

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

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

402. The emergency management framework classifies emergencies into different classes depending on the type of emergency being faced. The framework also designates which agency will be designated as the ‘control agency’ depending on the expertise required to respond to that emergency. A pandemic is classified as a Class 2 emergency and designates that DHHS is the control agency.
403. The use of the emergency management framework to respond to the COVID-19 pandemic was the first time it had been used in Victoria for a large-scale Class 2 emergency.
404. While there was a range of plans in place in this framework, none of those plans contemplated mass mandatory quarantining of people in response to a Class 2 emergency.
405. While there was no controversy about the appointment of DHHS as the control agency for this Class 2 emergency, there was considerable controversy that persevered throughout the Inquiry as to what it meant to be the control agency.
406. The meaning of the term ‘control agency’ is defined in the emergency management framework as the agency with the **primary responsibility** for responding to a specific form of emergency. The control agency’s responsibilities are set out in the EMMV and include the appointment of ‘controllers’ for the specific form of emergency.
407. The importance of having a control agency in emergency management is to ensure clear lines of command and control, as this is critically important to lead and manage the emergency, coordinate the response and ensure there is no ambiguity about who is accountable for the management of the emergency.
408. Notwithstanding that DHHS acknowledged it was the control agency, it characterised its role in the Hotel Quarantine Program as one in which it had a ‘shared accountability’ with DJPR. It relied on several lines of reasoning to characterise its role in this way. First and foremost, it relied on the concept that the overall response to the pandemic and the Hotel Quarantine Program, as part of that response, fell within the meaning of a *complex emergency* as contained in the EMMV. In such circumstances, the need for ‘shared accountability’ is referred to but the reference goes on to make clear that, in these collaborative responses as between agencies, there is a need for a single agency to be responsible as the lead agency.
409. To the detriment of the operation of the Hotel Quarantine Program, DHHS did not accept that role or responsibility of being the single lead agency, either during the running of the Program or, indeed, even on reflection, during this Inquiry. This left the Hotel Quarantine Program without a government agency taking leadership and control and the overarching responsibility necessary to run such a complex and high-risk program. DHHS was the government agency that had this responsibility. Not only was it the control agency in emergency management terms, but it was the repository of the public health expertise and was the government department that had responsibility for the legal powers exercised to detain people in quarantine.
410. Notwithstanding this fundamental mischaracterisation of its role and function, adopting the structure and language of the emergency management framework, DHHS appointed a range of ‘controllers’ and ‘commanders’ inside complex and, at times, inexplicable internal governance structures that served to complicate and obfuscate reporting lines and accountabilities rather than create clarity of role definition and lines of command.
411. Prior to the commencement of the Hotel Quarantine Program, the Secretary to DHHS, on the advice of one of her deputy secretaries, departed from the expectation of the emergency management framework that the CHO would be appointed State Controller for a public health emergency and, instead, appointed two emergency management experts as State Controllers. This was despite the disagreement of the CHO with this course of action. (Note that at 8.3.3 paragraphs 275 to 278, it appeared that Prof. Sutton was formally appointed as one of four State Controllers – Health but that he was not made aware of this.)

412. The decision to not (apparently) appoint Prof. Sutton was taken on the basis that the CHO would not have the 'bandwidth' to fulfil all of the functions he had in the context of the state-wide emergency, and on the basis that the role required emergency management logistics (hence, the appointment of two such experts).
413. The impact of this decision had three important ramifications. First, it contributed to the mischaracterisation of the operation of the Hotel Quarantine Program as a 'logistics' and 'compliance' exercise rather than a public health program. Second, it created another fragmentation in governance of the Program, as it removed the head of the DHHS Public Health Team from much-needed operational oversight of the Program and, third, it meant that those in leadership roles for the Program were not people with public health expertise.
414. It concerned both the CHO and the DCHO that people were being detained using the legal powers authorised by them and yet they did not consider they had sufficient authority or oversight or awareness as to how the operation was being run 'on the ground'. Further, there was considerable disquiet expressed from the senior members of the Public Health Team inside DHHS that there was a lack of clarity about the command structures inside DHHS.
415. Inside DHHS's internal governance structures, as between emergency management executives and the public health senior members, there was not an agreed view or consistent understanding as to who was fulfilling what functions and roles and who was reporting to whom. In the context of the operation of the Hotel Quarantine Program, this created confusion and fragmentation in governance structures.
416. The mischaracterisation of the Hotel Quarantine Program as a 'logistics' and 'compliance' exercise meant that focus did not fall on the need for expert infection and prevention oversight to be embedded into the Program.
417. The impact of the pandemic and its demands on the Public Health Team inside DHHS revealed, among other shortages, a significant lack of much-needed public health infection prevention expertise employed by DHHS.
418. By mid-April, it was recognised that the Hotel Quarantine Program would likely be in place for 12–18 months and, therefore, needed to be taken out of an emergency management response structure and run as a departmental program. To that end, a centre was set up, ironically called the Emergency Operation Centre, and run by DHHS 'commanders'. Unfortunately, DHHS did not take this opportunity to rethink its operation but, rather, continued to see itself as co-ordinating the day-to-day operation of the hotel sites but not taking overall responsibility for the Program.
419. DHHS executives continued to see DHHS as responsible for providing 'broad' policy support, supporting the health and wellbeing of people being held in quarantine, obtaining advice and guidance from the public health arm of DHHS and passing that on to various agencies on-site, including DJPR, hotel operators and private security firms, in the firm view that each agency was responsible for its own operation on-site.
420. The on-site presence that DHHS did have was through its Team Leaders and Authorised Officers. Neither of these roles had functions of oversight or direction or supervision. The Team Leaders were seen as problem solvers or liaison points on-site. The Authorised Officers were responsible for the exercise of legal powers to detain people in quarantine. They exercised the legal powers to grant leave and exemptions and discharge people from quarantine at the end of their 14-day period. Neither had any role or authority or expertise in supervising the safety of the site generally.

421. Just as DHHS did not see itself as the control agency responsible for the Program, it did not see itself as 'in charge' on-site. This left brewing the disaster that tragically came to be. This complex and high-risk environment was left without on-site supervision and management, which should have been seen as essential to an inherently dangerous environment. That such a situation developed and was not apparent as a danger until after the two outbreaks was the ultimate evidence of the perils of the lack of proper leadership and oversight.
422. Ultimately, the intractable problems of governance and control and leadership in the Hotel Quarantine Program presented like a 'Gordian knot' that was only 'cut' after the outbreaks in July when the responsibility for the Program was removed from DHHS.

8.4.1 Summary of Recommendations

74. That the Emergency Management Commissioner clarifies the language used in the Emergency Management Manual Victoria to ensure that there is no possibility of any ambiguity about the role and responsibility of the control agency, including a more fulsome definition of what constitutes a complex emergency and the role of the designated control agency in a complex emergency.
75. That the Secretary of DHHS engages in discussions with the President of the Australian Medical Association to address the availability of medical expertise to meet current and future surge and planning demands for public health emergencies.
76. That the Public Sector Commissioner examines the evidence that emerged in this Inquiry as to the lines of accountability and responsibility as between Departmental heads and Ministers and gives guidance across the public service as to the obligations, both in law and in practice, on heads of departments and senior public office holders.
77. The Emergency Management Commissioner, in collaboration with the Chief Health Officer, the Secretary of DHHS and other relevant agencies, reviews the suitability of the Emergency Management Manual Victoria framework to Class 2 public health emergencies, including how the Emergency Management Manual Victoria intersects with the *Public Health and Wellbeing Act 2008* (Vic).

Endnotes

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

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

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

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

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

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

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

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

- 421 Exhibit HQI0120_RP Email from Mr Euan Wallace to Ms Melissa Skilbeck.
- 422 Exhibit HQI0256_RP Documents referred to in affidavit of Mr Jason Helps, DHS.0001.0131.0065. For further evidence of concerns raised about governance, see Exhibit HQI0258_RP Documents referred to in affidavit of Mr Braedan Hogan, DHS.0001.0132.0152–DHS.0001.0132.0158; DHS.0001.0132.0147; Exhibit HQI0256_RP Documents referred to in affidavit of Mr Jason Helps, DHS.5000.0072.9118–DHS.0001.0131.0077.
- 423 Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 6 [18].
- 424 Exhibit HQI0135_RP Witness statement of Ms Merrin Bamert, 6 [18].
- 425 Exhibit HQI0137_RP Email from Ms Merrin Bamert to DHHS and Safer Care Victoria, SVC.0001.0002.0056.
- 426 Exhibit HQI0117_R Annexures to first witness statement of Prof. Euan Wallace AM, DHS.0001.0002.0058, DHS.5000.0089.2744.
- 427 Transcript of day 16 hearing 11 September 2020, 1312.
- 428 Exhibit HQI0256_RP Documents referred to in affidavit of Mr Jason Helps, DHS.0001.0131.0065.
- 429 Exhibit HQI0160_P Witness statement of Dr Annaliese van Diemen, 4 [21].
- 430 Ibid.
- 431 Ibid 4–5 [24].
- 432 Ibid 32 [146].
- 433 Exhibit HQI0252_P Second affidavit of Prof. Brett Sutton, 1 [8].
- 434 Ibid 2 [10].
- 435 Exhibit HQI0160_P Witness statement of Dr Annaliese van Diemen, 15 [68].
- 436 Exhibit HQI0145 Annexures to first witness statement of Commissioner Andrew Crisp, DOJ.501.001.9230.
- 437 Transcript of day 18 hearing 16 September 2020, 1492–1493.
- 438 Ibid; Exhibit HQI0153_RP Witness statement of Prof. Brett Sutton, 29 [160]
- 439 Transcript of day 18 hearing, 16 September 2020, 1530.
- 440 Ibid 1534; Exhibit HQI0160_P Witness statement of Dr Annaliese van Diemen, 18 [83].
- 441 Ibid.
- 442 Transcript of day 18 hearing 16 September 2020, 1535.
- 443 Transcript of day 16 hearing 11 September 2020, 1308 and 1328; Exhibit HQI0161_RP Annexures to witness statement of Dr Annaliese van Diemen, DHS.5000.0053.6652.
- 444 Exhibit HQI0135_RP Witness statement of Ms Merrin Bamert, 24 [80(a)].
- 445 Exhibit HQI0116_RP First witness statement of Dr Euan Wallace, 11 [39(d)].
- 446 Exhibit HQI0256_RP Documents referred to in affidavit of Mr Jason Helps, DHS.0001.0131.0073.
- 447 Ibid.
- 448 Transcript of day 19 hearing 17 September 2020, 1603.
- 449 HQI0161(1)_RP Annexures to witness statement of Dr Annaliese van Diemen, DHS.5000.0053.6653; Transcript of day 18 hearing 16 September 2020, 1530.
- 450 Exhibit HQI0255_RP Affidavit of Mr Jason Helps, 8 [30].
- 451 Submission 03 Department of Health and Human Services, 19 [104].
- 452 Exhibit HQI0135_RP Witness statement of Merrin Bamert, 23 [74].
- 453 Transcript of day 18 hearing 16 September 2020, 1533.
- 454 Submission 03 Department of Health and Human Services, 23 [123].
- 455 Transcript of day 19 hearing 17 September 2020, 1596.
- 456 Ibid.
- 457 Ibid.
- 458 Ibid.
- 459 Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 27 [55].
- 460 Ibid 27 [56].
- 461 Transcript of day 16 hearing 11 September 2020, 1286–1287.
- 462 Ibid.
- 463 Ibid 1287.
- 464 Exhibit HQI0009_RP Witness statement of ‘Nurse Jen’, 17 [143].
- 465 Transcript of day 6 hearing 20 August 2020, 264–265.
- 466 Ibid 264; Exhibit HQI0023_P Witness statement of Mr Luke Ashford, 1 [5].
- 467 Transcript of day 6 hearing 20 August 2020, 263–265.
- 468 Ibid 265.
- 469 Ibid 267.
- 470 Ibid 268.
- 471 Transcript of day 13 hearing 4 September 2020, 898.
- 472 Ibid 915.
- 473 Ibid 902.

- 474 Transcript of day 6 hearing 20 August 2020, 270.
- 475 Transcript of day 13 hearing 4 September 2020, 915.
- 476 Ibid 920–921.
- 477 Ibid 923–924.
- 478 Transcript of day 6 hearing 20 August 2020, 298.
- 479 Transcript of day 7 hearing 24 August 2020, 350.
- 480 Transcript of day 11 hearing 2 September 2020, 795.
- 481 Transcript of day 12 hearing 3 September 2020, 821.
- 482 Ibid 863.
- 483 Ibid.
- 484 Ibid.
- 485 Transcript of day 11 hearing 2 September 2020, 743–744.
- 486 Transcript of day 13 hearing 4 September 2020, 964–965.
- 487 Transcript of day 15 hearing 10 September 2020, 1188.
- 488 Ibid.
- 489 Exhibit HQI0162_P Witness statement of Ms Andrea Spiteri, 25 [109].
- 490 Ibid.
- 491 See Recommendations 15 and 16.
- 492 See Recommendations 17 and 18.
- 493 See Recommendations 27 and 28.
- 494 Exhibit HQI0160_P Witness statement of Dr Annaliese van Diemen, 32 [147].
- 495 Ibid.
- 496 Ibid 32 [148].
- 497 Exhibit HQI0164_RP Witness statement of Mr Jason Helps, 21 [80].
- 498 See Recommendation 65.
- 499 Exhibit HQI0164_RP Witness statement of Mr Jason Helps, 21 [80].
- 500 See Recommendation 63.
- 501 Exhibit HQI0151_P Witness statement of Ms Jacinda de Witts, 8 [27].
- 502 Ibid 8–9 [28].
- 503 Exhibit HQI0130_RP Witness statement of Ms Pam Williams, 11–16 [26]–[39]; Exhibit HQI0113_P Witness statement of Dr Finn Romanes, 4–5 [19]–[21].
- 504 Exhibit HQI0152_RP Annexures to witness statement of Ms Jacinda De Witts, DHS.0001.0015.0323.
- 505 Exhibit HQI0033_RP Annexures to witness statement of Ms Claire Febey, DJP:102.008.3855.
- 506 Exhibit HQI0152_RP Annexures to witness statement of Ms Jacinda De Witts, DHS.5000.0023.0395.
- 507 Ibid DHS.5000.0069.8348–8353.
- 508 Transcript of day 18 hearing 16 September 2020, 1455–1456.
- 509 Ibid 1534–1536.
- 510 Exhibit HQI0135_RP Witness statement of Ms Merrin Bamert, 24 [80].
- 511 Ibid.
- 512 Exhibit HQI0130_RP Witness Statement of Ms Pam Williams, 24 [51].
- 513 Exhibit HQI0186_RP First witness statement of Ms Kym Peake, 2–3 [8], [12].
- 514 Transcript of day 22 hearing 22 September 2020, 1909.
- 515 Ibid; Transcript of day 23 hearing 23 September 2020, 1966.
- 516 Transcript of day 24 hearing 24 September 2020, 2065.
- 517 Ibid 2065–2066.
- 518 Ibid 2071; Exhibit HQI0211_RP First witness statement of the Hon. Jenny Mikakos, former MP, 6 [29].
- 519 Transcript of day 24 hearing 24 September 2020, 2063.
- 520 Ibid 2055, 2057.
- 521 Ibid 2079.
- 522 Exhibit HQI0117_RP Annexures to first witness statement of Prof. Euan Wallace AM, DHS.0001.0002.0058, DHS.0001.0002.0032.
- 523 Transcript of day 25 hearing 25 September 2020, 2138.
- 524 Ibid 2139.
- 525 Ibid 2138.
- 526 Ibid 2139.
- 527 Submission 03 Department of Health and Human Services, 1 [3(e)].
- 528 Transcript of day 24 hearing 24 September 2020, 2079; Transcript of day 25 hearing 25 September 2020, 2151.
- 529 Exhibit HQI0180_RP Annexures to second witness statement of Mr Christopher Eccles, DPC.0014.0001.0004.
- 530 Exhibit HQI0179_RP Second witness statement of Mr Christopher Eccles, 4 [19].

- 531 Exhibit HQI0180_RP Annexures to second witness statement of Mr Christopher Eccles, DPC.0014.0001.0004.
- 532 Ibid.
- 533 Transcript of day 21 hearing 21 September 2020, 1773.
- 534 Submission 05 Department of Premier and Cabinet, 1 [2]–[3].
- 535 Transcript of day 23 hearing 23 September 2020, 1928.
- 536 Ibid 1929.
- 537 Ibid 1930.
- 538 Ibid 1931.
- 539 By letter dated 9 October 2020 from the Department of Premier and Cabinet; Board of Inquiry into the COVID-19 Hotel Quarantine Program (Interim Report, 6 November 2020) 68 [22] <<https://www.quarantineinquiry.vic.gov.au/reports>>.
- 540 Exhibit HQI1064_RP Witness statement of Mr Jason Helps, 10 [41].
- 541 Ibid 11 [41].
- 542 Exhibit HQI0162_P Witness statement of Ms Andrea Spiteri, 27 [118]; Exhibit HQI0164_RP Witness statement of Mr Jason Helps, 32 [153].



COVID-19
Hotel Quarantine Inquiry

COVID-19
Hotel Quarantine Inquiry
Interim Report and Recommendations

WWW.QUARANTINEINQUIRY.VIC.GOV.AU