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Political leadership and public service management in a crisis: Victoria's second wave

An ANZSOG Teaching Case by Dr Margaret Simons

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Summary

The state of Victoria's response to the corona virus pandemic is now the most examined and investigated of any jurisdiction in Australia – and possibly in the world. This is not surprising. The nation's response to the pandemic is internationally recognised as a success. Within this generally positive story, Victoria's second wave – dating from early May until the end of October 2020 – was the most significant failure. The second wave was caused by "leaks" of the virus from a hastily implemented and poorly managed hotel quarantine system for returned travellers. This case study draws on three inquiries into aspects of the Victorian government's handling of the second wave and asks what lessons can be learned. The inquiries found systemic failures by government, as well as problems with decision-making reflecting on ministerial responsibility. The case study identifies key decision-making points as well as both long and short-term issues of governance. These include the impact of emergency public health responses on human rights obligations; the consequences of government outsourcing of key services; the quality of emergency planning, particularly for pandemics and the implications of greater centralisation of policy; and decision-making, including

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through the establishment and operations of “National Cabinet”. Students are invited to reflect on these issues in the context of the core responsibilities of government in emergencies.

Key points

Australia is internationally recognised as a success story in the management of the COVID-19 pandemic. Australia has been described by *Time Magazine* as having “knocked it out of the park” through an early and aggressive response driven by the science and coordinated between state and federal governments (Bremmer, 2021). By the end of 2020, community transmission in Australia had been effectively eliminated. Since then, there have been only a few quickly controlled outbreaks from the hotel quarantine of international travellers. By mid-March 2021, there had been 29,166 cases and 909 deaths out of a population of about 25.3 million (Department of Health, 2021).

Within this overall success story, a second wave in the state of Victoria from May 2020 represents the biggest failure. Having virtually eliminated the virus by the end of April, the second wave peaked at 671 new cases in a day on 2 August, at which time there were 6,322 active cases. The second wave led to extended restrictions and eventually the declaration of a state of disaster, accompanied by a 112-day lockdown of the capital city, Melbourne, as well as shorter lockdowns in regional Victoria. Around 768 people died in the second wave (DHHS, 2021).

In June 2020 it was established through genomic testing that 99 per cent of Victoria’s second wave of COVID-19 cases were transmitted from return travellers to workers in the hotel quarantine system where they were detained. From these workers, community transmission escalated rapidly, with the second wave overwhelming the state’s contact tracing system – the process of identifying, assessing, and managing people who have been exposed to disease to prevent onward transmission (Coate, 2020b; Parliament of Victoria, 2020).

On the day the genomic testing was released, the Premier, Daniel Andrews, announced a judicial inquiry into the failures of hotel quarantine, and the associated government decision-making processes. A key issue was perceived to be the use of private security guards who were one of the main sources of transmission. Media reports suggested misbehaviour by these guards and lax and chaotic management – including sexual contact with detainees - might have caused the transmission (Whinnett & Johnston, 2020). The hotel quarantine inquiry later cleared the guards of blame, but found serious systemic issues in decision-making, leading to seriously poor management (Coate, 2020b).

Early in the second wave, on 3 July 2020, nine public housing towers were identified as an emerging cluster and were subjected to a “hard lockdown”, imposed without warning, with residents prohibited from leaving their homes while as many residents as possible were tested for the virus. The lockdown lasted for five days (in the case of four of the towers) and 14 days in the case of a single tower in North Melbourne.

In the aftermath of these events, there were three separate inquiries by different bodies into aspects of the Victorian Government’s management of COVID-19.

All three inquiries identified systemic issues with the Victorian public service, particularly but not only the Department of Health and Human Services (DHHS), which included the Chief Health Officer (CHO) and a public health team under his control. It was the CHO who had the statutory power to impose lockdowns and quarantine detention.

The Minister for Health, Jenny Mikakos and the Secretary of the Department, Kym Peake, both resigned before Coate’s final report. So, too, the Secretary of the Department of Premier and Cabinet, Chris Eccles. All these resignations were prompted by aspects of the Coate inquiry.

The three inquires: Systemic and resourcing issues

The Hotel Quarantine Inquiry, led by Justice Jennifer Coate, released two reports – the first, in November 2020, contained recommendations on how hotel quarantine should be run in the future (Coate, 2020a). These recommendations have been largely though not entirely adopted by the Victorian government and other Australian jurisdictions. The second Coate report, released in December 2020, is the focus of the narrative below. It reported on an investigation into how mistakes had been made and the associated government decision-making and planning, including the decision to use private security firms and the manner in which hotel quarantine came to be established (Coate, 2020b).

The Victorian Ombudsman, Deborah Glass, launched an own-motion inquiry into the impact of the public housing lockdown from a human rights standpoint (Glass, 2020).

Concurrently with these inquiries, a committee of the Victorian Parliament inquired into the state's capacity for contact tracing, and the public health capacity more generally. It reported on 14 December 2020 (Legal and Social Issues Committee, 2020).

Activity: Read the inquiry reports and access submissions and evidence at these links-

- The Coate Inquiry: <https://www.quarantineinquiry.vic.gov.au/>
- The Ombudsman's Inquiry: <https://www.ombudsman.vic.gov.au/our-impact/investigation-reports/investigation-into-the-detention-and-treatment-of-public-housing-residents-arising-from-a-covid-19-hard-lockdown-in-july-2020/#executive-summary>
- The Parliamentary Inquiry: <https://www.parliament.vic.gov.au/lsc-lc/article/4574>

Coate found both long- and short-term factors that lead to the failure of hotel quarantine.

First, there was a lack of planning for quarantine in the case of a pandemic. Coate indicated that the fault here lay chiefly with the Federal government. A pandemic was not, or should not have been, a surprise, she said. There were Commonwealth pandemic plans and Victorian counterpart documents, but none anticipated the need for a mass program of mandatory quarantine, despite a 2009 review of the Commonwealth plan recommending that this be attended to. The lack of planning meant that Victoria had to build its program from scratch, with just 36 hours between a National Cabinet decision to compulsorily detain travellers and the arrival of the first detainees.

Coate said:

This placed incredible strain on the resources of the State and, more specifically, on those Departments and people required to give effect to the decision of the National Cabinet. This was a most unsatisfactory situation from which to develop such a complex and high-risk program (Coate 2020b, p.16).

In this context, Coate found that decision making was faulty and ministerial responsibility was largely ignored which resulted in management issues on the ground that helped seed the second wave. This process is examined in more detail in the next section.

Coate was also highly critical of a toxic culture within the DHHS which had led to the public health team being sidelined and not involved in key decisions.

The Ombudsman, meanwhile, described the public housing lockdown as a “a very dark episode in our recent history,” (Eddie & Booker, 2020) in which the human rights of residents were not respected, and the government struggled to provide even the most basic of needs for locked down residents. While Glass found the hard lockdown was justified on public health grounds, she said the decision to impose it immediately and without warning had not been made on public health advice, but rather by Cabinet. Glass was denied access to Cabinet minutes, so said she was unable to comment on this aspect of the decision-making process. It is not clear from what has been made public whether Cabinet believed it was acting on public health officials' advice and overlooked the subtleties in the necessary rush of the decision-making process, or whether some other consideration intervened. Public health officials had expected to have 36 hours to prepare. In fact, they had no preparation time.

Glass, too, found a lack of planning was to blame, together with a history in which outsourcing of key management functions regarding public housing had led to government losing touch with tenant communities and their needs. It became apparent during the outbreak that the DHHS, which was the landlord for public housing tenants, did not have an accurate knowledge of who was actually living in the towers – many more residents were present than were on the departmental records. Trust between residents and the Department was low, partly because residents had for a long time been seeking attention to cleaning and maintenance issues – all handled by private sub-contractors. They felt their concerns were routinely ignored, and this impacted on their willingness to trust that the government was now acting in their best interests or able to meet their needs. At the same time, Glass said that documents relating to the lockdown showed the government agencies perceived the towers as “a hotbed of criminality and non-compliance” despite the fact that the vast majority of residents were law abiding people. Glass stated:

It is unimaginable that such stereotypical assumptions, leading to the 'theatre of policing' that followed, would have accompanied the response to an outbreak of COVID-19 in a luxury apartment block (Glass, 2020, p.5).

The DHHS, had not prepared an outbreak management plan for public housing. The lack of planning meant that urgent needs for food, health, and social supports as well as qualified interpreters for the multi-cultural community were not developed, nor were community leaders in the public housing towers briefed about the intervention.

Glass said she was not criticising the public health authorities, who were dealing with "huge logistical challenges" and that "[p]eople laboured heroically into the winter nights, above and beyond their official duties, to support the residents and respond to the public health emergency." However, she emphasised, "neglecting human rights comes at a deep human cost... We may be tempted, during a crisis, to view human rights as expendable in the pursuit of saving human lives. This thinking can lead to dangerous territory ... human rights are inherently and inseparably a consideration of human lives" (2020, p.5).

The Ombudsman recommended the State government make a public apology to the residents, but this recommendation was rejected. Other recommendations included establishing better relationships between the government as the landlord and the tenants (Glass, 2020).

The Parliamentary Inquiry, conducted by the Legislative Council Legal and Social Issues Committee, also heard evidence about longstanding cultural issues in DHHS, which was said to be defensive and reluctant to acknowledge errors. Public health had been subjected to long term cuts in resourcing, and the government had failed to adequately respond to reports which had called for this to be addressed. Again, outsourcing was an issue, with key public health functions entirely dependent on outside agencies.

In its report, the Committee said:

The Committee views the reluctance by the Victorian Government to concede or acknowledge errors as a contributing factor in the substantial delays in the implementation of a suitable contact tracing management system. Further, the Committee notes that however capable the current contact tracing solution is, it was not available when the Victorian public needed it. This failure cost lives and was unable to be rectified without strict lockdown measures throughout the state. Furthermore, the Committee notes that this lack of humility has the capacity to hinder progress by limiting opportunities for collaboration or building off developments made in other jurisdictions (2020, p.97).

The inquiry found that at the beginning of the pandemic the old fashioned, manual system of contact tracing had been inadequate for the task, and the government had been slow to admit this and to adopt technological solutions to change it. By the time the inquiry reported, it said that this had greatly improved, demonstrating the government was now willing to learn from its mistakes. However, the Committee said, "greater transparency in relation to processes and a willingness to acknowledge and take responsibility for failings by the Victorian Government would increase public trust and confidence in the capacity of the contact tracing system and testing regime" (Legal and Social Issues Committee, 2020, p. 97).

Hindsight is a wonderful thing, and all the problems identified by these inquiries arose in the context of an emergency, with time for decision-making extremely short and well-meaning people working extraordinarily hard to deal with life threatening conditions.

Nevertheless, all three reports raised issues of systemic importance, including decision-making processes, the culture of the public service, resourcing of public health, and the impact of outsourcing arguably core government functions.

The 27 March 2020: A day that was measured in minutes

We will now turn to an example of how these long-term systemic problems played out when the public service and system of governance came under extreme pressure. Unless otherwise referenced, this account is drawn from the Final Report of the Coate inquiry (Coate, 2020b).

On 27 March 2020, there was a meeting of "National Cabinet" – a body established as part of the federal pandemic response and comprising the Prime Minister and all the State Premiers and Territory Chief Ministers. Before this date,

returning international travellers were asked to quarantine in their homes, but there had been media reports of non-compliance, as well as alarm about increasing infection rates. The key health body advising National Cabinet had recommended enforced quarantine only for “high risk” cases. Nevertheless, National Cabinet decided to make detention mandatory for all international arrivals, with the states responsible for implementation.¹

Premier Andrews later told the Coate inquiry that he thought setting up a hotel quarantine system at short notice was feasible, despite the lack of a plan and the fact there were only 36 hours for implementation before the first arrivals were due.

During the National Cabinet meeting, the Secretary of the Department of Premier and Cabinet, Chris Eccles, (who was the head of the Victorian Public Service) rang the secretary of the Department of Jobs, Precincts and Regions (DJPR), Simon Phemister, and charged him with finding hotels for the quarantine scheme and beginning to set it up. DJPR had previously been involved in sourcing hotel accommodation for health workers, but otherwise, as Coate put it, “had no preparation for, or relevant expertise to operate, an enforced quarantine program” (2020b, p. 18). There was no planning for how the hotels would be identified, cleaned, staffed and how security would be maintained.

What followed was a scramble of meetings, phone calls and rushed decision-making involving several agencies.

Decision Making Point One: Imagine you are Chris Eccles on the afternoon of 27 March 2020, with decisions being made in an atmosphere of crisis and extreme time-pressures. Before the meeting, what advice would you give to the Premier? After the decision to establish hotel quarantine was made, what options do you have for maximising good implementation?

The rest of 27 March was described in evidence before Coate as a day “that was measured in minutes” – a phrase she adopted for her chapter on the decision-making process that followed (2020b, p.114).

The decision on use of private security

A key reason for the appointment of the Coate inquiry was because Premier Andrews said he could not determine who had been responsible for the key decision to use private security guards as the main compliance workforce in the hotels. Andrews admitted in his evidence before Coate that the government knew there were problems with this industry, due to previous reviews. He agreed that the failure of anyone to take responsibility for this decision was seriously concerning.

Both in his evidence and in a media conference after the inquiry, Andrews said that the problem was not so much the use of private security – other states had also used it. Rather, the problem was that the guards had not been adequately trained, managed, and supervised. The inquiry heard multiple accounts of chaotic management on the ground in the quarantine hotels, with nobody taking responsibility for problems.

But Coate found that these on-the-ground management problems followed directly from the inadequate decision-making processes on 27 March. Coate described that the decision to outsource security in the hotels was key. The government had decided to deprive citizens of their liberty, in the interests of protecting the wider community. There could hardly have been a more significant exercise of government power and responsibility. But the government then outsourced the exercise of the power, and the responsibility, to an industry which it knew had big problems.

Coate found that this decision, made in the context of a government grown use to outsourcing “services”. In this, she echoed Glass’s comments, in a different context, on the ease with which government was prepared to outsource key functions of government. In this case, said Coate, the decision was made without any proper process or consideration of alternatives. Responsibility for training in infection control was also largely outsourced.

No single person or agency took responsibility for the decision to use private security– nor was Coate able to determine individual responsibility. In her report, she laid out a detailed evidentiary trail and concluded that no Ministers were involved. Nor was there any proper risk assessment process or consideration of alternatives.

¹ Quarantine is usually a national responsibility. The Coate inquiry sought access to National Cabinet minutes so as to better understand the reasoning behind these decisions, however this was denied.

This, Coate described as “likely to shock the public” (2020b, p.20).

Coate found, though, that two individuals were the main “influencers” of the decision: the then Commissioner of Police, Graeme Ashton and Chris Eccles.

It was clear there was some discussion of private security at the National Cabinet meeting – though not, apparently, a decision. It was also clear that Victoria Police had expressed a preference that police not be used as the main security workforce.

In the early afternoon of the 27th, shortly after the National Cabinet meeting, Commissioner Ashton was texting and ringing around trying to find out what was going on with the decision to establish hotel quarantine, and whether police would be involved. After taking a phone call from Eccles at 1.17pm, Ashton believed that a “deal” had been set up by the Department of Premier and Cabinet under which private security guards would be used (Coate, 2020b, p.155). But in fact, no decision had been made, or at least not under any proper decision-making process.

Both Eccles and Ashton claimed to Coate not to remember the contents of that phone call. Initially Eccles failed to disclose the call at all. It came to light only at a later stage of the inquiry, after the Coate inquiry had requested phone records of people in the Premier’s Department. This oversight and failure to disclose led to Eccles’ resignation.

Victoria Police claimed in their submission to Coate that the decision to use private security must already have been made before the Eccles-Ashton phone call and suggested that National Cabinet was the source. Coate rejected this.

Rather, she found that an assumption formed and was carried forward into the afternoon through various communications and meetings until a meeting of various agencies at the State Control Centre (SCC) late in the afternoon of 27 March. It was only after this meeting that the Department of Jobs Precincts and Regions began to contract the private security firms.

At the SCC meeting, as Coate put it “the die was cast ... The meeting moved on to other topics, with the decision now made, though those at the meeting do not appear to have been aware that such a significant decision had been taken” (2020b, p.144).

Significantly, this major decision, going to the heart of government power over its citizens, was made without any ministerial involvement.

Decision Making Point Two:

- What does this case reveal about decision-making processes in the public service?
- What actions might have improved implementation in the wake of this decision-making process?
- Consider the arguments for and against the use of private security on the one hand, and the police force on the other.

Poor decision-making leads to poor management

The lack of a proper decision-making process, Coate found, led directly to poor management of hotel quarantine. Because nobody was responsible for the decision, there was also no clear responsibility for reviewing the implementation of the decision or making sure the system was working as planned.

Coate found there was no articulation of how the private security guards would be used, but in fact their role grew from an assumed “static” job of keeping people in their rooms to handling luggage, accompanying detainees on fresh air breaks and even buying toys for children. Private security guards ended up being stop gaps, a workforce used to do anything that needed to be done when the public sector employees were stretched.

Coate recorded how one provider, Unified Security, came to be preferred because its staff were prepared to pick up this extra work without comment or complaint. This was despite the fact that Unified was not on the government’s list of preferred suppliers. On the other hand, when another company, Wilson Security “rightly” raised issues about the risks involved it was effectively penalised as a result. This was despite the fact that Wilson had much better policies, practices and supports to mitigate the risk of virus infection (2020b, p.23).

These problems with management were greatly exacerbated and complicated by a dispute that emerged on 27 March and continued, between DHHS and DJPR as to who was in charge of the hotel quarantine operation.

After Eccles' phone call from outside the National Cabinet meeting charged DJPR with setting up the hotels and organising contracts for security, cleaning, and other services, it was decided later in the same afternoon that DHHS should be the lead agency. DJPR would continue to be responsible for the logistics of contracts and so forth, but DHHS would manage the overall operation of hotel quarantine. All the departments and agencies involved believed that from this point on, DHHS was in charge and taking responsibility for the operation. However, Coate found that DHHS never fully accepted this responsibility. Throughout the period that followed, and in evidence before Coate, the DHHS and Minister Mikakos insisted that the DHHS was "jointly responsible" with other agencies, rather than the lead agency. The State Controller for Health, Jason Helps, the Department Secretary, Kym Peake and Minister Jenny Mikakos all argued vigorously to the inquiry that the DHHS role was limited, and its responsibility shared.

Coate commented that this lack of acceptance of responsibility "was the source of considerable and significant problems with the way in which the Program operated" (2020b, p.19).

These problems included contract development and management, with DJPR responsible, although DHHS was "on the ground" in the hotels. The contracts failed to make it clear, for example, that private security guards were subject to the direction of DHHS. This led to a lack of clarity about who was responsible for enforcing infection control procedures among the security guards.

Coate concluded that the Hotel Quarantine Program had been left "without a government agency taking leadership and control and the overarching responsibility necessary to run a complex and high-risk program" (2020b, p.29). It was when Premier Andrews, in his evidence before Coate, agreed that it was DHHS, that Minister Mikakos, who was responsible, resigned. In a statement on her resignation, Mikakos continued to assert that her department had not been solely responsible, but she also made it clear that she felt she had not been properly briefed.

Mikakos said in her statement:

As I said to the Board of Inquiry, I take responsibility for my department, the buck stops with me. With the benefit of hindsight, there are clearly matters that my department should have briefed me on. Whether they would have changed the course of events only the Board and history can determine (Grattan, 2020).

Reviewing the extraordinary disagreement on whether or not DHHS was ultimately responsible for an operation that was, quite literally, a matter of life and death, Coate commented, "This was the source of considerable and significant problems with the way in which the Program operated" (2020b, p.19).

The on-the-ground result of this confusion about control and responsibility was that in the hotels, nobody was in charge. Coate said:

This left brewing the disaster that tragically came to be. This complex and high-risk environment was left without on-site supervision and management, which should have been seen as essential to an inherently dangerous environment. That such a situation developed and was not apparent as a danger until after the two outbreaks was the ultimate evidence of the perils of the lack of proper leadership and oversight (2020b, p.30).

Public servants and ministerial accountability

Coate found a number of points at which senior public servants failed to brief their ministers. Peake, as Secretary of DHHS, failed to brief Mikakos on emerging problems in hotel security, according to evidence from both women.

Another instance was on 8 April, when Eccles received an email from the Secretary of the Commonwealth Department of Prime Minister and Cabinet, Phil Gaetjens, which suggested that members of the Australian Defence Forces (ADF) might be available to Victoria to help in the quarantine hotels. Premier Andrews had earlier stated that he believed the ADF were not available. He had emerged from National Cabinet, he told Coate "with quite the opposite view".

However, Eccles did not pass the substance of this email on to Premier Andrews. Andrews agreed with Coate that the information would have been “very significant” to him, and he “certainly would have wanted to know, because it would have presented us with options we otherwise didn’t have” (2020b, p.149).

Coate described it as “surprising and inexplicable” that Eccles had not briefed the Premier on this email.

These instances added to a picture of public servants making key decisions without reference to ministers – and for that matter, ministers seeming to lack activism and curiosity.

As well as the failure to involve ministers in the decision to use private security, Coate found:

- Minister Mikakos was not consulted or advised about the operational plan for hotel security, nor did she approve any of the plans.
- The Minister for Jobs, Precincts and Regions, Martin Pakula, said that while he was briefed “from time to time”, he only became aware of some of the problems his department was dealing with as a result of evidence before the inquiry. He had not been aware of the fact that his department was contracting with private security, nor other contracts for cleaning services.

Coate commented:

Ensuring that Ministers are thoroughly and properly briefed is part of our system of responsible government, in place to create checks and balances on bureaucratic decision making. It is also in place to, thereby, confirm that the Minister for the department is performing the important function of maintaining oversight of his or her department’s actions for which he or she is answerable to the people of Victoria (2020b, p.310).

Decision Making Point Three:

- What does this case reveal about relationships between public servants and ministers?
- What lessons are there from this case?

The issue of ministerial briefings and public service briefings was outside Coate’s terms of reference. Nevertheless, she referred the evidence regarding the way senior public servants behaved, and the lack of ministerial accountability, to the Public Sector Commissioner – who has a statutory responsibility for reviewing and strengthening the public sector (see <https://vpssc.vic.gov.au/>).

Political leadership and the second wave

Despite the problems identified here, Victoria defeated the second wave, returning to zero community transmission, albeit with a few isolated outbreaks. This is a significant achievement not paralleled anywhere else in the world. Despite hostile media commentary, the population was largely compliant throughout the lockdowns.

In this, the role of the Premier was key. Throughout the second wave, he held a daily media conference, live streamed, at which he reported on the latest figures of COVID-19 infections and deaths and answered questions from journalists as well as urging public compliance with the lockdown and track and trace regimes.

Very little media commentary and reporting focussed on the systemic issues of public service resourcing and public service decision making identified here – the issues on which Andrews should arguably have been held to account.

Public opinion polls suggest that the Premier maintained political support despite depriving the population of many of its liberties, with great suffering and loss of jobs as a result. A poll at the end of the lockdown, in November 2020, found 71 per cent of the Victorian electorate approved of the way Andrews was doing his job and his Australian Labor Party government had maintained a clear lead over the Liberal Party opposition (Roy Morgan, 2020).

Towards the end and after the events described here, several other states in Australia had outbreaks of the virus from their respective hotel quarantine schemes. Unlike Victoria, they were contained. New Zealand also experienced similar outbreaks. By the end of 2020 it was clear that keeping the virus contained in hotel quarantine was an extremely difficult enterprise, and early in 2021 the emphasis had shifted in Victoria to the building of purpose-built facilities for quarantining.

Andrews led a vigorous response to the problems identified here. For example, the contact tracing system by the time the Parliamentary Inquiry reported judged to be fit for purpose and indeed one of the best in the world (Legal and Social Issues Committee, 2020). Following the first Coate report, Andrews established a dedicated agency to oversee hotel quarantine, and later announced that a purpose-built quarantine facility would be built. He also split the troubled DHHS into two, smaller Departments.

Conclusions and key lessons

The experience of Victoria through the pandemic casts significant light on the dilemmas of democratic governments in an emergency, including the various roles of public service cultures and political leaders.

Key lessons can be drawn about the need for robust planning for emergencies, the need to maintain robust decision-making processes, even in an emergency, and the importance of ministerial accountability and public service cultures that are respectful of that.

As well, the events described here should prompt reflection on what functions of government can properly be outsourced to the private sector, and which should remain “in house” and under direct ministerial control.

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