

National Review of Hotel Quarantine



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Executive Summary

Australia implemented international border restrictions early in the course of the pandemic in order to prevent the spread of COVID-19. From 28 March 2020 all returning travelers have been required to undertake 14 days of quarantine in a designated facility. Since then, some 130,000 international and domestic travelers have been quarantined slowing the spread of COVID-19 in Australia.

The review has examined quarantine systems and processes in all States and Territories except Victoria, met with relevant agencies and reviewed hotel quarantine arrangements and witnessed passenger arrivals. A model of good practice in an end to end quarantine system, together with the role of coordination of decision making, risk mitigation, community safety and patient care has been described.

Hotel quarantine is difficult to endure, particularly for vulnerable people. It is an expensive resource and requires a highly specialised workforce to support the system including clinical, welfare and security services in order to mitigate risk and discharge duty of care obligations. Infection prevention and control processes need to be tightly managed. Clear communication and decision making across agencies must be defined - including clear lines of accountability and risk ownership. Clinical and mental health support needs to be integrated within the system and should not rely on guests needing to reach out. Guests also need access to clear communication channels before they travel and timely review and appeals mechanisms.

States and Territories can improve hotel quarantine practices by adopting best practice. End to end assurance is necessary to ensure standards are maintained. With six months of quarantine experience and the likelihood that hotel quarantine will remain in place for some time, Australia's one size fits all approach should be reconsidered to take account of greater knowledge of the virus, different prevalence in countries of origin of travelers, an understanding of how to incorporate risk-based approaches in system design and different models of quarantine made possible by new testing and monitoring arrangements. This will be essential to place quarantining arrangements on a more sustainable footing into the medium term.

This is important as pressure to increase travel to and from Australia is growing. Existing models of quarantine are unlikely to be able to expand significantly above current levels and new approaches that manage risk are needed. An ability to add scale through surge capacity should be considered.

In this context the review recommends:

1. States and Territories should embed end-to-end assurance mechanisms and look to continuously improve hotel quarantine to ensure that it is delivered consistent with good practice.
2. Information on the quarantine system should be easy to access by travelers in order to ensure their understanding of quarantine and to better psychologically prepare them for the experience. This should be provided across relevant Commonwealth/State and Territory websites.
3. People in quarantine should have access to timely decision making and review processes, and complaints mechanisms including pathways for escalation.

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4. Options for new models of quarantine should be developed for consideration by National Cabinet including a risk assessment of these options and an analysis of traveler suitability.
 5. National Cabinet should consider exempting low risk cohorts, such as travelers from New Zealand, from mandatory quarantine.
 6. The Australian Government should consider a national facility for quarantine to be used for emergency situations, emergency evacuations or urgent scalability.

Introduction

In December 2019, China reported cases of a viral pneumonia caused by a previously unknown pathogen. The pathogen was identified as a novel (new) coronavirus (recently named severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)), which is closely related genetically to the virus that caused the 2003 outbreak of SARS. SARS-CoV-2 causes the illness now known as Coronavirus disease 2019 (COVID-19).¹

After diagnoses of the initial cases the virus spread quickly throughout the world and on 30 January 2020 the World Health Organisation declared the outbreak of COVID-19 as a Public Health Emergency of International Concern (PHEIC).

Public health authorities globally began to implement a range of non-pharmaceutical interventions (NPIs) in order to protect the public and slow the spread of the virus. Pending better understanding of the ecology of the virus, these measures included social distancing, improved hand hygiene, temperature checking, mask wearing mandates, school closures, limiting gatherings and isolation of infected patients.

The first case of COVID-19 was recorded in Australia on 25 January 2020². By 1 February 2020, 12 cases had been confirmed domestically and by late March there were approximately 4,000³ confirmed cases in Australia.⁴

In the absence of effective treatments and/or vaccines, slowing the spread of the virus was widely agreed as crucial in the effort to limit disease and deaths, flatten the epidemiological curve and ensure limited and critical resources such as intensive care were readily available to patients who required it.

Countries such as Australia and New Zealand implemented border restrictions together with 14 days quarantine in order to prevent spread of the virus.

The increase in cases between February and March was an important consideration in the decision to implement hotel quarantine and part of efforts to slow the passage of the virus into Australia and through the community.

All States and Territories have experienced COVID-19 cases, with some jurisdictions experiencing higher numbers and more community based transmission. As at 11 September 26,565 cases of COVID-19 have been reported in Australia, including 797 deaths, and 23,211 have been reported as recovered from COVID-19.⁵

¹ <https://www.who.int/news-room/detail/29-06-2020-covidtimeline>

² Moloney.K, Moloney. S (2020) 'Australian Quarantine Policy: From Centralization to Coordination with Mid-Pandemic COVID-19 Shifts' Public Administration Review, 80:4, 671–682. DOI: 10.1111/puar.13224.

³ 29 March – 4,159 cases and 16 deaths

⁴https://www1.health.gov.au/internet/main/publishing.nsf/Content/novel_coronavirus_2019_ncov_weekly_epidemiology_reports_australia_2020.htm

⁵ <https://www.health.gov.au/resources/publications/coronavirus-covid-19-at-a-glance-11-september-2020>

Quarantine in Australia

Quarantining people who may have come into contact with an infectious pathogen is not new. During the 14th century ships arriving in Venice from infected ports were required to remain at anchor for 40 days before landing⁶.

Last century during the 1918 Spanish flu, 1957–58 influenza pandemic and the 1968 flu pandemic, several countries implemented quarantine measures to control the spread of the disease⁷⁸.

In 2003 during the SARS epidemic, quarantine and temperature checkpoints were used extensively, while moving infected patients to isolation wards and home-based self-quarantine was the main way the Western African Ebola virus epidemic was ended in 2016⁹.

Australia has an intermittent history of human quarantine. Human quarantine measures were enacted in response to smallpox (1913) and to the Spanish flu (1918)¹⁰ and maritime arrivals were directed to quarantine as needed at dedicated quarantine stations. Australia's early quarantine policy largely rested on its geography as an island state, in which being an 'island' enabled the regulation of disease importation. In Australia this has been significant for the health of humans, animals and agriculture.

Implementing quarantine for COVID-19

The Australian Government declared a human biosecurity emergency (18 March 2020), via the Biosecurity (Human Biosecurity Emergency) (Human Coronavirus with Pandemic Potential) Declaration 2020, made pursuant to section 475 of the Biosecurity Act 2015. On 27 March 2020, the Australian Government announced that as of 28 March 2020 all incoming travelers were required to undertake a 14 day supervised quarantine period in a designated hotel or accommodation facility at their port of entry.

States and Territories enacted complementary legislation/declarations and set up hotel quarantine arrangements across Australia. Each State and Territory adopted an approach consistent with its administrative, policing and health arrangements and geography, including the location of entry ports.

States and Territories were required to establish hotel quarantine across Australia at short notice and scale up services more broadly in response to an unprecedented public health emergency. All arriving passengers have been quarantined since the day after the Australian Government's

⁶<https://www.cdc.gov/quarantine/historyquarantine.html#:~:text=The%20practice%20of%20quarantine%2C%20as%20we%20know%20it%2C,Italian%20words%20quaranta%20giorni%20which%20mean%2040%20days.>

⁷ <https://www.parliament.vic.gov.au/publications/research-papers/download/36-research-papers/13957-epidemics-and-pandemics-in-victoria-historical-perspectives>

⁸Tognotti, E. (2013). Lessons from the History of Quarantine, from Plague to Influenza A. *Emerging Infectious Diseases*, 19(2), 254-259. <https://dx.doi.org/10.3201/eid1902.120312>.

⁹<https://apps.who.int/ebola/current-situation/ebola-situation-report-16-march-2016>

¹⁰ Moloney, K, Moloney, S (2020) 'Australian Quarantine Policy: From Centralization to Coordination with Mid-Pandemic COVID-19 Shifts' *Public Administration Review*, 80:4, 671–682. DOI: 10.1111/puar.13224.

announcement and these hotel quarantine arrangements have undoubtedly slowed the passage of COVID-19 through the Australian community.

Until such time as a safe and accessible vaccine is available or other therapeutic and pharmaceutical responses to COVID-19 are developed, access to quarantine remains a necessary response to COVID-19 for public health protection.

This type of suppression measure has been effective and has saved lives but the Hotel Quarantine System is vulnerable to breaches and these are hard to eliminate. It is also an expensive resource and comes at a high cost to individual, social and economic wellbeing.

The Review

On 10 July 2020 the Prime Minister announced that the National Cabinet had agreed to a national review of hotel quarantine. The Prime Minister's announcement, including the Terms of Reference for the review, are at [Appendix 1](#). On 16 July the review wrote to each State and Territory seeking existing frameworks, policies, and procedures governing hotel quarantine. During July, August and September additional data and information requests were made to States and Territories, in parallel to a number of site visits.

With six months of quarantine experience the design of the Hotel Quarantine System can be informed by improved knowledge about the virus, an understanding of how to incorporate risk based approaches in system design, and wherever possible, standards improved through adoption of best practice.

The review has not audited every detail of hotel quarantine nor every hotel or facility used across the country, rather the review has examined hotel quarantine management, structures and operations and has had the opportunity to compare systems in the States and Territories, and identify areas of good practice in order to identify how the Hotel Quarantine System can be put on a more sustainable footing into the medium term.

Consistent with the need to improve performance the review has provided contemporaneous feedback to jurisdictions to enable ongoing improvement.

As it is likely that restrictions on movement of some people will continue for some time it is also important that the experience of people who enter quarantine, their health and welfare, is reviewed. This includes psychological wellbeing and preparedness in order to ensure the experience of quarantine is as positive as possible.

The Victorian arrangements were not reviewed as a separate inquiry is being conducted by the Hon. Jennifer Coate AO. Where the report makes references to 'jurisdictions' or 'States' Victoria is explicitly excluded.

Quarantine statistics

There is no single source of complete data on hotel quarantine. As a consequence the review used the national and State/Territory data sources available to build a comprehensive national view and noted, where relevant, any apparent differences in definitions.

Integrated data within many jurisdictions is also an issue. The absence of a single view of guests is an impediment to good management of the quarantine journey and can be the source of preventable errors in follow up, testing, and guest experience. Many jurisdictions are moving to resolve this and this will assist with preventing avoidable errors.

Quarantine statistics provided to the review and retrieved from open source information are provided at [Attachment A](#).

Throughput

The distribution of travelers across the Hotel Quarantine System is, in part, driven by typical travel pathways into Australia but has also been affected by the implementation of international flight caps into all jurisdictions as well as internal border restrictions and domestic quarantine. It should also be noted that some capital cities are not receiving regular international commercial flights due to COVID-19 and others are not international ports.

As at 28 August 2020, some 130,000 travelers have undertaken hotel quarantine comprising approximately 96,000 international and 34,000 domestic travelers. NSW has received 51,660 travelers into quarantine; however, only six percent have been domestic quarantine, while Queensland has received approximately 22,026 travelers into quarantine, of which 34 percent have been domestic quarantine. In the other States receiving international arrivals, domestic quarantine rates range between five and 16 percent. Smaller jurisdictions like Tasmania and the ACT, which are not international ports or receiving regular international flights are not comparable arrangements but are quarantining domestic travelers at a rate of 77 percent and 99 percent, respectively¹¹.

Nationally, domestic quarantine equates to approximately 26 percent of the total number of quarantined travelers between March and 28 August 2020.

Positivity

Despite the significant number of travelers quarantined in Australia since March, the Hotel Quarantine System has low positivity rates.

Since implementation of mandatory hotel quarantine, 851 travelers have been diagnosed with COVID-19 during their quarantine period; a positivity rate of 0.66 percent. In the two weeks to 30 August 2020 this rate was as low as 0.30 percent, based on 22 diagnoses of COVID-19 from in excess of 6,500 international travelers.¹²

¹¹ This includes home quarantine in the ACT

¹² All figures quoted are based on the review's calculations from open source material and information provided to the review by States and Territories

Point of Origin

Most current passenger arrivals into Australia are on flights from the Middle East, New Zealand, Singapore and the United States. Each of these countries has different rates of COVID-19 transmission and have adopted different responses to the pandemic.

Singapore and New Zealand have targeted largely successful minimisation or suppression strategies and adopted quarantine arrangements early in the pandemic ([Attachment B](#)). China, Hong Kong, Taiwan and Canada, among others, have also implemented similar quarantine arrangements.

Figure 1 details passenger arrival data for the two week period of 14 to 28 August¹³, in which passengers from New Zealand and Singapore accounted for 14 percent and 12 percent, respectively, of all international passengers into Australia. New Zealand and Singapore, among others, have low infectivity rates of COVID-19 cases per one million of the population.¹⁴

Countries with low infectivity rates are sometimes referred to as low prevalence settings. Arguably arrivals from these destinations, particularly those who can demonstrate they have been in the country for 14 days continuously prior to arrival in Australia pose a very low level of risk for importation of the virus.

¹³ Based on data from the Australian Border Force

¹⁴ Based on data from the World Health Organisation

Figure 1 - International Arrivals - Australia

| Flight Point of Origin ¹⁵ | Total PAX coming into AUS 14-28 August | % Incoming PAX | Total crew PAX | Total transit PAX | COVID-19 cases/million ¹⁶ [AUS=1,060] |
|--------------------------------------|--|----------------|----------------|-------------------|---|
| TOTAL | 13,089 | | 4,808 | 198 | |
| Unknown | 2,826 | 23% | 953 | 17 | - |
| Qatar | 2,418 | 19% | 811 | 92 | 43,436 |
| New Zealand | 1,310 | 14% | 156 | 4 | 306 |
| Singapore | 1,386 | 12% | 400 | 13 | 9,863 |
| United Arab Emirates | 1,290 | 8% | 581 | 22 | 9,248 |
| USA | 843 | 7% | 283 | 0 | 21,175 |
| China | 984 | 4% | 688 | 4 | 62 |
| Papua Nui Guini | 174 | 2% | 5 | 20 | 60 |
| India | 165 | 2% | 32 | 0 | 4,401 |
| Hong Kong ¹⁷ | 207 | 1.4% | 93 | 0 | Not recognised |
| Indonesia | 188 | 1.2% | 67 | 20 | 1,006 |
| Malaysia | 274 | 1.1% | 182 | 1 | 337 |
| Taiwan ¹⁸ | 204 | 0.8% | 137 | 2 | Not recognised |
| Thailand | 108 | 0.8% | 47 | 0 | 51 |
| Nauru | 51 | 0.6% | 1 | 0 | 0 |
| Philippines | 87 | 0.6% | 40 | 0 | 2,776 |
| Republic of Korea | 84 | 0.5% | 47 | 0 | 0 |
| Sri Lanka | 98 | 0.5% | 61 | 0 | 157 |
| Timor Leste | 34 | 0.4% | 0 | 0 | 20 |
| New Caledonia | 41 | 0.3% | 13 | 0 | 95 |
| Japan | 91 | 0.3% | 66 | 0 | 649 |
| Mauritius | 35 | 0.3% | 10 | 0 | 289 |
| Kiribati | 20 | 0.2% | 1 | 3 | 0 |
| Solomon Islands | 29 | 0.2% | 15 | 0 | 0 |
| Fiji | 43 | 0.2% | 30 | 0 | 36 |
| Brunei | 32 | 0.1% | 23 | | 334 |
| Vietnam | 32 | 0.0% | 31 | 0 | 11 |
| Azerbaijan | 7 | 0.0% | 7 | | 3,947 |
| Chile | 14 | 0.0% | 14 | 0 | 23,954 |
| Columbia | 7 | 0.0% | 7 | | 15,841 |
| Micronesia | 7 | 0.0% | 7 | 0 | 0 |

¹⁵ The review could not ascertain whether these 'point of origin' were preceded by a connecting flight from another country/region, as such the point of origin or may be the point of origin nominated by passengers on their incoming passenger declaration as opposed to the original departure point.

¹⁶ <https://covid19.who.int/>

¹⁷ Hong Kong is not recognised as a member state of the World Health Organisation. For data reporting purposes it is considered a part of the People's Republic of China

¹⁸ Taiwan is not recognised as a member state of the World Health Organisation. For data reporting purposes it is considered a part of the People's Republic of China.

Operation of the Quarantine System

The Hotel Quarantine System relies on complex logistical arrangements designed to ensure infection control and the movement, management and care for guests with their eventual release, infection free, into the wider community. This requires clear lines of authority, management and accountability. These were evident in all jurisdictions reviewed. In many States an emergency management framework has been deployed. Detailed State and Territory arrangements are outlined at [Attachment C](#).

The quarantine journey

To understand the operation of the quarantine system it is important to understand the traveler's experience. This commences before the traveler boards their flight.

While some travelers may have accessed information about the requirement to enter mandatory quarantine through government websites, social media or through family and friends, people entering quarantine may also only first encounter the quarantine process in flight or during the disembarkation process. This may mean a traveler is uncertain or unprepared for quarantine. After landing, flights are boarded by Human Biosecurity Officer/s and the Australian Border Force which deliver on-board briefings about quarantine requirements, immigration, customs and biosecurity clearances, and the airport transit process.

After disembarking, travelers pass through the various commonwealth clearance processes and undergo health screening by border nurses. The extent of health screening varies across jurisdictions; in some it is limited to a temperature and symptom check for COVID-19, while others undertake a more comprehensive screening to identify COVID-19 symptoms as well as other primary, acute or mental health issues. In scenarios where the more complete screening occurs it typically informs placement and the case management requirements for those travelers during quarantine. Transfer to hospital from the airport by patient transport services or ambulance for symptomatic cases is common across jurisdictions.

In some States, as required by legislation, travelers are issued with a quarantine notice around this time. The quarantine notice typically references the authorising legislation, how quarantine will occur and is provided in an easily understood, simple format.

After screening travelers are marshalled through baggage collection into loading zones for transport to hotels. Some jurisdictions undertake this function within the security controlled precinct (or airside¹⁹), which limits the risk of interaction with other people in the airport, while some use the usual arrivals passage through the airport to the landside zone. Buses are assembled in preparation for travelers. Travelers are loaded onto buses, which are usually limited to approximately 50 percent

¹⁹ Section 31 Aviation Transport Security Act 2005 (Cwth)

capacity, with the assistance of local police, ADF, contracted transport services or a combination. In most jurisdictions buses are sent to accommodation as they are filled.

If a traveler is identified as unwell while at the airport in nearly all jurisdictions this person will be transported to hospital or a dedicated health facility.

Oversight of accommodation and service delivery in the Hotel Quarantine System varies across jurisdictions. Police managed hotels and those managed by health services predominate. In some cases dedicated hotels are provided for those with COVID-19 and other complex health or identified vulnerabilities. The latter operate as hospital wards staffed by health practitioners while police and/or security largely provide perimeter security. In police managed hotels, police control the environment and health services provide clinical overlay. A smaller number are managed by welfare departments. In some states ADF personnel assist with cordon security, most notably in hotels where the physical layout of the premises requires multiple guard points to secure all exits.

On arrival at the hotel, travelers are offloaded from buses and enter the hotel foyer for the check-in process. In most instances this is a staggered approach, allowing small groups into the foyer at any one time. Hotels have usually received flight or passenger manifests from an agency in the airport environment, which assists with capturing family groups or other accommodation needs prior to the arrival of travelers in the hotel foyer. This is done to assist with room allocations and expedite the check-in process thus limiting the time spent in the foyer by potentially COVID-19 positive people.

Once checked in, travelers are escorted to their hotel room. The process for baggage delivery varies slightly across jurisdictions and is dependent on the service provider undertaking this role in each State and Territory. For example, in the larger jurisdictions these services are undertaken by airport ground crew operators, while smaller jurisdictions have made other service arrangements, using local public transport or public service officials to facilitate. ADF assist in some states.

Having commenced their quarantine period, travelers are contacted by health and support services to determine their health and wellbeing needs during quarantine. The assessments undertaken at this time may dictate the type/s of treatment, support and outreach provided. To this end, some jurisdictions undertake a comprehensive health screening early in the process, including a primary health assessment in the first 24 hours complemented by a mental health assessment, as well as outreach for other vulnerabilities, wellbeing, and/or addictions. Other jurisdictions undertake this process on an ad-hoc or as needed basis, or around day three of quarantine. In the latter there is also some reliance on self-reporting of health and wellbeing issues by travelers throughout their quarantine period.

In many jurisdictions the hotel staff will provide some level of structured entertainment for guests.

Access to fresh air and exercise varies across jurisdictions reviewed. Where this is available and can be delivered with appropriate infection control this contributes significantly to wellbeing.

For some people in quarantine their reasons for traveling to Australia are to visit sick or dying family members or to attend a funeral. Exemptions for compassionate reasons vary significantly in terms of the requests for escorted visits while in quarantine.

During the 14 day quarantine period, travelers are tested for COVID-19 irrespective of whether they are symptomatic, at approximately days two and 11 of quarantine. This is consistent with the AHPPC guidelines. In some jurisdictions a positive result will result in a change of accommodation in the

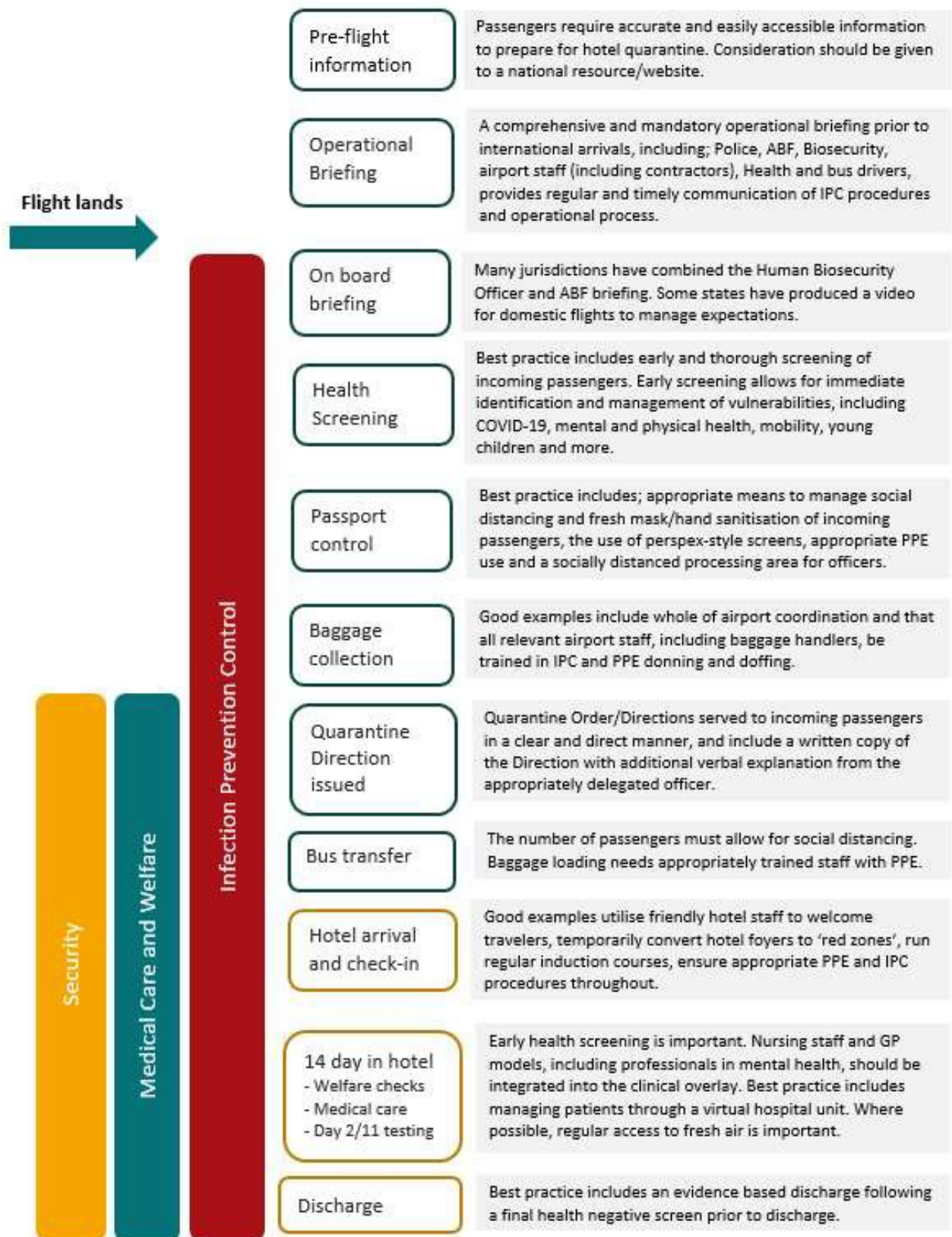
Hotel Quarantine System, for others it will result in transfer to hospital and for others it has no practical effect.

Compliance with testing requirements is very high as failure can result in an extended stay in quarantine.

At the end of the 14 day period and in receipt of a negative COVID-19 test result travelers are discharged from the hotel. In some cases travelers are issued a statement or letter acknowledging their completed quarantine and negative test results.

Different operational practices throughout the quarantine journey are largely informed by different risk tolerances within jurisdictions; however, the process detailed at Figure 2 outlines the typical hotel quarantine journey in States and Territories.

Figure 2 – Typical State/Territory Quarantine Journey



Legal basis for quarantine and exemptions

Travelers can be quarantined under either Commonwealth or State/Territory legislation.

The Commonwealth Constitution contains only one specific power which directly relates to public health,²⁰ the power to make laws in relation to quarantine, which at the Commonwealth level are typically enacted through the Biosecurity Act 2015 (the Act). The quarantine power may be exercised concurrently with the States and Territories.

Under the Act, the Commonwealth Chief Medical Officer may declare a human health response zone and may impose on individuals a human biosecurity control order for the purpose of managing risks to human health, such as requiring people to be quarantined²¹.

States and Territories have a broad range of public health and emergency response powers available under public and emergency legislation for responding to public health emergencies like COVID-19. The various orders, instruments or directions (subordinate law) enacted by States and Territories prescribe the core requirement for various categories of people to be held in hotel quarantine, and the requirements imposed on them while they are in quarantine. The details of which can be found in [Attachments C and D](#).

Australia quarantines people who may have or are confirmed to have come into contact with COVID-19 through three means; hotel quarantine, quarantine or isolation at home, and admission to health facilities. State and Territory legislation also provides for exemptions from quarantine either on an automatic basis, for example flight and maritime crew or essential and highly skilled workers, or on application for individual circumstances, such as for compassionate reasons or health concerns. States and Territories have conferred the discretion on their Chief Health Officers, Police Commissioners or the relevant Minister to grant these exemptions, which tend to include:

- Certain essential travelers (such as law enforcement and health professionals, border communities, government and security personnel)
- Consular staff, in keeping with requirements to preserve diplomats freedom of movement and travel, and protection from detention, under the Vienna Convention on Diplomatic Relations 1961

²⁰ The Commonwealth also has powers for various medical benefits. The Commonwealth may also have recourse to other constitutional heads of powers (e.g. in relation to external affairs and immigration and emigration) to achieve public health.

²¹ On 21 January 2020, after consultation with the Chief Health Officer for each State and Territory and the Director of Biosecurity, the federal Director of Human Biosecurity (aka the Chief Medical Officer) formally declared COVID-19 as a 'listed human disease' under the Biosecurity Act 2015.

On 3 February 2020 human health response zones were declared under Commonwealth legislation the Director of Human Biosecurity made two determinations deeming the Royal Australian Air Force Base Learmonth in Western Australia, and the North West Point Immigration Detention Centre in Christmas Island, as human health response zones restricting the movement of people in and out of those areas to prevent the spread of COVID-19.

On 7 February 2020 the Howard Spring Accommodation Village in the Northern Territory was also listed as a human health response zone with the same conditions of entry and exit. These determinations were made in consultation with the relevant Chief Health Officer (however described) for the State or Territory in which the human health response zone were located.

-
- Border communities (in the case of quarantine requirements being imposed due to internal border restrictions)
 - Unaccompanied minors
 - In some cases, where people have already undertaken 14-days quarantine in another jurisdiction

The subordinate law put in place in each State and Territory is not identical as it has been made under either public health or emergency management legislation in the relevant jurisdiction.

Similarly the process for applying for exemptions varies significantly. Information about criteria, the application process including evidentiary requirements, timeframes and appeal mechanisms were often unclear and/or hard to find. This causes considerable stress to potential applicants and should be a focus for improvement. Publicly available clear criteria, application and appeal processes would assist travelers.

Types of quarantine accommodation

Quarantine can be undertaken in any place where the effective isolation of a person can be achieved. The majority of arrivals into Australia have been quarantined in hotels (this includes apartment hotels); however, both the ACT and the NT have used alternative approaches.

In the NT quarantine is undertaken at the Howard Springs Accommodation Village (Howard Springs), a former 3,000 bed mining camp located near Darwin's Central Business District (CBD). It is a unique facility.

Unlike hotels, where each person is isolated in their room, Howard Springs' accommodation comprises single rooms which are grouped in compounds. Each room has a veranda and hence all guests have access to a shared outside space. While this requires guests to observe strict social distancing and mask wearing protocols, there were high levels of customer satisfaction.

In the ACT the majority of quarantine is undertaken in a private home with appropriate supervision. Hotel quarantine is used in the minority of cases.

Health and welfare

A clear focus on the health and welfare of guests is required in order to discharge the duty of care owed to these guests. While many arrivals may consider themselves psychologically robust and in good physical health proper screening and support should be provided.

The review has observed significant variation in the standard of screening and care. Jurisdictions should ensure that wherever possible all guests get early access to screening and ongoing support to ensure good mental and physical health.

A clinical overlay, including access to specialists and treatment, is critical to the health of guests. Levels of clinical oversight varies significantly and should be an early focus for improvement in those States not currently delivering best practice arrangements.

The role of entertainment and diversionary activities is also key. Good hotels where the guest experience and hospitality was a focus of hotel management included actively engaging with guests through initiatives such as; guest specific Facebook pages/groups, providing exercise; quizzes and other activities; age specific activities; and delivery of a structured day.

Customer feedback

The review has spoken with a number of people with experience of hotel quarantine. Feedback to the review indicates a lack of information about quarantine, specifically that participants found navigating government websites challenging and that information about hotel quarantine was more frequently sourced from family, friends and through social media. Many people reported, while challenging, the experience of quarantine was acceptable. The care provided by health and hotel staff was widely acknowledged; however, a lack of fresh air, support for mental health and the quality of hotel food also featured in feedback to the review.

Through consultation with the Australian Human Rights Commission, and the Ombudsmen (Commonwealth, and all State and Territory equivalents), the review sought details regarding formal complaints about the experience of quarantine. For these complainants the experience has not been positive.

In the period up to 28 August 2020, in the order of 90 complaints were made to the Human Rights Commission about the requirement to quarantine and/or conditions of quarantine including: lack of access to fresh air, food, quality of the accommodation, and size (especially for people with psychosocial disabilities). For the same approximate date range advice to the review indicated 218 complaints or enquiries to Ombudsmen offices. Similar themes were evident in these complaints being: cleanliness, food, access to air and exercise; the requirement to quarantine and the costs; the exemption process; and access to medical support – including mental health support²². These are also distinct from complaints specifically made against police.

The review has not canvassed complaints made direct to State and Territory government agencies responsible for administering hotel quarantine nor the resolution process or rate. The review did, however, also engage with a range of other stakeholders, including peak advocacy groups and the business sector. Other feedback through these processes posed questions about oversight, transparency of processes, and complexity of the legal framework and the feasibility of a more coordinated approach, including centralising hotel quarantine administration in each State and Territory into a specific agency with the necessary expertise in biosecurity operations.

This feedback points to a number of areas for improvement.

Infection control and quarantine breaches

There have been widespread reports of breaches of quarantine. These include the infection of guards and escape of hotel quarantine guests.

²² These numbers do not include general enquiries or complaints made directly to the responsible government agencies nor complaints or enquiries that fall outside of the Commission or Ombudsmens' formal jurisdiction.

While the potential impact of breaches may be high the number of incidents was low in absolute and relative terms²³. The actual impact of these breaches (excluding Victoria) was also low with incidents identified early and appropriate actions taken.

The review has not examined each of these incidents in detail but rather has sought access to incident reporting (where this exists) in order to understand the system design and management issues indicated. These are reflected in the best practice section below and attached.

Infection prevention and control are fundamental to an effective quarantine system. Appropriate PPE use, training and assurance processes must be practiced throughout the quarantine journey.

The review has observed all parts of the quarantine system and has seen donning and doffing of PPE throughout the journey. Advice on opportunities to improve practices has been provided during the course of the review. Issues identified included inconsistent PPE use in airports and across agencies, opportunities to improve distancing between staff and the need to install physical barriers to provide additional protection to staff and passengers.

Clear operational instructions together with the provision of training, including regular refresher courses and auditing enables consistent application of good infection control practices. This has been implemented successfully in a number of jurisdictions across the full range of staff, including police, hotel and transport staff, private security, and health and welfare professionals.

While the system is managed to limit these incidents some errors are inevitable. The nature and scale of breaches is, however, important as a measure of system performance and should be monitored to identify opportunities for improvement. Jurisdictions all provided evidence which demonstrated they were using this information to improve hotel quarantine.

Quarantine constitutes a first line of defence in preventing the importation of COVID-19. While the quarantine system should be managed to limit breaches the robustness of elements of the second line of defence (testing, contact tracing in the community) are also crucial as it will not be possible to manage a quarantine system that is completely error free.

Breaches in the Victorian system have not been considered as these are being considered by the Hon. Jennifer Coate AO as part of her inquiry. As previously noted, references to 'jurisdictions' or 'States' does not include Victoria.

Changing needs of people entering quarantine

The review has heard that the needs of people in quarantine has changed since the system was inaugurated in March 2020. Early returning cohorts were reported as having a lower level of needs in terms of their health and wellbeing, were largely returning residents and did not require the same level of support as more recent arrivals.

While detailed demographic information was not available to the review to validate this impressionistic reporting, jurisdictions indicated that the level of health, social and other supports

²³ Based on material provided to the review and consultation with States and Territories. There is no centralised data source for this information.

needed by more recent arrivals including assistance with adjustment into the community through access to housing was also significant. In this respect there are differences between the people entering domestic versus international quarantine.

Risk settings

The threat to Australia from COVID-19 was recognised by public health authorities early in the pandemic and steps were taken to reduce/eliminate risks where ever possible. The Australian health system and public had no experience with a pandemic of this scale and severity and systems were severely tested in the early days with rapid decision making and implementation necessary to protect the community. The measures adopted were founded on solid public health knowledge and good infection control principles. This was important as knowledge of COVID-19 was in its early stages and detailed assessment of specific risks were difficult if not impossible to make.

In this context and while the review could not find any explicit consideration of formal risk settings it was clear that the risk posed by COVID-19 and the need to reduce this risk were fundamental to decision making from the outset. However, the timeframes required to set up the arrangements led to a one size fits all approach to people crossing our international (and some domestic) borders in which everyone enters mandatory 14 day quarantine unless they are exempted.

The 14-day quarantine period is based on the incubation period for COVID-19, which is widely accepted as a range of 1 – 14 days. It is estimated that fewer than 1 in 100 people who are exposed to COVID-19 will develop disease after the 14-day period.

In June 2020 the AHPPC considered the ongoing requirement to quarantine international travelers. The AHPPC considered two options; reducing the time of quarantine and combining it with home quarantine arrangements; or continuing the 14 day hotel quarantine model. The AHPPC concluded that risk of COVID-19 in travelers returning from many countries is increasing, reinforcing the importance of quarantine as a protection measure and consequently recommended that all international travelers continue to undertake 14 days quarantine in a supervised hotel²⁴.

The objective of Hotel Quarantine is to prevent the spread of the virus from any arriving traveler who is infected into the wider community. The design, management and delivery of quarantine services is therefore critical to the achievement of this objective. However, the current system does not balance or calibrate all risks nor take decisions informed by absolute or relative risk (for example, exemption categories, transit passengers, airline crew, and the impact on people in quarantine).

Approaches to balancing or managing relative risk in a measured way were only seen in respect of day release for compassionate reasons and activities such as fresh air breaks and exercise in some jurisdictions. In a number of jurisdictions travelers who arguably offered the same risk profile were treated differently based on whether they were a resident or not.

Existing approaches also do not differentiate between the risks posed by arrivals from countries where there is widespread community infection versus those where there is limited or no virus in

²⁴ <https://www.health.gov.au/news/australian-health-protection-principal-committee-ahppc-statement-on-hotel-quarantine>

the community. This means that expensive resources are used in a way that may be disproportionate to the risk posed particularly if there are alternative ways to treat or manage this risk effectively.

Where there is very high prevalence of infection in a country or region temporarily closing borders or enforcement of mandatory quarantine can be an appropriate response. Experience to date in Australia has shown that this can be effective. However, as previously noted the costs of these actions need to be properly weighed against the actual risk. In addition, no system (both for granting exemptions or managing quarantine) is foolproof and as such an effective second and third line of defence will always be necessary to respond to any quarantine breaches.

A proper assessment of second and third line defences is crucial to determining the risk capacity of the system (see below).

We now know that COVID-19 is a highly infectious pathogen predominantly spread by respiratory droplets. The most effective way to stop the spread of COVID-19 is to prevent or reduce the spread of droplets from person to person. Interventions known to be effective are; physical distancing, the use of appropriate PPE, especially facemasks and face shields in higher risk situations, hand hygiene (although this has a lower impact owing to the nature of COVID-19 transmission), keeping away from others who are sick with respiratory symptoms, isolating when feeling unwell, and isolation of confirmed infections (these observations are expanded at [Attachment E](#)).

We know that the effective application of these strategies will limit and potentially stop the spread of the virus.

At present hotel quarantine is used by most jurisdictions as the mechanism to ensure compliance with the measures noted above, that is to limit contact and hence the possible spread of the virus. However, in a number of jurisdictions arrangements such as home based quarantine (assuming this can be done safely) and the use of devices and apps are being used to ensure this compliance. These strategies are also being used effectively in a number of other countries.

A clearer focus on actual risk together with a structured approach to risk management through agreement on risk appetite (the amount of risk accepted in the management COVID-19), risk tolerance (the amount of risk we can take) and risk capacity (the amount of risk we cannot exceed) would help in creating a framework for the adoption of different approaches.

Clear guidance regarding expectations for material types of risk should be supported by qualitative and quantitative metrics and should use language that is meaningful to everyone. It should also encourage risk management and not risk aversion together with accountability and ownership of risk. If a risk moves outside the clearly expressed upper limit of appetite, then action needs to be taken immediately and relevant settings changed as appropriate.

It is timely to revisit the risk settings and thresholds about who should be undertaking hotel quarantine and examining options that do not introduce an unacceptable risk. This should include an explicit consideration of the prevalence of COVID-19 in source countries noting that an assessment should also be made of the extent and nature of testing regimes in those countries, and any evidence based risk of inflight transmission.

An evidence based approach

The use of evidence to inform the design and delivery of hotel quarantine was observed in most jurisdictions. This included in respect of infection control and the experience of people who are in quarantine, including their mental and physical health needs.

A more evidence based and nuanced approach to managing risk is now possible as there is more knowledge of the prevalence of the virus and its characteristics, more options available to effectively ensure compliance with known mitigations and there is greater public understanding of how less restrictive alternatives can be used effectively.

Continuous improvement

The first cohorts of people to be quarantined during COVID-19 were specific groups of repatriated residents (for example, from Wuhan and the Diamond Princess Cruise ship) who were able to be accommodated at dedicated facilities²⁵. These were largely organised as one off arrangements and were delivered under Commonwealth legislation. However, following the decision of National Cabinet that restrictions would be placed on all people entering Australia (excluding those with an exemption granted by an authorised state health official) State based quarantine arrangements were established rapidly.²⁶

The scale of the logistics required to accommodate all returnees in the system was considerable and officials, police forces together with deployed ADF personnel have worked well to give effect to the decision of National Cabinet.

These arrangements have continued to improve since their establishment including through lifting of the quality of hotels, attention to the quality of food and customer experience, more attention to the health needs of guests and greater attention to infection control.

Consistent with the need to improve performance the review has provided contemporaneous feedback to jurisdictions to enable ongoing improvement. Further opportunities for improvement are available to all jurisdictions (see best practice definitions at [Attachment F](#)).

²⁵ Refer to footnote 21.

²⁶ On 13 March 2020 the Council of Australian Government formed the National Cabinet, made up of the nation's first ministers (the Prime Minister, Premiers and Chief Ministers) and advised by the AHPPC, to deliver a whole-of-government response to the COVID-19 outbreak. This saw the National Partnership on COVID-19 Response and the Australian Health Sector Emergency Response Plan for Novel Coronavirus (COVID-19) being activated (also on 13 March 2020) and reaffirmed that all jurisdictions have public health responsibilities, but the primary responsibility for managing the impact of COVID-19 lies with the state and territory governments with the financial support of the Commonwealth.

System Performance – Good Practice

The review has had the opportunity to examine quarantine arrangements in most States and Territories. Many jurisdictions demonstrate a high standard and many features of good practice, including at scale, while others are implementing the minimum standards. There are, however, areas for improvement in each jurisdiction.

What does ‘good’ look like?

The review has identified a range of features that constitute good practice in hotel quarantine, many of which have been demonstrated in systems around the country. These features have been grouped under five core components: planning and preparedness; the hotel quarantine framework; procurement; the health, mental health and wellbeing of people in quarantine; and the broader customer experience.

Planning and Preparedness

Good operating systems are hallmarked by strong incident control governance and mechanisms that assist in planning and preparedness. These are underlying principles of crisis and/or emergency management functions, of which many jurisdictions are well rehearsed in.

Governance and multidisciplinary approach

Emergency management type operations provide the necessary framework for appropriate accountability and clear line of sight for operations. They are multidisciplinary but well integrated and feature open lines of communication, collective and consultative decision making that incorporates all perspectives in the command and operation chain. This approach limits opportunities for ambiguity and fractured decision making.

This aspect of quarantine arrangements is fundamental and cuts across all phases of any program (as illustrated in Figure 2) – if this element does not work well in any phase or aspect of the program, it will lead to systemic failures.

Pre-flight

The review has identified the need for better information for people entering hotel quarantine. Good practice would result in the existence of centralised information in a location that makes sense to incoming travelers, for example the landing pages of the Australia.gov.au website and State and Territory government websites. These websites require better integration.

Information should be in lay terms and ideally on landing pages. A website akin to the New Zealand Managed Isolation and Quarantine website represents good practice.

Consideration should be given to adding material to on-board videos shown to all international arrivals on commercial aircraft.

Operational briefing and airport arrival

The airport is a discrete place of work in the hotel quarantine system and requires a well-coordinated, integrated approach. In good practice operations this is demonstrated with an operational briefing prior to each flight arrival or commencement of a shift.

Sometimes referred to as a 'toolbox' or 'huddle', operational briefings bring together key agencies participating in the airport arrivals process prior to arrivals to discuss how the event will proceed, including command structures, role definition as it pertains to each agency, what to do in the event of uncertainty and reiterating the importance of appropriate regard for risk, including adherence to strong IPC practices.

Transfers

The airport arrivals process has many steps as travelers disembark the aircraft and proceed through clearances and screening. In good operations travelers are issued with a quarantine notice or similar which explains the legal basis for quarantine and provides travelers with information in a format that is easily understood.

Best practice also recognises risk and that travelers may be COVID-19 positive. The result is proper marshalling through the airport and risk mitigations, including physical barriers to protect staff, appropriate PPE and handling of luggage, distancing measures by keeping functions dispersed through the transit line, and timeliness of transfer to hotel transport. The same principles extend to the transit passengers, and the risk they may pose in airports and, where relevant, into and from hotel quarantine.

Hotel check-in

The hotel check-in the process in good practice operations is expedient, proportionate to risk and mindful of the customer experience. Good examples include a staggered but timely offloading from buses which limits the numbers of travelers in the hotel foyer at any one time. This is aided by good information sharing through the early receipt of flight manifests and other complimentary information. The latter ensures quick check-in and early allocation of appropriate accommodation.

In all components of the arrivals process best practice involves declaration of 'hot zones'. Hot zones require increased safety protocols and risk mitigations for the risk associated with travelers whose COVID-19 status is unknown. Hot zones may be spatial or determined by time but feature strong IPC practices with due regard for environmental risks. In best practice examples there were clear processes, including visual and auditory signals when the status of zones (such as hotel lobby/airport arrivals) was changing status.

Hotel Quarantine Framework

Risk strategies

All components of hotel quarantine involve risk. Environmental risks are present in all stages (arrivals, clearances and screening, the hotel) while system risks typically present when there are

failures in management, accountability and assurance structures or protocols and where risk has been inadequately considered.

In good practice operations decisions about risk are guided by an overarching risk policy statement that explicitly details the tolerance for risk in hotel quarantine. This type of risk statement is supported by risk framework documents, such as matrices and control plans that document risk ownership.

Many jurisdictions have not adequately considered and documented their approach to risk, and have mainly focussed on exemptions.

Strong end to end IPC, comprehensive IPC training, assurance processes

Good hotel quarantine practice incorporates proper IPC practice throughout the entire process and at appropriate levels for the risks associated with each environment. Standard IPC precautions include hand and respiratory hygiene, the use of appropriate PPE, safe waste management, proper/ IPC compliant linen rotation and cleaning cycles, environmental cleaning, and sterilization of patient-care equipment.

Implementing standard precautions as a first-line approach to IPC minimises the risk of transmission of infectious agents from person to person, even in high-risk situations. In good practice operations IPC practice is informed by comprehensive and regular IPC training and assurance processes, including independent audits by a team of qualified and experienced IPC practitioners and other professionals examining the entire process. This could include audits by teams from within jurisdictions auditing each other's systems.

Comprehensive IPC training is competency based and delivered through regular face to face training and demonstrations of correct PPE donning, doffing and disposal as well as environmental cleaning practices. Training and practice, however, must be reinforced through scheduled and/or random compliance checks by appropriately qualified IPC experts, coupled with treatment and rectification plans for identified issues or breaches.

In cases of significant or persistent breaches changes to staffing arrangements should occur, including termination if appropriate.

Assurance processes are a key component on continuous organisational improvement, a specific risk control in the hotel quarantine system and one of the strongest indicators of good practice.

Clinical overlay and case management/data integration

Clinical supervision and treatment for hotel quarantine guests is paramount. Clinical overlay is cognisant of the duty of care responsibilities that are inherent in the hotel quarantine system and should be applied conscious of the risks posed by failures to identify all health needs of travelers. Good practice also includes pathways for escalation and evidence of clinical governance structures. In good practice, clinical overlay demonstrates strong clinical governance structures which provides additional assurances with respect to duty of care obligations.

Clinical overlay is aided by good case management practices and data integration, which links the various records pertinent to a hotel quarantine guest's quarantine period in a manner that enables quick and fulsome access to all parties and accurately capture an individual's hotel quarantine journey.

Testing

Testing should be undertaken consistent with AHPPC guidelines, at approximately day two and 11 of quarantine, with clinical staff donned in full PPE. It should also inform hotel discharge, that is testing is part of an 'evidence based discharge' or 'criteria led discharge' in which people in quarantine need to pass two COVID tests, have a health screen, and corresponding paperwork in order to be discharged.

Exemptions and leave

Good practice as it pertains to exemptions and leave should be evidenced by clear lines of accountability and a transparent decision making framework. Decision making frameworks should document how and when decisions are made about who is exempted from quarantine, how risk has been considered and applied, and timeframes should be expedient. Applicants should have access to appeal mechanisms.

Procurement

Best practice in procurement, whether it is for hotels, medical, welfare or security services have clear oversight of contracts and an understanding of risk with explicit strategies to manage these risks.

Supervision of contracts and procuring hotels

Good practice in hotel quarantine has a strong foundation in proper government procurement processes and contractual management. Contractual management is premised on ownership of risk, who is authorised to exercise various powers and functions, and proper decision making mechanisms at all stages.

Good practice is demonstrated by documented strong administration processes and accountability structures that effectively manage external service provider contracts, from the procurement of hotels through tender or, where relevant, single select methodology, to the supervision of contracts and rectification or cessation where services are not delivered in accordance with contract provisions.

In procuring hotels, good practice informs decisions about the quality and variability of hotel venues while contracts for service provisions are determined on a merit basis after demonstration of capacity to meet contract requirements.

Quality of hotels

The quality of accommodation for hotel quarantine is important including consistency of accommodation within a jurisdiction. Travelers appear to manage expectations and understand that the quality of available accommodation is dependent on their geographical location. However, issues quickly arise when the quality of available accommodation differs markedly between hotels in the same location, such as within a central business district.

Health, mental health and wellbeing

Good systems recognise the health, social, emotional and psychological impact of quarantine on the individual and provide necessary health and wellbeing support throughout the process.

Health screening, triage and placement

Comprehensive health screening and wellbeing assessment to identify all health needs of returned travelers should occur at the commencement of hotel quarantine. During airport arrival a complete screen for COVID-19 symptoms and other vulnerabilities should occur. This should include cognitive impairment and mobility. Health screening should identify the amount of intervention and clinical input needed in order to properly manage risk and ensure proper care for each individual undertaking quarantine.

Good practice health screening is not limited to whether a traveler is symptomatic for COVID-19 rather, it includes assessments for any mobility or cognition issues, comorbidities, mental health concerns, drug and/or alcohol health issues, pregnancy including any high risk indications, or any other issue that may affect someone's capacity to undertake or manage the hotel quarantine environment. This assessment determines a traveler's placement in appropriate accommodation for the quarantine period, ideally supports segregation of COVID-19 positive and negative populations but also ensures the right services and level of engagement are evident and commensurate to a traveler's needs.

In best practice situations, health screening is aligned with clinical overlay present in the system. The availability of health services should be proportionate to the needs of the population in quarantine at any particular point in time.

Mental health

The pressures on mental health and wellbeing during hotel quarantine is arguably one of most important considerations in the hotel quarantine system, as even those who have not previously experienced mental ill health may find the experience taxing.

Good practice operations of mental health support is demonstrated by the presence of assertive mental health screening and treatment available to hotel quarantine guests, particularly with evidence of the use of validated mental health assessment tools. Further, good practice includes assertive in-reach and assessment, which is not reliant on the traveler to seek out support, in a timely manner (no later than 24 hours into quarantine).

Good practice in this respect includes screening and in-reach to identify immediate mental health and wellbeing concerns, and daily follow up with guests to identify emerging or escalating psychological distress, until guests decline further contact and/or support.

It is also clear that psychological preparedness for quarantine is material in a person's ability to cope. Provision of information prior to embarkation can assist with this.

Addictions, disability and other vulnerable groups

These types of assessments extend to screening for addictions and other vulnerabilities, particularly disability and the elderly. In good practice operations, treatment plans and necessary supports for addictions is recognised and implemented early to alleviate increased anxiety associated with

withdrawal symptoms from dependency, while assessment for other vulnerabilities should result in ongoing assessment of an individual's capacity and suitability for hotel quarantine or occupational therapy, other supports and proper adjustments that are necessary. Like health screening for primary or acute issues, screening for mental health, addictions and other vulnerabilities is relevant to the level of clinical overlay in the hotel quarantine system.

Particular attention should be paid to the needs of people with disabilities to ensure appropriate assistance and that necessary adjustments are made.

Customer experience

Entertainment and community

Fourteen days in hotel quarantine system can be a difficult and taxing experience. Good practice seeks to lessen the burden by providing tools and strategies for shared experiences, ideally lessening the isolating elements of hotel quarantine. In good practice operations those tools and strategies include entertainment and community building arrangements, including exercise, craft, trivia, and facilitated conversations through online platforms. These offerings provide an opportunity for quarantined guests to engage in a 'structured day' and build routine, both of which has been shown to be effective against mental fatigue, feelings of isolation, and vulnerability.

Good practice enables individual hotels to share resources with a community of practice enabling a more consistent standard of experience for customers.

Food

Timely food options that cater to all dietary requirements and the ability for guests to receive regular food and/or grocery deliveries are also a feature of good practice in the hotel quarantine system. Deliveries should not be limited to one a day and guests should be able to receive these as requested. Good practice also provides child appropriate options and sufficient variety for children and adults.

Support for parents

Supports for parents and their children during hotel quarantine are imperative. Good practice operations evidence consideration of these cohorts and have put in place tools, strategies and counselling options to ease the pressure on parents supporting children through quarantine. This is particularly relevant for single parents and those with very young children, and ensuring there are opportunities for those parents to exercise self-care practices. This is distinct from mental health screening.

The Quarantine System going forward

‘Standing up’ capacity to accommodate the needs of thousands of returning travelers in an environment when little was known about COVID-19 and at short notice is a significant logistical achievement. Since the commencement of the Hotel Quarantine System agreed by National Cabinet on 27 March 2020, the system has accommodated some 130,000 people who have subsequently been allowed to enter the wider community following the mandated period of 14 days in quarantine. This includes 33,827 people travelling around Australia who have been subject to domestic quarantine orders²⁷.

To date hotel quarantine has proven largely effective as a first line of defence against the importation of COVID-19. In concert with a small number of countries Australia has done well in limiting the importation and domestic spread of the virus. There is now a clear difference between countries and regions in the amount of virus circulating in these communities.

Pressure to increase travel for both personal and business needs is increasing. The review has heard from a number of individuals and organisations who are being significantly impacted by their inability to organise travel to Australia. This can be expected to increase as the current limits on arrivals which are largely dictated by quarantine capacity are impacting those who wish to return to Australia and cannot. The need to import skilled labour including for agricultural and critical maintenance tasks has been highlighted as an increasing priority.

The current system has a high cost, requires highly specialised skills and impacts guests financially, emotionally and physically. While the system has largely performed well and there are ways to improve the operation of the existing system through the adoption of best practice, the need to increase the flow of travelers has been brought to the attention of the review. This is particularly important as some form of quarantine will be needed for some time.

It is likely that an effective vaccine for COVID-19 will not be available for wide adoption in the near future and effective treatments are yet to be identified. While a number of vaccine candidates are currently in phase three trials and look promising there remains a significant challenge in scaling up manufacturing and subsequent distribution. Australia has secured a number of supply agreements for candidate vaccines and is participating in the COVAX facility. Notwithstanding this the sheer scale of vaccinating vulnerable people globally will mean an effective first line of defence will need to be maintained.

In this context and some six months since the hotel quarantine system took in its first guests, it is timely to consider what the system should look like going forward, what the demands on the system will be (how much capacity is needed) and how this might be best delivered.

A number of the system settings should be reviewed as part of this consideration. With greater operational maturity, knowledge about the virus and how it is transmitted, improved contact tracing

²⁷ As at 28 August 2020 based on the review’s calculations

and access to greater testing capacity, a one size fits all model will unnecessarily restrict system capacity.

Maintaining an effective first line of defence that is both proportionate and effective using a mix of hotel and home based quarantine with the period of quarantine determined based on risk settings combined with increased testing can deliver improved capacity and better experience for travelers.

There are four overarching strategies that, if implemented, will improve quality and increase capacity in the Hotel Quarantine System:

- Improve system performance and the experience for people in hotel quarantine
- Develop and implement a number of quarantine options for the allocation of arrivals based on an assessment of risk
- Exclude arrivals from very low risk jurisdictions from the need to quarantine
- Consider a national quarantine facility to provide surge capacity

Improve system performance and guest experience

System performance can be improved through the implementation of a more standardised approach to hotel quarantine. The review's good practice guide has been prepared with this in mind and provide a template for States and Territories to make improvements.

States and Territories should now consider their hotel quarantine operations in line with the features of good practice and make adjustments where necessary to meet these baselines. Noting issues about scalability and the specialised nature of the workforce required to implement hotel quarantine, States and Territories should also investigate establishing standing arrangements with AUSMAT in the event of the need to scale up operations quickly.

System performance is also measured on how guests experience quarantine. Feedback to the review from hotel quarantine guests and through consultation with oversight agencies suggests there are several areas for improvement.

The review has been made aware of many poor experiences of hotel quarantine as they relate to cleanliness, food, access to air and exercise; the requirement to quarantine and the costs; the exemption process; and access to medical support including mental health support.

The features of good practice should also be considered as they pertain to the hotel environment, infrastructure and services provided to hotel quarantine guests.

Improving the experience of hotel quarantine by implementing the range of good practice features will ideally produce a net effect of fewer complaints and fewer mental health episodes or wellbeing issues. This net effect should provide residual capacity to better deliver core components of the Hotel Quarantine System.

New models of quarantine

The current one size fits all model of 14 days hotel based quarantine served Australia well in the early days of the pandemic. It is now possible, based on better evidence about risk, to consider additional models to augment standard approaches to hotel quarantine.

Consideration should be given to the design of options which include changes to the period of quarantine, the use of testing taking account of the availability and speed of testing together with alternative locations for quarantine and the availability of technological options for arrivals to validate their location in order to expand the range of options available and hence significantly expand quarantine capacity. The origin of travelers should be considered in deciding the appropriateness of available options.

A number of international jurisdictions have implemented changed quarantine arrangements to utilise testing before travel and on arrival, quarantine for a seven day period combined with testing thereafter, isolation in the home (if suitable) and the use of devices to monitor location, including through smartphone applications or wearable monitoring devices (on a voluntary basis). International counterparts are also gradually introducing travel corridors, green lists etc.

A risk assessment including likely compliance together with enforcement options should form part of this analysis.

It is noteworthy that Australian businesses have indicated willingness to manage quarantine arrangements for essential workers, including through the use of wearable monitoring devices for low risk travelers to ensure that businesses can continue to operate.

The experience of the ACT and a number of international jurisdictions have successfully demonstrated that different models of quarantine can be implemented effectively. As such home quarantine with appropriate checks and/or options for participants to opt in to other forms of monitoring should not be discounted.

Exempting some arrivals from quarantine requirements

A significant percentage of hotel quarantine capacity is being utilised by travelers from low prevalence settings. This includes domestic quarantine. Both cohorts arguably do not represent a high risk for importation or transmission of COVID-19.

Australian governments should contemplate a more considered approach to quarantine based on low prevalence settings and other monitoring options on the basis of risk. Excluding some travelers, such as those from New Zealand, from the Quarantine System will provide net capacity within the system with no or very little risk.

Hotel quarantine is one line of defence for limiting transmission but needs to be complemented by other, secondary defences. The risk settings informing hotel quarantine in each State and Territory will depend on the maturity of their systems to capture the rare instances in which someone who is

COVID-19 positive is not captured by quarantine, this includes the testing and contact tracing regimes in each State and Territory.

A national quarantine facility in reserve

With a large number of Australian citizens and permanent residents currently offshore, the need to significantly increase arrival numbers, including for business and agricultural purposes, and the changeability of the COVID-19 situation, consideration should also be given to the establishment and maintenance of a national facility in reserve to facilitate large scale evacuations from international ports, if or when required.

Should there be a need to scale up services significantly and at short notice as the Northern Hemisphere winter descends and people continue to arrive into Australia from this region who require hotel quarantine, it would be beneficial to consider national facility for emergency or surge situations. Changeability or localised outbreaks may also necessitate large scale evacuations from particular regions.

The Australian Government has the capability to declare a human health response zone, as seen with evacuations of early quarantine cohorts to national facilities or State/Territory facilities gazetted for this purpose, including the Learmonth RAAF base or immigration detention facilities, and the Northern Territory's Howard Springs facility.

The Howard Springs facility has the capacity to house some 3,000 people and is well suited to the provision of this reserve capacity.

Recommendations

1. States and Territories should embed end-to-end assurance mechanisms and look to continuously improve hotel quarantine to ensure that it is delivered consistent with good practice.
2. Information on the quarantine system should be easy to access by travelers in order to ensure their understanding of quarantine and to better psychologically prepare them for the experience. This should be provided across relevant Commonwealth/State and Territory websites.
3. People in quarantine should have access to timely decision making, review processes and complaints mechanisms, including pathways for escalation.
4. Options for new models of quarantine should be developed for consideration by National Cabinet including a risk assessment of these options and an analysis of traveler suitability.
5. National Cabinet should consider exempting low risk cohorts, such as travelers from New Zealand, from mandatory quarantine.
6. The Australian Government should consider the establishment a national facility for quarantine to be used for emergency situations, emergency evacuations or urgent scalability.

Glossary

AHPPC is the Australian Health Principal Protection Committee. The AHPPC is the key decision making committee for health emergencies. It is comprised of all State and Territory Chief Health Officers and is chaired by the Australian Chief Medical Officer.

Aerosols are a collection of pathogen-laden particles in air. Aerosol particles may deposit onto or be inhaled by a susceptible person.

Border nurses are nurses employed by the State or Territory authorities which are positioned at the health screening point of the arrivals process into airports.

Droplets are particles of relatively larger size (more than 5 to 10 um in size) and produced in large numbers when people cough or sneeze and can also be produced when people speak, sing or shout. They are called droplets because they “drop”. This “drop” usually occurs for most droplets in under 1m from the source.

Fomite is any inanimate object that, when contaminated with or exposed to infectious agents (such as pathogenic bacteria, viruses or fungi), can transfer disease to a new host

Isolation means separation of ill or contaminated persons or affected baggage, containers, conveyances, goods or postal parcels from others in such a manner as to prevent the spread of infection or contamination. Quarantine and isolation as terms are frequently used interchangeably.

Jurisdictions for the purpose of the review process and this report refer to NSW, QLD, WA, SA, NT, the ACT and Tas. Victoria is excluded.

PAX is the abbreviation for passengers. It is commonly used in the aviation sector.

Quarantine is the restriction of activities and/or the separation of persons who are not ill, but who may have been exposed to an infected person. Quarantine and isolation as terms are frequently used interchangeably.

SARS is the abbreviation for ‘severe acute respiratory syndrome’, a viral respiratory illness caused by a coronavirus, called SARS-associated coronavirus (SARS-CoV). Earlier SARS-CoV outbreaks are generally referred to as SARS while SARS-Cov-2 is the strain that causes COVID-19.

States and Territories for the purpose of the review and this report refer to NSW, QLD, WA, SA, Tas, and the ACT and NT, respectively. Victoria is excluded.

Attachment A – Quarantine – National Statistics

| | | | NSW | VIC | QLD | WA | SA | NT | ACT | TAS | Total |
|---|--|------------------------------|----------------|----------------|----------------|----------------|---------------|----------------|----------------|-----------------|------------------|
| Number of incoming international flights | * including charter flights, but not freight | 2 weeks: 14-28 August | 150 (46%) | 0 (0%) | 98 (30%) | 37 (11%) | 10 (3%) | 30 (9%) | 0 (0%) | 0 (0%) | 325 (100%) |
| | | 28 March to 28 August | 1663 (50%) | 340 (10%) | 714 (21%) | 336 (10%) | 36 (1%) | 263 (8%) | 3 (0%) | 0 (0%) | 3355 (100%) |
| | | | | | | | | | | | |
| Number of incoming international PAX | * excluding crew | 2 weeks: 14-28 August | 4549 (62%) | 0 (0%) | 975 (13%) | 1252 (17%) | 478 (6%) | 109 (1%) | 0 (0%) | 0 (0%) | 7363 (100%) |
| | * including exemptions + hospital transfers | 28 March to 28 August | 50657 (49%) | 21821 (21%) | 15680 (15%) | 11110 (11%) | 2472 (2%) | 1432 (1%) | 516 (0.5%) | 0 (0%) | 103688 (100%) |
| | | | | | | | | | | | |
| PAX entering quarantine 28 March to 25 August | Total PAX to quarantine (International + Domestic) | | 51660 (40%) | 21027 (16%) | 22026 (17%) | 11168 (9%) | 2913 (2%) | 13203 (10%) | 2143 (2%) | 5726 (4%) | 129866 (100%) |
| | International PAX to quarantine | | 48668 (94%) | 19898 (95%) | 14632 (66%) | 9367 (84%) | 2602 (89%) | 355 (3%) | 503 (23%) | 14 (0.2%) | 96039 (74%) |
| | Domestic PAX to quarantine | | 2992 (6%) | 1129 (5%) | 7394 (34%) | 1801 (16%) | 311 (11%) | 12848 (97%) | 1640^ (77%) | 5712 (99.8%) | 33827 (26%) |
| ^ 1347 ACT home, 293 ACT hotel | | | | | | | | | | | |
| | | 2 weeks: | 18 | NA | 0 | 4 | 0 | 0 | 0 | 0 | 22 |

| | | NSW | VIC | QLD | WA | SA | NT | ACT | TAS | Total |
|--|-----------------------|---------------|---------------|--------------|----------------|--------------|--------------|-----------|--------------|---------------|
| COVID-19 cases diagnosed in quarantine <small>* not including Artania</small> | 17-30 August | (0.4%) | | (0%) | (0.3%) | (0%) | (0%) | (0%) | (0%) | (0.3%) |
| | 28 March to 28 August | 393 (0.8%) | 236 (1.1%) | Not provided | 196* (1.8%) | 24 (0.8%) | 1 (0.01%) | 0 (0%) | 1 (0.02%) | 851 (0.7%) |

28

| | | New Zealand | | South Island | North Island |
|--|---|--------------------------|--|--------------|--------------|
| Number of incoming international flights from NZ | * including charter flights, but not freight | 2 weeks: 14-28 August | 51 flights | 9 flights | 42 flights |
| | | 28 March to 28 August | 423 flights | 90 flights | 333 flights |
| Number of incoming international PAX from NZ | * excluding crew | 2 weeks: 14-28 August | 1386 (19%) | 29 | 1357 |
| | * including exemptions and hospital transfers | | * plus 158 crew (inc. freight) and 5 transit | (2%) | (98%) |
| | | 28 March to 28 August | 13015 (13%) | 416 | 12599 |
| | | | * plus 894 crew (inc. freight) and 373 transit | (0.5%) | (99.5%) |

²⁸ Data regarding breaches is not included as there is no centralised data source for this information. Advice about breaches was provided to the review in written material and consultation with States and Territories.

Attachment B – International approaches

In response to the WHO’s PHIEC declaration, many WHO member states declared a state of emergency, public health emergency, or similar, and implemented varying degrees of border restrictions and isolation or quarantine. The review has considered the quarantine approach adopted in similar economies and some current international approaches more broadly.

Canada

Like Australia, Canada implemented a complete ban on inbound travel with limited exceptions for citizens, residents and immediate family members. From April 2020, Canada’s Quarantine Act required all arrivals to undertake 14 days isolation on entry to Canada²⁹. Anyone entering Canada—whether by air, land or sea is required to:

- isolate for 14 days, if they have COVID-19 or symptoms of COVID-19, or
- quarantine for 14 days if they do not have signs and symptoms of COVID-19.

Either may be undertaken in the home environment provided it is suitable for isolation/quarantine. In the event it is deemed unsuitable, isolation/quarantine occurs in a designated quarantine facility chose by the Chief Health Officer. In June 2020, the Government of Canada extended the Emergency Order requirements related to mandatory isolation and quarantine for travelers entering Canada.³⁰

Canada’s exemptions are largely similar to Australia’s, and exist for essential workers, transiting passengers, and those in Canada in the national interest, and, like Australia, Canada implemented extensive internal border restrictions. Many of those have now been lifted.

Singapore

From 18 March 2020 all arrivals into Singapore have been required to self-isolate for 14 days under a “Stay Home Notice” (SHN) in a hotel room or similar accommodation provided by the Singapore government.

Changes were made to the SHN regime in June 2020 for travelers from Australia, Brunei Darussalam, Hong Kong, Japan, Macao, Mainland China, New Zealand, Republic of Korea, Taiwan and Vietnam, all of which were low prevalence settings at that time. On the proviso that travelers could demonstrate 14 consecutive days in those settings, the changes removed the requirement for travelers from these countries to serve their SHN at dedicated

²⁹ <https://www.canada.ca/en/public-health/services/publications/diseases-conditions/travelers-with-symptoms-return-canada.html>

³⁰ <https://orders-in-council.canada.ca/attachment.php?attach=39482&lang=en>

SHN facilities and allowing those travelers to undertake 14 days self-isolation with family, their residence or accommodation at their own cost.³¹

Singapore has also now reduced the self-isolation duration from 14 days to seven days for travelers entering Singapore from low risk countries or regions (Australia - excluding Victoria, Macao, Mainland China, Taiwan, Vietnam, and Malaysia), with COVID-19 testing prior to the expiration of the seven day period.³²

As of September 2020, travelers entering Singapore from Brunei Darussalam and New Zealand are no longer required to undertake self-isolation if they can demonstrate 14 consecutive days in those countries and receive a negative COVID-19 result upon testing at the airport.

Singapore also introduced mandatory electronic monitoring devices to boost compliance with quarantine. All incoming travelers, including Singaporeans, who complete quarantine at home or in hotels (rather than government facilities) are issued with a device on arrival for the duration of their 14 day quarantine. The devices use GPS and 4G/Bluetooth to determine if the person is within the range of their place of residence.

New Zealand

Since April 2020, all travelers entering New Zealand irrespective of previous travel locations are required to enter 14 days quarantine in a managed isolation/quarantine facility, enacted under the COVID-19 Public Health Response (Air Border) Order 2020 (the Air Border Order). New Zealand's borders remain closed, as such travelers entering New Zealand are citizens or permanent residents only.

The Air Border Order was amended on 13 July 2020 and remains in force until the end of September 2020, subject to any extensions.

Taiwan

Taiwan³³, similar in population to Australia, is widely lauded for its success in managing COVID-19 despite being closely located to the epicentre in mainland China.

Taiwan requires that all arrivals present a negative COVID-19 test taken three days before boarding a flight to Taiwan and quarantine for 14 days upon arrival, but has eased restrictions for short-term business travelers from 'low-risk' and 'medium-risk' countries. Business travelers from low-risk countries who present negative COVID-19 tests before and after arrival in Taiwan are only required to quarantine for five days rather than 14, while medium-risk arrivals must quarantine for seven days.

Taiwan's successful COVID-19 response and limited community transmission has also been linked to the integration of government health and immigration databases, enabling the government to monitor track individuals at high risk because of recent travel history in affected areas³⁴.

³¹ <https://www.moh.gov.sg/news-highlights/details/gradual-re-opening-of-travel-and-changes-to-border-measures>

³² <https://www.moh.gov.sg/covid-19>

³³ Taiwan is not defined as member state by the WHO

³⁴ Wang CJ, Ng CY, Brook RH. Response to COVID-19 in Taiwan: Big Data Analytics, New Technology, and Proactive Testing. JAMA. 2020;323(14):1341–1342. doi:10.1001/jama.2020.3151

South Korea

Travelers entering Korea after 1 April 2020 are subject to quarantine for 14 days from the day after entry in accordance with the Quarantine Act. Quarantine can be undertaken at home. Short-term travelers (foreign-nationals) without a confirmed address in Korea are subject to quarantine at a facility designated by the Korean government at their own expense.

South Korea was one of the first countries to experience a COVID-19 outbreak, with its first case, imported from Wuhan, China, reported on January 20 2020. The government established an emergency response committee within days of the case becoming known.

The number of confirmed cases ranged from zero to two per day for the first month of the outbreak, until a cluster was identified in Daegu. As soon as the first case was reported, South Korea turned its focus toward preparing for large-scale testing. In late January 2020, South Korea started requiring special entry procedures for travelers coming from Wuhan. Procedures initially included special entry lines and questionnaires, and later expanded to temperature checks, border-testing for all travelers, and mandatory quarantines that were monitored for 14 days.

Those identified as having had contact with a confirmed or suspected case were required to self-quarantine at home or in designated facilities for 14 days, as were travelers into the country. This policy of tracing and quarantining, rather than restricting entry, is in line with international health regulations, whereas border closures are not.³⁵

Other

There is a mixture of other approaches internationally for managing travel into and out of countries and regions, including traffic light approaches, travel corridors or green lists, traveler cohorts, other means of monitoring and testing, in place of quarantine, as borders begin to open up. Generally, countries have adopted a combination of approaches.

Under a traffic light system, countries are designated as either green (low-risk), amber (medium-risk) or red (high-risk). Generally, travelers and nationals returning from 'green' countries are permitted to enter with no restrictions, while those from amber and red countries will be subject to some restrictions upon re-entry. Some countries operating a traffic light system are Belgium, Czech Republic and Ireland.

Although originally considering a traffic light approach, the UK has switched to a more binary system for its border settings in which designated countries are listed as red or green rather than red/green/amber. All travelers from countries not on the travel corridor list must self-isolate for 14 days. The UK's 'travel corridor' list is reviewed weekly and countries are added or removed depending on the situation in countries and regions.

Israel has a similar system, with countries designated as either green (with no quarantine required) or red (14 days quarantine required upon entry to Israel). Travelers from green countries who have been in a red country in the previous 14 days must isolate for 14 days upon entry to Israel.

Iceland's borders are currently open to EU/Schengen zone countries, as well as 14 'safe' third countries recommended for exemption from border restrictions by the European Commission. On arrival in Iceland,

³⁵ <https://ourworldindata.org/covid-exemplar-south-korea>

travelers are given the choice of 14 days quarantine or undertaking two screening tests for COVID-19, separated by five to six days and quarantining until the results of the second test are known.

While each country has determined its own border settings, the Council of the European Union determined a set of quantitative and qualitative criteria for lifting restrictions including being close to or below the EU average, whether cases in other countries have been stable or decreasing in the previous 14 days and the country's overall response to COVID-19 taking into account available information on aspects such as testing, surveillance, contact tracing, information and data sources.

Attachment C – State and Territory Arrangements

The review consulted States and Territories regarding these summaries, which are accurate as of 29 September 2020.

New South Wales

Legal overview

The Minister for Health and Medical Research has mandated that a person who has been in Victoria or overseas within 14 days of arrival in NSW by aircraft must generally quarantine in a government-designated facility. The requirement to be quarantined is mandated through the [Public Health \(COVID-19 Air Transportation Quarantine\) Order \(No 3\) 2020](#).

The [Public Health \(COVID-19 Maritime Quarantine\) Order \(No 3\) 2020](#) sets out the quarantine requirements for people arriving in NSW from overseas by vessel. These orders are made by the Minister under section 7 of the [Public Health Act 2010](#), in exercise of his powers to give directions as he considers necessary to deal with a public health risk and its possible consequences. The Minister has also required that non-NSW residents who have been in Victoria in the previous 14 days and have not been authorised to enter NSW can be asked to leave NSW or stay in quarantine (clause 8 of the [Public Health \(COVID-19 Border Control\) Order 2020](#)). A state of emergency does not need to be declared to use these powers. The Minister for Health and Medical Research (or a duly authorised delegate) is responsible for exemptions to the requirement to quarantine in government-designated facilities.

Exemptions have been made relating to, for example, unaccompanied children ([Exemption under Public Health \(COVID-19 Air Transportation Quarantine\) Order 2020](#)), Year 11 and 12 students and teachers (exemption under [Public Health \(COVID-19 Border Control\) Order 2020](#)), and flight crew who have only been in a Victorian airport ([Exemption under the Public Health \(COVID-19 Border Control\) Order 2020](#)). Special arrangements are also in place for flight crew more generally (required to quarantine at home or accommodation arranged by their employer, subject to the provision of certain information to NSW Health). There are also certain classes of people who have been in Victoria in the previous 14 days who are not required to quarantine in a government-designated facility, subject to certain conditions. This includes (but is not limited to) NSW residents who have been quarantined in Victoria for the previous 14 days under Victoria's Public Health and Wellbeing Act 2008, border region residents, people providing critical services, people entering for medical services or on compassionate grounds, people needing to meet legal obligations imposed by a court or an Act, travelers transiting through NSW by air and consular officials. The exemptions also include the ability for people in quarantine to leave quarantine for short periods of time under supervision to enable them to visit loved ones who are having critical treatment or who are dying in hospitals under certain circumstances.

The Commissioner of Police designates premises or types of premises as appropriate quarantine facilities. The Chief Health Officer (or delegate) can clear someone for release after 14 full days of quarantine if they are satisfied that the person does not pose a risk of infecting others with COVID-19. They must have regard to the

results of any COVID-19 testing which occurs on day two and day 10 of hotel quarantine. A refusal to be swabbed on day 10 may result in a further 10 days quarantine.

The courts can issue fines of up to \$11,000 or imprisonment of up to six months, as well as a further fine of \$5,500 for each day the offence continues (Public Health Act 2010, s 10). Under Schedule 4 of the Public Health Regulation 2012, on-the-spot fines can also be issued.

Available remedies include a merits review (Public Health Act 2010, s 7(7)) and judicial review. Complaints can also be made to the Ombudsman about the conduct of a public authority. Complaints about the conduct of the NSW Police Force are to be directed to the Commissioner of Police or the Law Enforcement Conduct Commission instead of the Ombudsman. Damages or other compensation is not payable in any civil proceeding for damages or other compensation brought against the State or any authority of the State for alleged negligence, defamation or other breach of duty arising because of the exercise of, or the failure to exercise, any function under the Public Health Act 2010 in good faith (Public Health Act 2010, s 132).

Fees for hotel quarantine are \$3000 for one adult, \$1000 for each additional adult and \$500 for each child over the age of three years. There is no charge for children aged under three. Hardship arrangements are available.

Governance arrangements

Hotel quarantine in NSW is a joint operation led by NSW Police and NSW Health and is supported by other government departments including the Department of Communities and Justice, the Department of Customer Service (Service NSW and Revenue NSW), the Department of Regional NSW (Public Works Advisory), Transport for NSW, NSW Treasury, and the Department of Premier and Cabinet.

The principle cross-agency governance body is the Interagency Operational Protocol Governance Committee for Quarantine Services during COVID-19, chaired by the Chief Executive of the Sydney Local Health District. This group is responsible for overseeing the interagency agreements and arrangements under which individuals arriving in NSW are required to quarantine in a designated quarantine hotel or health facility pursuant to the public health order.

Underneath this Interagency Governance Committee, sits the NSW Hotel Quarantine Operational Governance Committee during COVID-19, chaired by the Deputy Controller of the State Health Emergency Operations Centre (SHEOC). This group provides a forum for consultation between key stakeholders, including NSW Police and NSW Health, in relation to hotel quarantine.

The operational delivery of the quarantine system is oversighted by two committees, one responsible for airport operations and the other responsible for overseeing hotel operations. This overall structure is outlined in the diagram below, with agency representation at each forum detailed in their respective terms of reference.

Incident Controller
SHEOC – State Health Emergency Operations Centre

**NSW Interagency Operational Governance Committee
for Quarantine Service during COVID-19**

Chair – Chief Executive Sydney Local Health District

**NSW Hotel Quarantine Operational Governance
Committee during COVID-19**

Chair – Deputy Controller SHEOC

Airport Operations Committee

Director Operations SHEOC

Hotel Operations Committee

Director Operations SHEOC

Queensland

Legal overview

The Chief Health Officer has mandated that various people are required to quarantine in a premises nominated by the government. Under the [Self-quarantine for Persons Arriving in Queensland from Overseas Direction \(No. 5\)](#) (Overseas Quarantine Direction), this requirement applies to a person who arrives in Queensland from overseas (whether Queensland is the person's final destination or not) (paragraph 5). Under the [Border Restrictions Direction \(No. 14\)](#), this requirement applies to people who in the 14 days prior to arrival in Queensland;

- have been overseas,
- had contact with a confirmed COVID case,
- have been in a COVID-19 hotspot and have been permitted to enter,
- had a cleared case of COVID-19 and given an exemption to enter Queensland by the CHO,
- had symptoms consistent with COVID-19, or
- who are a Queensland-based border zone resident who travelled outside border zone in NSW.

These directions are made under section 362B of the [Public Health Act 2005](#), in exercise of powers conferred specifically for the purpose of dealing with COVID-19. Under section 362B, the Chief Health Officer can give specified directions if she believes it is reasonably necessary to assist in containing, or respond to the spread of COVID-19 in the community. Such orders include; restricting the movement of persons; requiring persons to stay at or in a stated place; requiring persons not to enter or stay at or in a stated place, and any other directions the CHO considers necessary to protect public health.

Both the Self-quarantine for Persons Arriving in Queensland from Overseas Direction and the Border Restriction Direction contain provisions exempting certain classes of people from quarantine (e.g. border zone residents) or permitting quarantine to be completed in a premises other than that nominated by the government (e.g. certain government officials, law enforcement officials and military personnel, aircrew). Under the Directions the Chief Health officer (and where applicable the Deputy Chief Health officer or their delegate) may also grant exemptions for individual or classes of persons on compassionate grounds or where a person may be deemed essential for the proper functioning of the State).

The location of quarantine is directed by an emergency officer (public health). Emergency officers (general) include (s 333) people appointed by the Chief Executive by instrument if they are satisfied the person has the relevant qualifications, and they must be public service officers or employees, health service employees, persons employed by a local government, SES members under the Fire and Emergency Services Act 1990, ambulance officers, police officers, fire service officers and harbour masters. Emergency officers (medical) are doctors appointed by the Chief Executive if they are satisfied that they have the necessary expertise and experience.

Release occurs after completion of 14 days of quarantine (excluding the day of arrival). Under the Directions, a person may be quarantined for a further period of ten days from the end of the quarantine period if the person is not tested for COVID-19 when requested to do so by an emergency officer (public health). An emergency officer can use any necessary and reasonable force to enforce a public health direction (s 362L).

The courts can issue fines of up to \$13,345 or 6 months imprisonment, unless there is a reasonable excuse (s 362D). On-the-spot fines of \$1,334 can also be issued.

Available legal remedies include judicial review and complaint to Ombudsman. Excluded remedies include interlocutory orders staying operation of emergency powers (s 57, cf. s 109(4)) and remedies against people

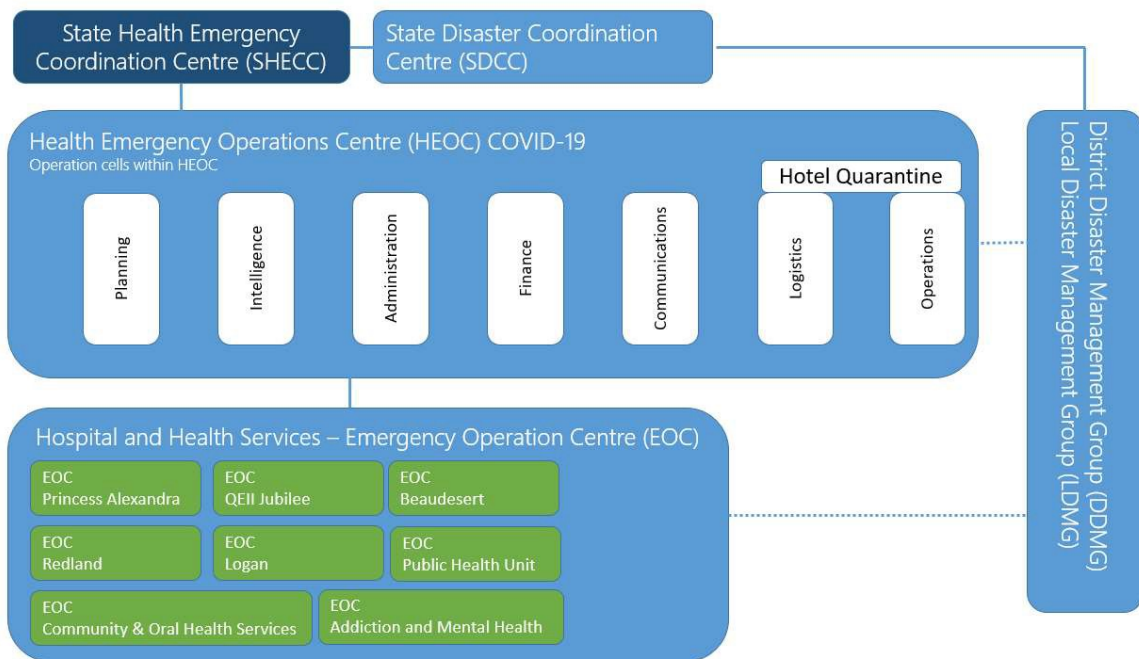
exercising functions under the Act in good faith (subject to the Police Administration Act 1978). This does not affect the State’s liability (s 131).

Prescribed fees under the [Public Health Regulations 2018](#) for hotel quarantine are \$2,800 for an adult and \$2,345 for a child. The fee includes components for accommodation (including cleaning) and meals. Where two or more people share quarantine accommodation the accommodation component of the fee is only charged for one of the relevant persons. A waiver can be sought from the payment of all or some of the fees for financial hardship or being a vulnerable person (s 362ME).

Governance arrangements

Queensland Police Services have lead agency status at the airport. Police officers serve the Quarantine Direction order and also are the lead enforcement agency onsite at each hotel.

Queensland Health is the functional lead agency for pandemics under the State Disaster Management Plan and is responsible for implementing state-wide strategies to manage the outbreak as well as advice and guidance to the State Disaster Coordination Centre and other agencies as required. This is centralised through Queensland Health’s State Health Emergency Coordination Centre.



Western Australia

Legal overview

The Police Commissioner (in his capacity as the State Emergency Coordinator (SEC)) has given the Quarantine (Closing the Border) Directions (the Directions). The Directions create a general prohibition on entry to the State of Western Australia other than for exempt travelers. Even if a person is able to enter Western Australia as an exempt traveler, their entry may be subject to terms and conditions, which may include a quarantine direction (either at a quarantine centre or at suitable premises), physical distancing measures, or a requirement to present for testing for COVID-19. The terms and conditions that will apply to such a person will depend on the category of exempt traveler that the person falls into.

If a person enters Western Australia in breach of the prohibition and is not able to leave Western Australia immediately, the person is to be given a quarantine direction. In general, such a person is to be given a centre direction (a direction to remain in a quarantine centre, being one of a number of hotels run by the State Health Incident Coordination Centre (SHICC)). Some people are issued with self-quarantine directions where there are exceptional circumstances (such as disability or serious medical condition) and some may be issued with hospital directions (where their condition (COVID-19 related or not) requires hospitalisation). Western Australian residents who have completed a period of supervised quarantine in another State/Territory can be given a self-quarantine direction to quarantine for 14 days. Unaccompanied children are given a self-quarantine (unaccompanied child) direction along with a movement direction to parent/parents in to whose custody the child will be released.

The Directions are made under section 61, 67, 70 and 72A of the [Emergency Management Act \(EMA\)](#). In particular section 72A enables authorised officers to, inter alia, take, or direct a person or class of person to take, any action that the officer considers reasonably necessary to prevent, control or abate risks associated with a state of emergency. For the purposes of the Quarantine (Close the Border) Directions, authorised officers include the SEC, police officers, Member of the Australian Border Force or the Australian Federal Police and Emergency Officers (authorised by the Chief Health Officer under the Public Health Act 2016).

Where a person is required to undertake quarantine in a quarantine centre, the quarantine centre is specified on the direction issued to a person by an authorised officer. Release from the quarantine centre generally occurs after 14 days following receipt of two negative results after COVID-19 testing on Days 2 and 12, and a health screening on Day 14. If a person in a quarantine centre tests positive for COVID-19, they are then managed under the Isolation (Diagnosed) Directions and any close contacts identified are managed under the Quarantine and Isolation (Undiagnosed) Directions.

An authorised officer may do all such things as are reasonably necessary to ensure compliance with the direction. They can use as much force as is reasonable in the circumstances (EMA s 76). An officer may exercise a power under the relevant Part of the EMA with the help and using the force reasonable in the circumstances.

The courts can issue fines of up to \$50,000 or imprisonment of up to 12 months for a breach of the directions made under the EMA, unless there is a reasonable excuse for non-compliance. On-the-spot fines of \$1,000 can also be issued.

Available legal remedies include judicial review and complaint to the Parliamentary Commissioner (Ombudsman). A person who suffers loss or damage because of the exercise, or purported exercise, of certain powers under the EMA may apply for compensation. A person dissatisfied with a compensation decision may seek merits review in the State Administrative Tribunal.

The fee for hotel quarantine is \$180 per room, per day with an additional \$60 per day for each additional person in the room. There is no charge for children under the age of 6. Effective price for one child aged over six years and one adult is \$3360.

Governance arrangements

The Commissioner of Police is the State Emergency Coordinator (SEC) and is authorised to make directions under the [Emergency Management Act](#). While the centre directions are issued by the WA Police, the quarantine centres are managed by the SHICC.

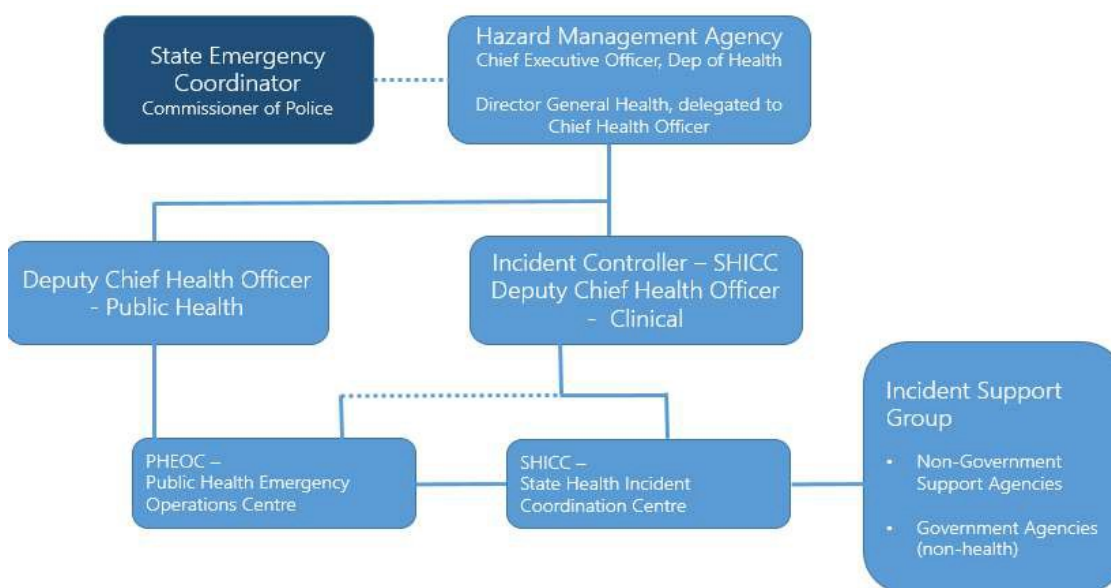
Under the EMA, the Hazard Management Agency (in this case, the Department of Health, represented by the delegate, the Chief Health Officer (CHO) for the purposes of the current WA State of Emergency) is responsible for appointing the Incident Controller, activating the Public Health Emergency Operations Centre (PHEOC) and activating the SHICC (if required). For the purposes of WA’s current State of Emergency, the Deputy Chief Health Officer, Clinical Services, is the Incident Controller.

The PHEOC is headed by the Deputy Chief Health Officer, Public Health, who reports to the Chief Health Officer (the Hazard Management Agency), and oversees the public health activities of the pandemic response, including oversight of disease surveillance, data management, and public health management of infected persons and their contacts.

The SHICC is under the direction of the Hazard Management Agency (or Delegate – namely the Chief Health Officer in this case), addressing strategic management of an incident/disaster as well as facilitating management of state-wide events. During a human epidemic, clinical health services (including hospitals), and non-public health sector responses will be coordinated by the SHICC, in conjunction with the Hazard Management Agency.

Hotel quarantine is managed by the Non-Health Operations Cell in SHICC who deal with the logistics and management of security, and health and wellbeing within the quarantine centres. PHEOC provides and the public health management of any COVID-19 positive cases and any close contacts, including contact tracing.

The ADF and the Department of Communities feed into the SHICC either directly or via the Incident Support Group (ISG). Members of the WA Police sit on the ISG, hold roles within the SHICC, and also report through normal reporting lines to the Commissioner of Police.



South Australia

Legal overview

There is a major emergency declared under the [Emergency Management Act 2004](#) (“the EM Act”) in this State. The Police Commissioner (in his capacity as State Co-Ordinator) has mandated that people arriving from overseas must quarantine in government-designated accommodation. This includes people arriving in South Australia via a direct or connecting flight, or a person arriving in South Australia via a cruise ship. This requirement is mandated under the [Emergency Management \(Cross Border Travel No 15\) \(COVID-19\) Direction 2020](#). The direction is made in exercise of the State Co-Ordinator’s powers under section 25 of the EM Act. Section 25, inter alia, enables the State Co-Ordinator (or authorised officer) to do, or cause to be done, various things, to deal with a declared major emergency. Directions or requirements can be applicable to persons across South Australia and include:

- Directing or prohibiting the movement of persons, animals or vehicles
- Directing a person to remain isolated or segregated from other persons or to take other measures to prevent the transmission of a disease or condition to other persons
- Directing a person to undergo medical observation, examination (including diagnostic procedures) or treatment (including preventative treatment).

Various aspects of the emergency powers framework set out in the EM Act were amended by the [COVID-19 Emergency Response Act 2020](#) (“the COVID-19 Act”). These amendments are time-limited and will expire within 6 months of commencement of s 6 of the Act (8 October 2020). On 24 September, an amendment Bill was passed by the Parliament of South Australia, extending the Act until 6 February 2020.

Upon returning to South Australia, following a period of quarantine in another State or Territory, a further 14 days of self-quarantine will apply in South Australia, unless the period of quarantine occurred in a State or Territory that is deemed to be a low community transmission zone.

The State Co-Ordinator has prescribed various exemptions from the requirement to essential travelers. Unaccompanied minors are not exempt, rather a carer must remain present with them in quarantine. Under s 25(6) of the EM Act (a temporary provision pursuant to the COVID-19 Act), the State Co-ordinator, or an authorised officer can exempt (conditionally or unconditionally) any person or class of persons from the direction. The State Co-ordinator may delegate any of his functions to an Assistant State Co-Ordinator, a person holding or acting in a particular person, or to any other person or body (s 18 EM Act).

Under the Emergency Management (Cross Border Travel No 15) (COVID-19) Direction 2020, the location of quarantine for overseas arrivals is determined by an authorised officer under the EM Act. A person can be released after 14 days of quarantine commencing on the day of arrival.

Under the temporary provisions of the COVID-19 Act, the State Co-ordinator or an authorised officer may use such force as is reasonably necessary to exercise or discharge powers or functions, or in ensuring compliance with a direction or requirement under s 25 of the EM Act. The courts can issue fines of up to \$20,000 or two years imprisonment, unless there is a reasonable excuse under s 28 of the EM Act. On-the-spot fines of \$1,000 can also be issued.

Available legal remedies against a direction or requirement under the EM Act include judicial review or a complaint to Ombudsman. No civil or criminal liability attaches to the Crown, or to any person acting in good faith, for acts or omission in connection with actions taken in response to COVID-19 under the EM Act.

Fees for hotel quarantine are \$3,000 for an adult, \$1,000 for each additional adult and \$500 for each additional child (with the exception of a child under three for which there is no additional cost). Fees can be waived, reduced or refunded if the State Co-ordinator considers it appropriate (EM Act s 25AA).

Governance arrangements

As the control agency for COVID-19 in South Australia, SA Health is responsible for the planning and implementation of quarantine requirements. To be successfully implemented this requires a coordinated approach and to support SA Health a State Control Centre Health (SCCH) has been established with participation from emergency services, SAPOL, health professionals, private sector and local government.

As the SA Policy Commissioner is the State Coordinator under the EM Act, SAPOL leads the instruction of drafting of legal directions under this Act taking into consideration the public health advice and other relevant factors.

To support the planning and development of quarantine arrangements, an Effective Quarantine Workstream has been established within SA Health as part of SA Health's COVID-19 response structure to provide advice on systems and controls for the provision of high quality, safe and sustainable quarantine arrangements³⁶.

³⁶ A schematic for South Australian governance arrangements was not available.

Northern Territory

Legal overview

The Chief Health Officer has mandated that various people are required to quarantine in a specified place as determined by the Chief Health Officer. In most cases, this is one of the two government-designated facilities in the Northern Territory. The people required to quarantine are; people who enter the Northern Territory from a place outside of Australia; people who enter the Northern Territory from another State or Territory who in the previous 14 days were either in a place from outside Australia or in a COVID-19 hotspot and people who refuse to make a declaration required under the Direction (covering inter alia where they have been and where they intend to stay).

The requirement to be quarantined is mandated through the [COVID-19 Directions \(No. 49\) 2020 Directions for Territory Border Restrictions](#), as amended by Directions No.50 2020 – Directions for Freight Workers). The Directions are made under section 52 of the [Public and Environmental Health Act 2011](#), in exercise of the Chief Health Officer's powers to take actions considered necessary, appropriate or desirable, to alleviate a public health emergency declaration. The Act specifically provides that the Chief Health Officer may take action to segregate or isolate persons in an area or at a particular place, prevent persons accessing or entering into an area of a particular place, or require people to undergo medical examinations.

The Chief Health Officer is responsible for exemptions to the requirement to quarantine in government-designated facilities. This includes exemptions granted by the Chief Health Officer to a person who has been in a place outside of Australia and had not been in an area that at the time of their entry into the Northern Territory, was a designated COVID-19 hotspot (Direction 28). The Chief Health Officer must be satisfied that the person poses a minimal risk to the public health of the Territory and has a compelling reasons to justify the exemption, such as; essential workers, that they may suffer an unusual, undeserved or disproportionate impact of being quarantined or the person is governed by a COVID-19 management plan imposed by the employer to prevent the transmission of COVID-19 to the public. This exemption provision is only valid while the person is in the Northern Territory. The Chief Health Officer (NT) does not have jurisdiction to provide an exemption to a person outside of the Northern Territory.

Other exemptions prescribed by the Chief Health Officer include freight/transport services (as per Directions No.50), maintenance/repair of critical infrastructure or health practitioners requested to enter the Territory (Direction 29 of Directions No.49). Flight crew have an exemption in place (Directions 26-27 of Directions No.49).

People must quarantine in a place specified by the Chief Health Officer and as directed by authorised officers. Authorised officers include the Chief Health Officer, persons appointed by the Chief Health Officer (subject to CHO being satisfied that the person holds qualifications, knowledge, skills or experience), and police officers exercising or purporting to exercise powers/functions under the Act.

Persons are released from quarantine following completion of 14 days (excluding day of arrival). However if they have been in a declared hotspot within the last 14 days but then spent time in an area that is not a hotspot immediately before crossing the NT Border, that time is deducted from their 14 days in quarantine.³⁷The Chief Health Officer can direct people to undergo COVID-19 testing conducted by an authorised person or another person approved by him. If that direction is refused then the person must remain quarantined for an additional 10 days.

³⁷ For example, if they were in an area that is not a declared hotspot for 5 days immediately before crossing the NT border, those 5 days will now be counted as part of the required 14 day quarantine period. This means they will be required to quarantine for 9 days in the NT.

Police officers who are authorised officers under the Act can assist the Chief Health Officer by any means that the Chief Health Officer considers necessary, appropriate or desirable, to ensure compliance with directions he made ([COVID-19 Directions \(No. 5\) 2020 Assistance of Police Officers](#)).

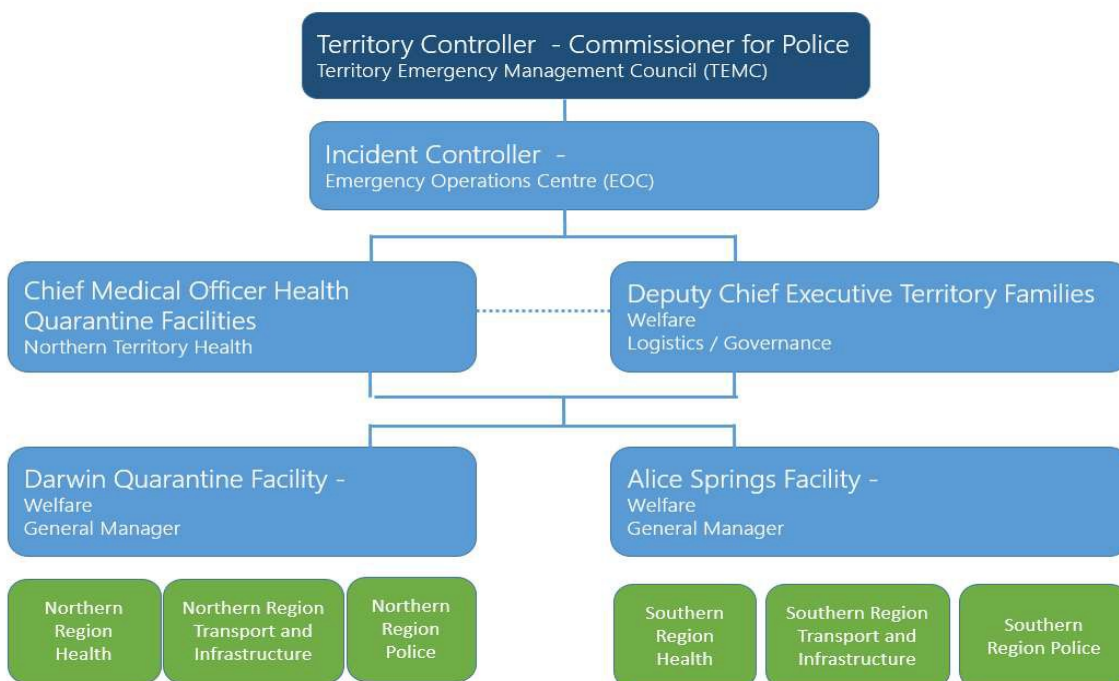
If a person contravenes a direction made by the CHO under section 52(1) of the Public and Environmental Health Act, the person may be found to have committed an offence under section 56 of the Act. The maximum penalty that may be imposed by a court is 400 penalty units (\$63, 200). A Defence is available if there is a reasonable excuse. On-the-spot fines of \$5,056 can also be issued.

Available remedies include common law judicial review and complaint to the Ombudsman. Excluded remedies include interlocutory orders staying operation of emergency powers (s 57, cf. s 109(4)) and remedies against certain people exercising functions under the Act in good faith (subject to the Police Administration Act 1978). This does not affect the Territory's liability (s 131).

The fees for hotel quarantine are \$2500 for an individual for 14 days, with a family rate of \$5000 for family groups of two or more people in shared accommodation. A daily rate will be applied to those who are not required to quarantine for the full 14 days (\$175 for an individual and a family rate of \$350 per day). An additional 10 days of quarantine is required if a test is refused and will cost \$1750 for an individual or \$3500 for a family. Australian residents with a low income may be eligible for a reduced quarantine fee of \$1250 per person or \$2500 for a family of two or more people. Low income threshold is \$52,706 (singles) and \$68894 (families). In the case of an unaccompanied minor the fee is \$1250 and the accompanying adult does not get charged.

Governance arrangements

The Commissioner for Police is the Territory Controller and the lead of the operation. He works closely with the Chief Medical Officer Health Quarantine Facilities who provides the lead on infection control and medical support, while the Deputy Chief Executive of Territory Families is responsible for the lead on welfare and logistics.



Australian Capital Territory

Legal overview

The Chief Health Officer has mandated a requirement to quarantine in a government-designated facility if someone arrives in the ACT following a flight from outside Australia. The requirement to be quarantined is mandated through the [Public Health \(Returned Travelers\) Emergency Direction 2020 \(No 7\)](#).

This Direction is made under section 120 of the [Public Health Act 1997](#), in exercise of the Chief Health Officer's powers to issue directions necessary or desirable to alleviate a specified emergency. The Act specifically provides the Chief Health Officer with powers to require people to move away from or to a specified area, to remain in a specified area, and to undergo a medical examination. In some circumstances, people arriving in the ACT from Victoria may be required to quarantine in government-designated facilities ([Public Health \(COVID-19 Interstate Traveler\) Emergency Direction 2020](#)).

The Chief Health Officer is responsible for exemptions from the requirement to quarantine in a government-designated facility and includes exemptions such as; previous 14-day quarantine in another jurisdiction, unaccompanied children (reside in premises), international flight crew, air ambulance or medevac crew, and consular staff (with risk mitigation guidance).

The Chief Health Officer or authorised officers (person authorised by the Chief Health Officer) approve the facilities in which a person can be held. A doctor appointed by the Director-General of the ACT Health Directorate can clear someone for release from quarantine after 14 days, if the person has been COVID-19 tested. Otherwise, the person will be released after an additional period of quarantine up to 10 days or until they return a negative COVID-19 test.

An authorised officer (police officer, member of the ambulance service or other person authorised by the Chief Health Officer) is able to exercise appropriate powers and assistance that is reasonably necessary. They can also require someone to provide identification and take all reasonable steps to ensure compliance with such a request.

Individuals that fail to comply with the public health direction can be issued with an infringement notice for which the penalty is \$1,000, or charged with an offence for which the maximum penalty is \$8,000.

Judicial review under the Administrative Decisions (Judicial Review) Act remains open to affected persons, as does the ability to lodge a complaint to the Human Rights Ombudsman. Public Health Emergency Directions and decisions pertaining to the administration of such decisions are not reviewable by the ACT Civil and Administrative Tribunal, and there is no right to compensation for loss or damage done in the exercise of a function under the Public Health Act under a COVID-19 declaration (apart from control or disposal of property)

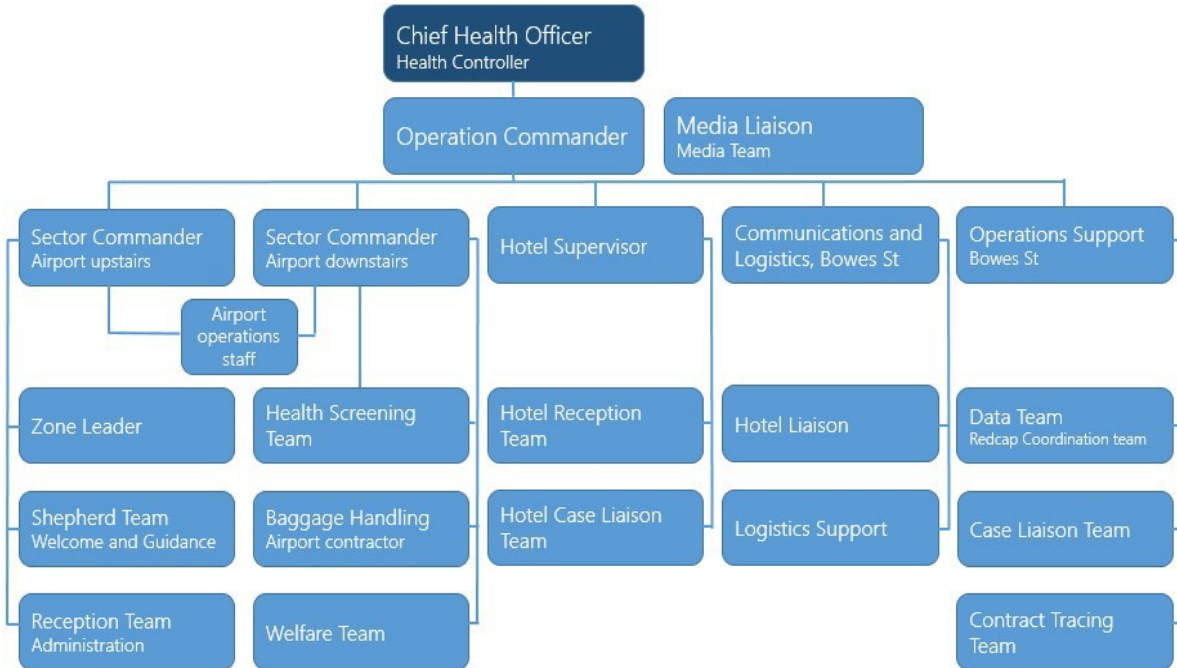
Costs of hotel quarantine were initially met by the ACT Government. However, since 14 August 2020 persons in quarantine are now subject to fee under the Public Health (Quarantine Fees) Determination 2020.

Governance arrangements

ACT Health is the lead agency in responding to the Public Health Emergency, and the Chief Health Officer is the Health Controller with overall responsibility for the health response and quarantine arrangements. The nominated Operation Commander has direct responsibility for quarantine operations, and reports directly to the CHO. The Chief of Police leads quarantine compliance activity reporting through to the CHO.

The ACT's Hotel Quarantine System is a low volume Hotel Quarantine System, although ACT also runs a larger Home Quarantine System in parallel.

The ACT has adopted a holistic philosophy towards hotel quarantine with a strong emphasis on the mental and physical wellbeing of returnees in quarantine. This approach has been used to ensure the experience for the quarantining person is acceptable while also reducing the likelihood of a breach of quarantine.



Tasmania

Legal overview

The Police Commissioner, in his role as State Controller³⁸, has mandated that people arriving into Tasmania must quarantine in government-designated accommodation. This includes those who; do not have a Tasmanian residential address, are displaying COVID-19 symptoms, have been overseas or disembarked a cruise ship within the previous 14 days, have COVID-19, are a close contact with a COVID-positive person, or have been in an affected area or premises.

The primary requirement is mandated under the [Directions in Relation to Persons Arriving in Tasmania \(General\)](#). However there are a separate set of requirements, titled [Directions in Relation to Persons Arriving in Tasmania from Affected Regions and Premises](#) that apply to people who have arrived in the State from Affected Regions and Premises which have a higher risk of COVID. These directions are made in exercise of the State Controller's powers under section 40 of the [Emergency Management Act 2006](#). Section 40, inter alia, enables the State Controller to authorise the exercise of emergency powers if they are satisfied that there is an emergency or threat of emergency occurring in Tasmania. This means that there are reasonable grounds to exercise those powers to protect people from distress, injury or death. Authorisations can be made irrespective of whether a State of Emergency has been declared.

Schedule 1 specifies the emergency powers that can be exercised, including to;

- prohibit, direct, regulate or limit the movement of persons into, within or out of Tasmania, any area in Tasmania or any premises,
- require any person to answer any question asked by an authorised officer or provide any document or other information required, or
- give directions to, and make requirements of, a person as necessary or practicable, for the purposes of exercising emergency powers.

Schedule 2 specifies special emergency powers that can be exercised if a State of Emergency is declared, including to;

- direct the resources of the State and any council or other person be made available for emergency management, and
- requiring the owner or person in charge of resources to surrender them and place them under the control of any person in emergency management, and
- take such other action as the State Controller or Regional Controller considers appropriate.

The State Controller has prescribed various exemptions from the requirement to quarantine in government-designated facilities including; unaccompanied minors, those with a Tasmanian address who have not travelled from an affected area, and those entering Tasmania for essential work purposes related to national and state security and governance (eg: on duty military personnel); health services; transport, freight and logistics; specialist skills critical to maintaining key industries or businesses; paramedics and ambulance officers; police officers and any other persons approved by the State Controller such as on compassionate grounds. In relevant cases, expert advice and recommendations are considered in making essential traveler decisions.

³⁸ On 7 September 2020 the State Controller delegated all his functions and powers under the Emergency Management Act 2006 and any other Act to the Deputy State Controller for the purpose of carrying out functions and powers relating to the emergency management response to the COVID-19 pandemic. The Deputy State Controller is the Deputy Commissioner of Police.

The quarantine accommodation facility is specified by an authorised officer who is authorised by the State Controller. Police officers are authorised officers. Biosecurity Tasmania officers have also been authorised by the State Controller to exercise powers in relation to specifying quarantine facilities.

Authorised officers or persons assisting and under direct supervision of an authorised officer may use such force as is reasonably necessary (s 52). Police officers can use reasonable force as necessary to arrest a person where the officer reasonably believes that a person is committing, has committed or is about to commit, an offence against s 60 of the Act (including failing to comply with a lawful requirement or direction of an emergency management worker) (s 60B).

The courts can issue fines of up to \$17,200 or 6 months imprisonment. Police can issue on-the-spot fines of \$774. Available remedies include judicial review and complaint to Ombudsman. Excluded remedies include a merits review.

Fees for hotel quarantine are \$2,800 for an adult, \$1,000 for each additional adult, and \$500 for each child over the age of three years. The fee is capped at \$4800. People can make application for a fee waiver or reduction on the grounds of financial hardship, compassionate or medical reasons for travel and exceptional circumstances that would make it unreasonable or unfair to pay fees.

Governance arrangements

On 19 March 2020, the Premier of Tasmania declared a State of Emergency under the Emergency Management Act 2006, and the State Emergency Management Controller (State Controller) began co-ordination of the whole-of-government activities.

On 28 March, the Premier announced the State Controller’s Direction that from midnight Sunday 29 March any non-essential traveler arriving in the state either through airports or through ferry ports will be placed into quarantine for 14 days in a government-run facility.



Attachment D – Domestic Legal Framework

Commonwealth

Commonwealth biosecurity legislation and State and Territory public health and emergency response laws provide a legislative framework to underpin the domestic actions that have been taken in response to the COVID-19 outbreak.

The Commonwealth Constitution contains only one specific power which directly relates to public health³⁹; the power to make laws in relation to quarantine, which are typically enacted through the Commonwealth Biosecurity Act 2015. The quarantine power may be exercised concurrently with the States and Territories.

States and Territories

States and Territories have legislative powers that enable them to implement biosecurity arrangements within their borders and that complement Australian Government biosecurity arrangements. They also have a broad range of public health and emergency response powers available under public and emergency legislation for responding to public health emergencies. Consequently the breadth of legislation made in respect of COVID-19, the core requirement for various categories of people to be held in hotel quarantine, and the requirements imposed on them while they are in quarantine are made and enforced at the State or Territory level.

In most jurisdictions, the legislative framework used to regulate hotel quarantine requirements is triggered upon the declaration of a 'state of emergency' (or similar). In the two jurisdictions that do not specifically require some kind of declaration (NSW and Tasmania), the relevant decision maker must still be satisfied that there is a 'public health risk' or an 'emergency' warranting the exercise of the relevant powers. In most jurisdictions, reliance has been framed on the general emergency management framework that has already been legislated. In the case of Queensland and South Australia, however, the legislative framework is wholly or to a significant extent built on powers specifically conferred for dealing with COVID-19.

Exercising Powers

Jurisdictions adopt a range of approaches to authorising officials to exercise powers in respect of the hotel quarantine requirements. In some instances there is a level of specificity around who can exercise powers under the relevant directions or orders, or specific powers. This may be explicitly stated or indicated through notes in the relevant directions or orders.

Often reference is often made to 'authorised officers' as empowered under enabling legislation. In some instances, these personnel are specified or traceable, in other cases the discretion is conferred broadly (sometimes guided by particular criteria or requirements) or relies on authorisations being made that are not always readily visible (whether such authorisations have been issued or who those authorisations have been conferred to).

³⁹ The Commonwealth also has powers for various medical benefits. The Commonwealth may also have recourse to other constitutional heads of powers (e.g. in relation to external affairs and immigration and emigration) to achieve public health

Attachment E – COVID-19

In December 2019, China reported cases of a viral pneumonia caused by a previously unknown pathogen that emerged in Wuhan, a city of 11 million people in central China. The pathogen was identified as a novel (new) coronavirus (recently named Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)), which is closely related genetically to the virus that caused the 2003 outbreak of Severe Acute Respiratory Syndrome (SARS). SARS-CoV-2 causes the illness now known as Coronavirus disease 2019 (COVID-19)⁴⁰.

Due to heightened and growing global concerns around the pandemic potential of COVID-19, on 30 January 2020 the World Health Organisation (WHO) declared the outbreak of COVID-19 as a Public Health Emergency of International Concern (PHEIC). The WHO declared COVID-19 a Pandemic on the 11th of March 2020. The virus has now spread widely around the world, and did so within a few months of being first reported in China.

COVID-19 spreads readily from person to person. All major authorities (CDC in the US⁴¹ WHO in Geneva⁴² and the Australia Government⁴³) have the view that current evidence suggests the transmission of COVID-19 is predominantly by respiratory droplets, as opposed to aerosols. Aerosols carrying virus are produced by people with COVID-19 and can cause infections; however, they are unlikely to be a major factor in transmission unless produced in large numbers, for example during some medical procedures. COVID-19 is also spread by fomites, making hand hygiene washing, and in some circumstances the use of gloves, important components of infection prevention and control.

Droplets appear to be the main way that most respiratory pathogens spread. The most effective way to stop the spread of COVID-19 is to prevent or reduce the spread of droplets from person to person. Interventions that likely will be very effective are; physical distancing, the use of appropriate Personal Protective Equipment (PPE), especially facemasks and face shields in higher risk situations, hand hygiene, although this has a lower impact owing to the nature of COVID-19 transmission, keeping away from others who are sick with respiratory symptoms, isolating when feeling unwell, isolation of confirmed infections, and closing international borders from countries/regions with high prevalence of infections.

Laboratory tests for COVID-19 aim to detect the causative virus, SARS-CoV-2, or an immune response to SARS-CoV-2. Since COVID-19 is a recent emerging viral infectious disease, evidence available is more limited to assess the accuracy and clinical utility of all available COVID-19 tests. Available evidence mainly comes from symptomatic patients, and therefore the reliability of COVID-19 tests for detecting asymptomatic carriers is less clear.

The indications (reasons) for conducting a COVID-19 test have changed through the course of the pandemic. The current testing criteria can differ between each State and Territory, but for people with symptoms, generally includes some of these; fever; respiratory symptoms such as cough, sore throat, shortness of breath and/or other symptoms such as; runny nose, headache, muscle or joint pains, nausea, diarrhoea, vomiting, loss of sense of smell, altered sense of taste, loss of appetite and fatigue.

The three main types of SARS-CoV-2 tests are:

⁴⁰ <https://www.who.int/news-room/detail/29-06-2020-covidtimeline>

⁴¹ <https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/how-covid-spreads.html>

⁴² <https://www.who.int/news-room/commentaries/detail/modes-of-transmission-of-virus-causing-covid-19-implications-for-ipc-precaution-recommendations>

⁴³ <https://www.health.gov.au/news/health-alerts/novel-coronavirus-2019-ncov-health-alert/what-you-need-to-know-about-coronavirus-covid-19>

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1. Nucleic acid PCR detection tests - to detect SARS-CoV-2 viral (Ribonucleic acid) RNA;
 2. Rapid antigen tests - to detect antigen viral proteins from the SARS-CoV-2 virus; and
 3. Serology tests - to detect antibodies (IgM and/or IgG) against SARS-CoV-2.

Polymerase Chain Reaction (PCR) tests detect SARS-CoV-2 RNA. Most of these assays typically take several hours (including specimen processing time) to generate results and require complex laboratory equipment and trained technicians. There are now some instruments available that can be used outside of a laboratory. These systems can provide quicker results, but cannot do as many tests at once as in a laboratory. PCR tests are currently considered to be more sensitive than antigen testing for detecting early infections. Serology is much less reliable in detecting early infections.

Rapid antigen tests intended for use at the point-of-care detect the presence of viral proteins from SARS-CoV-2 and have been used in the diagnosis of a SARS-CoV-2 infection in a symptomatic patient. COVID-19 antigen tests are generally intended for use with nasopharyngeal, throat or nasal swabs and testing should be performed by health professionals in accordance with the manufacturer's instructions for use.

While rapid antigen tests can provide a result within 15-30 minutes, they are generally considered to be less sensitive than a PCR test which is still currently the gold-standard in SARS-CoV-2 diagnosis. There are marked differences in performance with different antigen kits and many in the past have had poor performance. However, more recently rapid antigen tests with much better performance are becoming available.

Serology tests detect antibodies to SARS-CoV-2 from blood samples. These tests look similar to common pregnancy tests and results take about 15–30 minutes. However Antibodies can take up to two weeks or more to become detectable in blood after infection with SARS-CoV-2. While IgM antibodies develop earlier than IgG antibodies, there is still a delay of many days after infection before IgM antibodies develop. IgG antibodies take even longer to develop. So consequently serology testing generally provides historic information about viral exposure and are not very useful in diagnosing active infections. They can however indicate whether an individual has past exposure to SARS-CoV-2.

Current clinical management of COVID-19 cases focuses on early recognition, isolation, appropriate infection control measures and provision of supportive care⁴⁴. There is no specific antiviral treatment currently recommended for patients with suspected or confirmed COVID-19 and there is currently no safe vaccine. As such, most of the principles underpinning successful interventions relate to isolation and social distancing.

⁴⁴https://www1.health.gov.au/internet/main/publishing.nsf/Content/novel_coronavirus_2019_ncov_weekly_epidemiology_reports_australia_2020.htm

Attachment F – Definition of good practice

Planning and Preparedness

Governance and multidisciplinary approach is the existence and application high level Governance arrangements in addition to incident control governance structures and mechanisms for managing hotel quarantine.

Governance and incident control are underpinned by emergency management principles which enables good accountability, decision making, escalation pathways and line of sight for operations.

Pre-flight information is the availability and accessibility of information about hotel quarantine as early as possible in the system; ideally prior to boarding an aircraft, including on Commonwealth, State and Territory websites.

Information should be comprehensive, easily accessible, meet web-accessibility guidelines and be available in several languages, and should be located with minimal navigation.

Operational briefing may be referred to as a ‘toolbox’ briefing or ‘huddle’. Good practice includes preparatory, comprehensive, situational information relative to all agencies participating in the airport arrivals process and processing of passengers through transfer and check-in, including command structure and how staff/officers/members should navigate any uncertainty.

Airport arrival should be a well-coordinated disembarkation and processing through the various agencies operating in the environment. Agencies are well integrated and operating seamlessly with one another. Strong IPC practices with due regard for environmental risks will be evident and the process should be mindful of the customer experience.

Transfers is how travelers are moved from the arrivals process through to and including transport to the hotel. Features of best practice include proper marshalling, appropriate PPE and handling of luggage, timeliness of transfer (that is, travelers are not confined to a bus for a long period of time) and appropriate distancing.

Transfers extends to the management of transit passengers through and in airports and, where relevant, into and from hotel quarantine.

Hotel check-in is the process and expediency for arrivals at the hotel including offloading from buses, transit through the hotel foyer and into hotel accommodation. Strong IPC practices will be evident and due regard for environmental risks.

Hotel Quarantine Framework

Strong end to end IPC incorporates proper IPC practice applied throughout the entire hotel quarantine process. Standard IPC precautions include hand and respiratory hygiene, the use of appropriate PPE, safe waste management, proper linens, environmental cleaning, and sterilization of patient-care equipment. Implementing

standard precautions as a first-line approach to IPC minimises the risk of transmission of infectious agents from person to person, even in high-risk situations.

Strong IPC is commensurate with environmental risks should be evident during the all stages of the hotel quarantine process and in the hotel environment.

Comprehensive IPC training is regular and as-needed face to face training including demonstrations of correct donning and doffing and disposal of PPE and environmental cleaning practices. Ideally training is competence based.

Assurance processes include scheduled and/or random compliance checks by appropriately qualified IPC experts. Good practice demonstrates the use of IPC practitioners to audit IPC practices, and treatment plans for rectification of identified issues. Assurance processes should be incorporated as a regime for organisational improvement.

Case management/data integration is the integration of various records pertinent to a hotel quarantine guest's quarantine period. Data integration should reflect good case management supported by ICT infrastructure. Data should be accessible to relevant parties and accurately capture an individual's hotel quarantine journey.

Clinical overlay is the presence, physical or virtual, of clinical supervision and treatment for hotel quarantine guests. Clinical overlay is cognisant of the duty of care responsibilities that are inherent in the hotel quarantine system and should be applied conscious of the risks posed by failures to identify all health needs of travelers. Good practice also includes pathways for escalation and evidence of clinical governance structures. The level of clinical overlay and strong clinical governance structures evident in the system provides additional assurances.

Testing includes testing early in the hotel quarantine period and on approaching exit. Typically occurring at the 2 and 11 day mark and largely in line with national guidelines.

Exemptions and leave is evidenced by a robust decision making framework, clear lines of accountability and role definition as it pertains to temporary (leave) or permanent exemptions from quarantine. The framework should document how and when decisions are made about who is exempted from quarantine, how risk has been considered and applied in the approach and escalation or appeal pathways.

Risk strategies is the existence and application of an overarching risk policy statement or similar regarding the risk appetite for the hotel quarantine process. Successful hotel quarantine models are hallmarked by and strong coordination of all components within the Hotel Quarantine System, clear lines of accountability and ownership of risk.

Risk strategies should be supported by statements, frameworks and/or matrixes that identify the range of environment and system risks associated with hotel quarantine including how risk controls are captured, applied and measured.

Hotel infrastructure is the environment or physicality of the hotel/quarantine venue insofar as it supports the wellbeing of hotel quarantine guests. Hotel infrastructure should enable access to open spaces and fresh air independently (that is, without escort).

Procurement

Supervision of contracts is evidenced by strong administration processes and accountability structures to manage external service provider contracts. Documented contractual management and oversight will be evident.

Procuring hotels is well documented decision making, including relevant tender or single select, or similar, processes under standard government procurement processes or under powers associated with state emergency/public health legislation.

Quality of hotels is the variation in hotel type within a local region. Hotels should be of similar quality and rating for the regional context.

Health, Mental Health and Wellbeing

Health screening is a comprehensive health and wellbeing assessment to identify all health needs of returned travelers. Health screening is proper health assessment to ensure that the amount of intervention and clinical input needed is properly determined in order to manage risk and ensure proper care.

Good practice health screening is not limited to whether a traveler is symptomatic for COVID-19 and should include assessments for any mobility or cognition issues, comorbidities, mental health concerns, drug and/or alcohol health issues, pregnancy including any high risk indications, or any other issue that may affect someone's capacity to undertake or manage the hotel quarantine environment.

Health screening is relevant to clinical overlay.

Triage and placement is based on health screening to determine appropriate placement in hotel quarantine. Ideally triage results in appropriate placement in the hotel quarantine system that segregate COVID-19 positive and negative populations and that are commensurate to a hotel quarantine guests other health and wellbeing needs.

Mental health is the presence of assertive mental health screening and treatment available to hotel quarantine guests. Good practice includes assertive in-reach in a timely manner including administering mental health assessment tools. Ideally this is in-reach and undertaken on day one of hotel quarantine to identify immediate concerns, and with daily follow up with guests to identify emerging or escalating psychological distress, until guests decline further contact and/or support.

Mental health screening and support should not be reliant on the guest seeking out support and is relevant to clinical overlay.

Addictions is the evidence of screening for alcohol, nicotine and/or other drug issues. Ideally it is undertaken during the health screening process or shortly thereafter. On identification appropriate treatment plans, replacement therapies and counselling is available to hotel quarantine guests.

Vulnerable groups is the identification process and support available for people with, for example, a disability, cultural and linguistically diverse populations, the elderly and risk for falls, the availability of occupational therapy and other non-clinical support. This feature is relevant and complemented by good health screening and clinical overlay.

Customer Experience

Entertainment is the presence of engagement or entertainment activities, either in person with appropriate controls or through online platforms, which may include exercise, craft, trivia etc. Good operations are mindful of the need to provide hotel quarantine guests opportunities to engage in a 'structured day' and opportunities to establish a routine, both of which has been shown to be effective against mental fatigue, feelings of isolation, and vulnerability.

Food is the availability and reliability of quality meals delivered in a timely fashion and available for all dietary requirements. Good practice also entails unrestricted access to meal and/or grocery delivery services. It should not be limited to one a day; guests should be able to receive these as requested.

Community is the existence of online platforms in which hotel quarantine guests and their children can engage in facilitated conversations, share experiences and build a sense of community.

Support for parents is quarantine systems that recognise the challenges for parents with young children in the hotel quarantine environment. Good practice involves support for parents in the form of counselling, strategies and/or tools that may assist in managing children in the hotel quarantine environment.

This is particularly relevant for single parents and those with very young children, and ensuring there are opportunities for those parents to exercise self-care practices. This is distinct from mental health screening.

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Appendix 1 – Terms of Reference

Hotel Quarantine

National Cabinet agreed to a national review of hotel quarantine arrangements. The review will be undertaken by the former Secretary of the Commonwealth Department of Health, Jane Halton AO, in consultation with states and territories. AHPPC recommends, and National Cabinet has agreed, that a review should address:

- Infection prevention and control training (clinical, hotel and security staff)
- Compliance with infection prevention and control requirements (clinical, hotel and security staff)
- Evidence of community cases attributed to cases in international travelers in hotel quarantine (including cases in hotel and security staff)
- Rates of compliance with testing
- Legislative or contractual basis for mandatory testing
- Management of suspected and confirmed cases
- Provision and effectiveness of support services (medical, mental health, social services, financial support)
- Management of vulnerable people
- Management of cultural diversity
- Logistics arrangements
- Administrative arrangements
- Changing capacity requirements related to changes in border restrictions

States and territories are moving toward a model of charging for hotel quarantine. Further details will be provided by states and territories in the coming days, with National Cabinet agreeing to work toward a uniform model across the country.