

Special Commission of
inquiry into the Ruby Princess,
2020

COVID-27 MARCH
2020

REPORT



New South Wales
Australia

Special Commission
of
Inquiry into the
Ruby Princess

Report of the Special Commission of Inquiry
into the Ruby Princess

ISBN

978-0-646-82315-7 (print version)

978-0-646-82316-4 (online version)

Published 14 August 2020

© State of NSW through the Special
Commission of Inquiry into the Ruby Princess

SPECIAL COMMISSION OF INQUIRY INTO THE RUBY PRINCESS



New South Wales
Australia

SPECIAL COMMISSION OF INQUIRY INTO THE RUBY PRINCESS



Special Commission of Inquiry into the Ruby Princess

14 August 2020

Her Excellency the Honourable Margaret Beazley AC QC
Governor of New South Wales
Office of the Governor
Macquarie Street
SYDNEY NSW 2000

Your Excellency

I was appointed by Letters Patent dated 15 April 2020, issued pursuant to the *Special Commissions of Inquiry Act 1983* (NSW), to conduct a Special Commission of Inquiry into the voyage of the Ruby Princess from 8 to 19 March 2020 and subsequent efforts to diagnose and treat, and to contain the community transmission of COVID-19 by, Ruby Princess passengers.

I now present to you the Report of the Special Commission, comprising one volume.

Pursuant to s 10(3) of the Act, I respectfully recommend that the whole of the Report be made public promptly as it deals with important matters of public concern.

Yours faithfully

A handwritten signature in black ink, appearing to read 'Bret Walker'.

Bret Walker SC

Commissioner

Special Commission of Inquiry into the Ruby Princess

Level 3 | Registrar General's Building | 1 Prince Albert Road, Queens Square | SYDNEY NSW 2000
T (02) 92285795 |

SPECIAL COMMISSION OF INQUIRY INTO THE RUBY PRINCESS

Contents

Chapter 1: Introduction and Overview	15
Chapter 2: Key Findings and Recommendations	31
Key Findings	31
Chapter 9	31
Chapter 12	32
Chapter 13	33
Recommendations	34
Chapter 11	34
Chapter 3: Chronology of the COVID-19 pandemic	37
Detection of a new coronavirus in China	37
Virology and clinical characteristics of SARS-CoV-2	40
CDNA National Guidelines	43
Suspect case definition	44
Infectious period	45
Advice for cruise ships	45
Communicable Diseases Intelligence Reports	46
The Diamond Princess	47
The Grand Princess	49
Pandemic declaration and escalating public health responses	50
Chapter 4: Legal Framework for Cruise Ship Arrivals	53
Introduction and key legislation	53
The Constitution	53
The Commonwealth Statutes	53
<i>Biosecurity Act</i>	54
Relevant objects and definitions	54
Responsibilities for administration and enforcement	54
Pratique	55
Chapter 10 of the Biosecurity Act – governance and officials	56
Chapter 2 of the Biosecurity Act – managing biosecurity risks in relation to human health	58
Chapter 4 of the Biosecurity Act – conveyances	59
Commonwealth Policies	60
Chapter 8 of the Biosecurity Act – biosecurity & human biosecurity emergencies	63

Other relevant Commonwealth legislation	64
<i>Australian Border Force Act 2015</i> (Cth)	64
<i>Customs Act 1901</i> (Cth)	65
<i>Migration Act 1958</i> (Cth)	65
Relevant New South Wales legislation	66
<i>Public Health Act 2010</i> (NSW)	66
Legislation relevant to the Port Authority of NSW	68
Chapter 5: Enhanced Cruise Ship Procedures	71
The Port Authority's coronavirus guidelines	71
The division of public health responsibilities in NSW	72
NSW Health's cruise ship surveillance program	73
The decision to develop an enhanced screening procedure for cruise ship arrivals in NSW	74
The early draft procedures	76
The request for assistance from the Port Authority	79
The refinement of a risk assessment procedure	80
The 19 February draft procedure	82
Letter to the Cruise Line Industry dated 22 February 2020	84
The procedure for confirmed cases of COVID-19	85
The draft "Standard Operating Procedure"	86
The National Protocol	87
Border Screening	87
Risk assessments	88
Procedures for dealing with suspected cases of COVID-19 and outbreaks of influenza-like illness	89
Further letter to the Cruise Line Industry of 9 March 2020	90
The risk assessment procedure in practice	91
Modification of the risk assessment form and pre-arrival questions	92
Chapter 6: Prior Voyages of the Ruby Princess in 2020	95
The voyage between 11 and 24 February 2020	95
The voyage between 24 February 2020 and 8 March 2020	96
Communication issues surrounding the Ruby Princess's arrival on 8 March 2020	101
The "false declaration" made by the Commodore on 8 March 2020	104

Chapter 7: The Voyage of the Ruby Princess from 8-19 March	107
The departure of the Ruby Princess on 8 March	107
The pre-embarkation health screening	108
Passengers embark the Ruby Princess	110
The health of travellers during the voyage	111
Policies and procedures of Carnival relevant to the COVID-19 pandemic	111
Observations from passengers in relation to hygiene protocols	111
Respiratory illness on board the Ruby Princess	112
Passengers who attended the medical centre	112
Use of viral swabs by the medical centre	117
The 8 March voyage is cut short	118
Public health measures imposed during the 8 March voyage	118
The response on board the Ruby Princess	119
The Ruby Princess approaches the Port of Sydney	123
Biosecurity clearance processes from 16-18 March 2020	123
Change to arrival time	124
Communications between the Ruby Princess, NSW Ambulance, the Port Authority, the ABF, the NSW Police Force and NSW Health on 18 and 19 March 2020	126
The docking and disembarkation of the Ruby Princess on 19 March	140
The Ruby Princess enters Sydney Harbour	140
The medical disembarkation of Mrs Bacon and Mr Londero	143
Biosecurity clearance and the grant of pratique by DAWE	144
Further testing and confirmation of COVID-19 cases from the Ruby Princess	149
Chapter 8: The risk assessment of 18 March 2020	153
The NSW Health Expert Panel	153
The documents provided for the risk assessment	154
The Expert Panel's risk assessment	157
The rationale for the "low risk" assessment	160
The evidence of Professor Mark Ferson	160
The evidence of Dr Sean Tobin	162
The evidence of Dr Isabel Hess	163
The evidence of Associate Professor Bradley Forssman	164
Chapter 9: Analysis of the risk assessment of 18 March 2020	167
Introduction	167
Nature of the disease	168
CDNA Guidelines	171

“Free” health assessment	174
The ARD Log of 18 March	177
The log should have been read by all members of the Expert Panel	177
An updated ARD Log should have been requested by the Expert Panel	179
Summary re the ARD Log	181
“Low, medium, high” risk assessment	182
The 1% marker for influenza-like illness	187
Dissemination of the CDNA Guidelines	189
Procedures relating to swabs for COVID-19 testing	190
Final observations and key findings	194
Key findings	195
Recommendations	196
Chapter 10: Review of cruise ship procedures	199
A better procedure	199
Chapter 11: Analysis and conduct of human biosecurity arrangements	205
Introduction	205
The arrangement between NSW and the Commonwealth	206
The terms of the arrangement	206
Policies concerning human biosecurity	206
Communication and coordination	208
The establishment and role of the Expert Panel	211
The performance of DAWE’s human biosecurity role	212
The grant of pratique to the Ruby Princess on 19 March 2020	212
The Commonwealth’s response to issues raised by the Commission	214
Updated TIC on 18 March	215
The Human Health forms in MARS	216
The adequacy of training provided to CHBOs and HBOs	218
NSW Quarantine Order	219
Possible improvements to the <i>Biosecurity Act</i>	221
The potential for group Control Orders in the <i>Biosecurity Act</i>	221
The requirement for updated human health information	221
Recommendations	222

Chapter 12: The conduct and actions of Princess Cruise Lines and Carnival plc	225
Introduction	225
Enhanced hygiene procedures	226
Pre-embarkation screening	227
NSW Health Enhanced Procedures	228
Swabs	231
ARD Log	232
Requirement to isolate	232
Additional communication between NSW Health and Ruby Princess	233
Project Gladiator	234
Specific issues	236
Swabs	236
“Free” health assessment	238
“Significant spike” in ARI/ILI cases	238
Suspect cases of COVID-19	239
20 March ARD Log	241
Key Findings	243
Chapter 13: The Public Health Response After Disembarkation	245
Advice provided to passengers on 19 March 2020	245
Self-isolation	245
Onward domestic and international travel	247
Events following detection of COVID-19 on the Ruby Princess	250
Confirmation of COVID-19 positive cases	250
Locating the first positive COVID-19 passengers	252
First communications sent to Ruby Princess passengers	253
Concerns about the authenticity of communications from NSW Health	254
Engagement of Service NSW to contact passengers by telephone	255
Communication with Commonwealth agencies	256
Advice about onward travel included in the passenger communications	258
Case management, contact tracing and testing of passengers	261
Key Findings	263
Chapter 14: Epilogue	265

Appendix A: Letters Patent	269
Appendix B: Abbreviations and Acronyms	273
Appendix C: Staff of the Commission	277
Counsel Assisting the Commission	277
Staff seconded from the NSW Crown Solicitor's Office	277
Executive Assistant to the Commission	277
Media Liaison Officer	277
IT Assistance	277
Appendix D: The Special Commission Website and Advertisements	279
Appendix E: The Approach of the Special Commission	281
Establishment of the Special Commission of Inquiry	281
Terms of Reference	281
Accommodation	281
Processes through which the Special Commission acquired information	281
Public Submissions	281
Documents produced on summons	283
Summonses to Attend	284
Hearings of the Special Commission	284
Legal Representation	285
Those with leave to appear and cross-examine	285
Exhibits	285
Appendix F: Dramatis Personae	287
Port Authority of New South Wales	287
NSW Health	288
Princess Cruise Lines Ltd and Carnival plc	288
The Commissioner of Police, NSW Police Force	288
International Transport Workers Federation, Maritime Union of Australia, Australian Institute of Marine Powered Engineers and Australian Maritime Officers Union	289

Appendix G: Schedule of Hearings and Witnesses who appeared before the Special Commission	291
Appendix H: Exhibits Tendered in the Commission	295
Appendix I: Risk Assessment Form	301
Appendix J: Expert Reports and Statements	305
Professor Anthony Kelleher and Professor Andrew Grulich	305
Professor Andrew Wilson	305
Appendix K: Submissions received relevant to the Commission's Terms of Reference	307
Table 1: Passengers of the Ruby Princess on the 8 to 19 March 2020 voyage	307
Table 2: Passengers of the Ruby Princess on the 24 February to 8 March 2020 voyage	310
Table 3: Passengers of other cruises	311
Table 4: Public submissions	312
Appendix L: Legislation and Subordinate Legislation	315

SPECIAL COMMISSION OF INQUIRY INTO THE RUBY PRINCESS

1

Introduction and Overview

- 1.1 This Special Commission of Inquiry responds to the mishap that was the disembarkation of passengers from the cruise ship Ruby Princess on the morning of 19 March 2020. The setting, of course, was the COVID-19 pandemic then, as now, dominating the public health concerns of Australian governments, and people, like no single threat has in living memory.
- 1.2 The detailed account of the events immediately around the disembarkation is found in Chapter 7. The context provided by recent experience for the Ruby Princess is set out in Chapter 6. Critically, the development of public health procedures to meet this emergency is captured, in detail, in Chapter 5 – and its particular application during the crucial days of 18 and 19 March 2020 is tracked step by step in Chapter 8.
- 1.3 The considered assessment by this Commission of the quality of the public health actions that resulted in the disembarkation of so many passengers infected with SARS-CoV-2 (responsible for the possible disease outcome called COVID-19) is expressed in Chapter 9. More general assessment is found in Chapter 13.
- 1.4 The public health procedures and decisions were grounded in, and an attempt to carry out, requirements (including the exercise of legal powers) laid down by an interlocking system of Commonwealth and New South Wales (**State**) statutes and administrative rules and practices. They are described in Chapter 4, and to a degree critiqued in Chapter 11.
- 1.5 The Commission's evaluation of how an obviously unacceptable outcome could – and should – have been avoided or at least much alleviated is spelled out in Chapter 10, specifically with respect to how matters unfolded on the morning of 19 March.
- 1.6 Princess Cruises or Carnival, as the cruise ship business responsible for the passengers and crew is variously named in the Report, was notoriously the object of considerable blame and criticism in public discussion leading up to, and indeed during, this Commission. For the reasons that are explained in the body of this Report, such issues are not central to the course of conduct that brought about so many infected people departing relatively unrestrained that unfortunate morning from the ship, into the community – in New South Wales, other parts of Australia, and overseas especially in the United States of America. But it is not sensibly possible to pass over Carnival's part in this episode: Chapter 12 draws those threads together.

- 1.7 At this point, it should be noted that the Commission's Terms of Reference have not been regarded as encompassing all the matters concerning the welfare of the crew of the Ruby Princess that were pressed in that regard by the trade unions that represented those interests. Reasonable minds can no doubt differ on the merits of that decision by the Commissioner. The substantial claims by the unions for that expanded inquiry must be acknowledged. In the upshot, detailed consideration of the way the members of the crew were treated after the ship left Circular Quay following the disembarkation on 19 March was considered not to be unlike the way in which passengers, especially those who were infected and those who became sick, or died, were treated in the aftermath of the public health conduct that produced the disembarkation. Neither could be the subject of thoroughgoing inquiry by this Commission.
- 1.8 None of the comments in [1.7] above should be read as downplaying the gravity of the issues concerning the welfare of the crew. It was, and remains, very great. So was, and is, the position and fate of the passengers after 19 March 2020. The consequences of the dispersal, or scattering, of affected travellers (ie both passengers and crew) are self-evidently the most concrete of the public health and governmental reasons for this Commission's work.
- 1.9 The Commission commends the force with which those representing the unions and thus the interests of the crew reminded everyone of the basic human right to health and safety that is meant to protect individuals and communities, everywhere. That reminder was salutary. It was, overall, never contested.
- 1.10 The human consequences of the scattering upon disembarkation have not yet played out. That is the salient feature of an uneliminated infectious pandemic. An attempt to convey the current state of affairs is made in Chapter 14. Its facts and figures simply cannot convey the burden of pain, suffering and grief that COVID-19 has wrought on the Ruby Princess travellers. Those paramount matters were touched on in the evidence given by a selected sample of passengers. The Commission is indebted to these witnesses, whose affecting and dignified words are most eloquent. Inadequately, the staff of the Commission and I here record our deepest sympathies to the bereaved and the sick, and the disabled, who have suffered as a result of the Ruby Princess outbreak of COVID-19.
- 1.11 Here, it must be understood that the shortcomings in the public health response that are found in detail in the body of the Report are by no means to be regarded straightforwardly as causes of the suffering that has followed. There are several aspects to this cautionary note. First, as will be clear from the body of the Report, the Commission's inquiry is not at all the same as a common law adjudication, say, of actionable negligence. The Commission is fulfilling an executive, not judicial, function. Second, hindsight is used throughout the Report in order best to inform as to what went wrong and how it might be avoided in future. That exercise has only limited resemblance, nowhere near complete, to a court's investigation of *sine qua non* causation, and to a court's prospective judgement of alleged failures to achieve a reasonable standard of care.

- 1.12 Third, in particular, the implications of transmitted infection that are characteristic of this virus render near imponderable the reconstruction of what might have been, let alone on the balance of probabilities. As noted below, the tactic of home self-isolation, as was required of the Ruby Princess passengers, is in any event a really useful way to contribute to suppression of transmission. To what extent stricter transport and quarantine measures would have actually reduced the community burden compared to that which did follow from the scattering upon disembarkment is not reasonably possible to say with any confidence. The role of chance, or happenstance, in such networks of transmission is not so easily eliminated. Uncertainty is a constant. The speed with which people become infected at several removes is remarkable, probably partly because of the currently understood fact about the virus that it can be transmitted by persons who are, in the jargon, asymptomatic or pre-symptomatic – people who don't have, or yet have, reason to believe they are themselves already infected. (An instructive and readable illustration of this cardinal feature of SARS-CoV-2 is an article by Christian Tym, "How One Person Spread Coronavirus to at least 71 People".¹)
- 1.13 A general narrative of contextual events is found in Chapter 3. The key findings of the Commission in direct response to its Terms of Reference, including recommendations for future action, are found in Chapter 2.
- 1.14 What follows are the Commissioner's final reflections on this sorry episode. (It need hardly be stressed that they do not detract from the detail and specific content of findings recorded in the body of the Report.)
- 1.15 At the outset, the abiding impression is of seriousness: of the threat, and of the spirit in which officers of the State sought to meet it. We were not prey to the cavalier falsehoods spread by some, including the leaders of other nations affected by this pandemic. The medical science, provisional and early as it must be for this novel coronavirus, was at all material times well appreciated in important respects. First, the virus is lethal, as daily reports of deaths attest. Second, the virus can leave survivors of COVID-19 with grave disabilities and diminution in quality of life. That is, both mortality and morbidity were understood to justify prompt and vigorous precautions against community transmission.

1 See *A Rich Life*, Issue 32, 14 July 2020, <https://arichlife.com.au/4-real-life-examples-of-how-covid-19-clusters-happen/> (By way of disclosure, this periodical is owned by the Commissioner's son.)

- 1.16 Third, on the other hand, touch wood, it seems that a sizable proportion of those infected have not (or have not discernibly, yet) experienced disease let alone serious disease. Long may that continue to be observed. However, as a phenomenon widely believed, this aspect of the virus clearly poses a community risk of complacency – along the lines of “It very likely will not harm me or mine”. It does seem that the initial perception, perhaps still true by and large, that younger people are less susceptible to the virus exacerbates this state of affairs, given the common larger risk-taking by this part of the community. In the absence of ideal altruism, this attitude scarcely encourages the punctilious observance of distancing, hygiene and masking now universally thought to be indispensable for a strategy of suppression, let alone elimination. Thus, public health measures are compelled by biological and social circumstances to have to the forefront restraints on personal liberty that would not otherwise or normally be tolerable in a free and confident society.
- 1.17 Fourth, and for this Commission of central importance, is the evolving realisation as the medical world urgently studied the natural histories of SARS-CoV-2 and COVID-19 that the virus could be transmitted by those who had felt no symptoms (mainly, of a general respiratory kind, although not wholly so). Whether such infected carriers never developed disease (leaving the notion of occult pathology aside at present) ie the so-called asymptomatic, or did not do so until after they had transmitted the virus to another or others, ie the so-called pre-symptomatic, the implications are, and were by 18 March 2020, clear. Uncertainties, and approximations from early data, as to the incubation period, and related questions as to the potential for transmission onwards very soon after infection, should have led to one plain conclusion in public health thinking – namely, that preventing the promiscuous mingling of contacts of cases in the community was vital. It was simple to choose as a response. As should have been, and probably mostly was, appreciated by public health officials, a knowing failure to restrict the mingling of contacts (including asymptomatic and pre-symptomatic carriers) would amount to the knowing failure to take an elementary precaution.
- 1.18 The challenge of asymptomatic transmission (as the feature noted in [1.17] above will be called for convenience) includes the large doubts and unknowns as to its significance and extent. But, well before 18 March 2020, its likely reality was well accepted in the public health field. As the evidence before this Commission showed, it followed quite simply that the design of safeguards against community spread could not reasonably regard possible cases (ie sources of possible spread of infection) as confined only to those persons currently suffering relevant symptoms. That simple approach comes from the basic precautionary mission of public health, acutely to the fore in the case of an infectious pandemic. Applied to COVID-19 facts (or working hypotheses) accepted well before 18 March, the approach should have led to reasoning along these lines:

- There is a real possibility that merely checking for symptoms will miss the presence of infected persons.
- There is a real possibility that those (then) asymptomatic carriers may transmit the virus to others in the community.
- Infection presents a real possibility of death, suffering and disability.
- The risk of transmission is substantially reduced and contained by isolation or quarantine, if it is properly policed and maintained (including as to its permitted cessation).
- Unless there are countervailing factors against isolation or quarantine, that precaution should therefore be taken in relation to everyone who should be regarded as a contact, or close contact, of a case.
- The effectiveness of isolation or quarantine in restricting community spread of infection is reduced the longer its commencement is delayed from the time of possible transmission.

1.19 This simple reasoning long predates COVID-19. It predates, in its essentials, modern germ theory of infectious disease. It constitutes a very old form of empiricism in public health, familiar from tales of the plague. In short, the fact that SARS-CoV-2 is a novel coronavirus certainly did not, according to the evidence and common sense, detract from the validity of this simple approach. If anything, the shortage of reliable data and rigorous analysis rendered inevitable by the novelty of the virus, or at least its disease, amounted to a very powerful reason to proceed along the lines sketched in [1.18] above. As was said of the supposed Chinese approach observed by a World Health Organisation mission in February 2020, this simple approach is “very standard and what some people think of as old-fashioned public health tools”, involving “case finding, contact tracing, social distancing, movement restriction... to try and stop a new emergent respiratory-borne pathogen”.²

1.20 Of course, central to the simple approach sketched in [1.18] above is the vital step, and resource, of testing. It was not technically possible to prepare the necessary polymerase chain reaction laboratory procedure on board cruise ships. So swabs of so-called suspect cases had to be taken and properly stored for delivery to testing facilities on shore, a logistical exercise discussed in the body of the Report in several contexts. Obviously, the results of such delayed testing would be critical to the decision whether to regard a cruise ship as having on board one or more cases – so-called confirmed cases upon a positive result. Logically, before these results were known, the suspect cases could all have been assumed to be infected (and thus, they at least, assumed to be carriers – and to have been for some time during the voyage). Because by 18 March 2020 all travellers on a cruise ship were considered to be close contacts of even one case on board, that logical and precautionary assumption should at least have justified the public health authorities taking steps to prevent passengers (and, if their disembarkation were proposed, members of the crew as well) from scattering into the community after disembarkation.

² Bruce Aylward, quoted in James Meek, “The Health Transformation Army”, *London Review of Books* 2 July 2020, 15.

- 1.21 The logic in [1.20] would proceed on an assumed basis only until the results were known from the swabs taken from suspect cases on board. If all were negative, whatever arrangements were preventing disembarkation could be stopped, and travellers left to scatter or isolate according to a further public health assessment. By 18 March, that assessment required home isolation, but was unclear as to onward travel and transportation home, as described in detail in the body of the Report. One way to explain the mishap of the Ruby Princess on 19 March is that it came about because of a failure to follow this logically compelling pathway. And, it should be clear, the reasoning is not arcane, esoteric, scientifically challenging or socially extreme.
- 1.22 The alternative is false logic – ie to treat the ship as having no cases (ie carriers of the virus) on board because the results from testing were not yet known. A positive result would not convert the position from “no cases” to “one or more cases” – it would not alter the biological facts that the tests are designed to detect. Put another way, every suspect case had to be regarded as a real possibility that it was a case, a status which would be “confirmed” if a test result proved positive for the virus. Again, this does not now, in hindsight, appear abstruse or obscure. Neither was it so beforehand, well prior to public health decision-making on 18 March.
- 1.23 A third course should also be examined. Any logic to it, given the precautionary stance mandated by the threat of COVID-19, is completely lacking. That course would be, not to treat suspect cases before learning test results as not-cases, but to regard them as some intermediate or hybrid category, perhaps maybe-cases – but without proceeding therefore to make public health decisions in light of the possibility that they or some of them were in fact cases. There are no empirical data, then or now, to suppose any biological reduction in the threat of the disease or transmission from such suspect-cases-before-test-results, compared with confirmed cases. Common sense militates against the logistical factor of delayed test results producing any such difference. This third course probably did not directly inform what happened on 18-19 March, but serves to illustrate the muddled notion of not awaiting test results.
- 1.24 Once at least one positive result is known, it follows from the approach in [1.18], public health decisions can proceed to consider more fine-grained tracing, further testing of really close contacts, or of everyone. Testing may also permit genetic investigation, which has the potential to permit even better informed protection of the community. “Clusters,” so-called, can be more accurately mapped. Compulsory restraints on liberty could thereby be focussed on informed rather than assumed caution.
- 1.25 And it should go without saying, but cannot in light of President Trump’s unprincipled intransigence, that it is wrong, and immoral, to assert that “If we tested less, there would be less cases” [sic].³ Less testing does not mean fewer cases, but, rather, less intelligence.

3 Presidential tweet quoted in *The Guardian*, Edward Helmore “Donald Trump claims Anthony Fauci ‘wrong’ about cause of COVID-19 surge”, 2 August 2020.

- 1.26 As explained in the body of the Report, the proper approach to the COVID-19 threat posed by the Ruby Princess's nearing the Heads on 18 March 2020 called for the travellers on board to be regarded, in the absence of test results being known, as presenting a real possibility – not remote, not fanciful – that they included one or more infected people who could transmit the virus and perhaps spark an outbreak of infection, if no steps were taken to prevent or limit that outcome. And, wisely, the public health authorities had already decided that everyone on board a cruise ship should be regarded as a "close contact" of any COVID-19 cases on board. That is, the precautionary approach to the potential for contagion saw all cruise ship travellers as people whose health and movements (in the community) needed to be monitored and controlled if there had been even just one confirmed case on board with them. It followed that discovering whether the critical link existed had to precede any scattering upon disembarkation. It thus followed that awaiting test results was rudimentary and very important.
- 1.27 A great deal of the Commission's work addressed the evolving public health methods to meet the risk of COVID-19 on cruise ships arriving in Sydney. Much of that is common to the general efforts to meet that risk as it presented in the full range of circumstances, especially social mingling and travel. This Inquiry is emphatically not a comprehensive review of those overall, comprehensive and continuously adapting public health efforts. The focus rather was on the procedures devised specifically for cruise ships, and on their application on 18-19 March 2020 for the return of the Ruby Princess.
- 1.28 At bottom, the weakness in the procedures iteratively revised in February and March 2020 for cruise ships was the lack of robust redundancy in the screening of possible SARS-CoV-2 infections on board arriving cruise ships. As it turned out, the chances of human error leading to very undesirable social outcomes were not sufficiently reduced. It is part and parcel of all systems of human conduct that occasionally someone will make a mistake, or fail to achieve a reasonably required standard. There is no doubt that the public health officials involved in the Ruby Princess disembarkation well realised this perennial aspect of human (including bureaucratic) behaviour. A question for this Inquiry is whether it was appropriately accounted for in the design and execution of the relevant procedures.

- 1.29 On the whole, the State public health officials did adequately attempt to protect the public health against COVID-19 on cruise ships, by reference in particular to the need to check for human error. However, and it is a big however, their attempts sadly miscarried in this event. Had Ms Ressler not failed to update the epidemiological criterion (ie overseas connexions of travellers on board), it might be thought, at first sight, that a different assessment must have been made by the Expert Panel which actually assessed the Ruby Princess as “low risk”. As the detail in the body of the Report tries to explain, however, this would not be a fair or complete view. The fact is that the Expert Panel knew, as well as Ms Ressler as a senior epidemiologist knew, that during the voyage the class of possibly suspect cases of COVID-19 had substantially expanded by inclusion of the criterion of any recent presence overseas (such as arrival from the USA for the cruise). Members of the Expert Panel, not only Ms Ressler, failed to realise and act on this information. Combined, it was a serious mistake that contributed to the relatively unrestrained scattering of passengers on 19 March 2020.
- 1.30 As the discussion above shows, the failure to await test results on 19 March is a large factor in this Commission’s findings as to the mistakes and misjudgements that caused the scattering of infected passengers. As it happened, two other factors in relation to testing were also significant, if not so causally important. First, the avoidable delay in testing and notifying its results could have had real public health consequences – although the hypotheticals are quite beyond confident reconstruction. The sooner test results were appreciated, the sooner the scattering could be pursued and contact tracing (and associated further testing) carried out. Contacts multiply over time, if people are not completely isolated or quarantined (and then, sadly, subject to imperfect observance producing spread of infection, as in Melbourne recently).
- 1.31 Second, the small number of swabs taken on board the Ruby Princess and available for testing early on 19 March represented a woeful shortcoming in the stipulated number. As the number of swabs reduces, so does the possibility increase that as a sample it will miss any COVID-19 cases: that is not difficult reasoning, and presumably informed the prior explicit requirement that a COVID-19 swab be taken from every respiratory-symptomatic traveller using the ship’s medical facilities during the cruise. In a sense, it was lucky that the too small sample available on 19 March did produce positive results that could produce a belated public health response.
- 1.32 The reasons for the shortage of swabs are examined in the body of the Report. No doubt supply chains were stretched as the pandemic flourished. But it cannot constitute prudent public health administration to have tolerated a profitable leisure business like Carnival knowingly taking the risk of insufficient swabs to comply with pre-existing requirements.

- 1.33 Furthermore, given the expectation that there should have been as many swabs as there had been medical attendances for respiratory symptoms, and the huge deficiency notified to NSW Health as the Ruby Princess approached Sydney, the obvious response was to arrange for dockside swabbing of all such travellers, with swabs made available from the shore. The Commission obtained no satisfactory justification for omitting that fallback precaution.
- 1.34 One way of asking how things may have turned out better than they did is to remove, hypothetically, the basic mistakes committed by failing to observe pre-ordained public health procedures. The main ones are the out-of-date epidemiological criterion relating to travel from overseas, and the shortfall in swabs. If the serious mistake concerning the former had not been made, the Expert Panel would have been alerted of more than one hundred rather than zero travellers meeting that criterion for suspect cases. If the latter had been rectified dockside (if not by more efficient supplies earlier), then more disease intelligence would have been available – assuming results were not delayed – for more rapid response. And overall, it seems clear the dangerous scattering of passengers either would not have occurred, or else it would have been safeguarded with better social distancing, masking and supervised isolation or quarantine. But it is impossible to estimate how much better the outcome would have been with any really solid numbers: too many variables and sensitivities render modelling of alternatives an exercise with diminishing returns. What can confidently be concluded is that we – New South Wales and the broader community – would have been very likely considerably better off with respect to COVID-19 had those mistakes not been made.
- 1.35 The grading of assessed risk and response is a prominent feature of the procedures devised for COVID-19 on cruise ships. As a general method or mode of public health thinking, it is unexceptionable (and unexceptional). However, if only in hindsight, one wonders whether 3 stages from “low risk” meaning no precautions to “medium risk” meaning some precaution but not awaiting test results to “high risk” meaning awaiting test results before passengers scattered, was much of an aid to the public health decision-making called for by the COVID-19 threat. As explained in the body of the Report, the infectiousness of SARS-CoV-2 was understood to be such as to mandate taking all reasonable steps to prevent its spread from a cruise ship. Even a so-called “low risk” was never worth running. And it was a dichotomy, surely – either hold everyone until test results were received, so as then to make appropriate decisions to prevent spread, or not. Given the nature of the virus and the pandemic, that latter choice surely could be made only if there were effectively no risk – and the Ruby Princess on 18 March 2020 was emphatically not in that category.

- 1.36 This Commission's evaluation of the public health conduct on 18-19 March 2020 in relation to the Ruby Princess takes into account some candidates as countervailing factors against the approach described in [1.18] above. Was expense, public or private, a reason not to await results in order to consider eg quarantine arrangements rather than scattering? No – and the massive knock to public and private wealth as a result of every outbreak of COVID-19, including from the Ruby Princess, explains why concern about expense would never have justified a passive response. The public health officials did not act on the basis of false economy.
- 1.37 Was a disinclination to inconvenience returning passengers, especially our overseas guests, an explanation for the Expert Panel's assessment of low risk and not awaiting test results? No, again. Although personal liberty was properly considered, the evidence does not suggest that some misplaced preference for an individual's freedom from restraint over the community freedom from further infection motivated the course taken. Indeed, Carnival employees, as noted in the body of the Report, were actually surprised by the decision to allow disembarkation without further ado. Notwithstanding the probable absence of this factor from the Expert Panel's assessment and decision, nonetheless it is clear that far too much is made in public discourse about such liberty interests as coming anywhere near to outweighing the imperative to safeguard community health (here, and elsewhere). There was no inkling of any such sentiment in the evidence and other material about the feeling and opinions of the Ruby Princess passengers themselves. Rather, many of them voiced the decent regret that they may have unwittingly contributed to the spread of infection.
- 1.38 What about the risk of infection posed to passengers kept on board? Was the then recent experience of a rapidly and widely spread outbreak on the Diamond Princess in Japan a reason that drove a decision to get passengers off the Ruby Princess as soon as possible? It has to be said immediately that members of the Expert Panel did not say so, and the finding is that this fear did not motivate their decision. If it had, so much the worse, given the scarcity of swabs, the lack of health assessment on board, the omission of further swabbing of suspect cases, the lack of social distancing or masking upon disembarkation and onwards travel, and the merely standard home self-isolation requirement. That would have been on any view a sub-standard response if the Ruby Princess were in fact considered already to be so dangerous as a seat of infection that passengers should not be kept on board even for a few more hours in their own cabins.
- 1.39 Unfortunately, some retrospective defences of the State public health response included mention of the risk of infection for all passengers remaining on board to await test results from suspect cases. That consideration did not cause the decision that was actually made, and neither should it have, in light of the matters noted in [1.38] above. It might have justified urgent and secure removal into strict quarantine, but alas did not do so.

- 1.40 The experience of conducting this Inquiry confronts one with the unpleasant possibility of forming and expressing adverse judgement of one's fellows. It is all the more unpleasant when they are genuine experts, truly public servants, and hard workers. The Commission's Terms of Reference do oblige me to do so, if I reach relevant conclusions. I have done so, as noted in this Chapter and throughout the body of this Report. It is accordingly right that I acknowledge as Commissioner that these imperfections in the State's public health work on 18-19 March 2020 in relation to the Ruby Princess should not be taken as damning condemnation of the individual public servants involved. The lapses identified are not in some way typical or characteristic of them or their colleagues. Some of these estimable individuals, as the evidence showed, remain in charge of weighty aspects of the State's frontline response to the pandemic. I have to say that my confidence in their good faith and skilled diligence in these continuing efforts was not dented by the criticism I have expressed about the Ruby Princess episode. Everyone makes mistakes, and when we judge one another we should bear that in mind. As Commissioner in this Inquiry, I have been made sharply aware that, while we all make professional mistakes, the burden and stress created by life-and-death consequences in some but not all professions should engender sympathy and regard for those (like the Expert Panel in this case) whose duties are carried out under the weight of such consequences.
- 1.41 *Pace* the Prime Minister, it is not an adequate answer to scrutiny of a public health official's conduct in this Inquiry to assert that he or she was doing their best. The question this Commission's Terms of Reference presents is whether, on this occasion, that was good enough – not in order to stigmatize or denounce, but in order to explain and learn. Inherent in the comments made in [1.40] above and in this [1.41] is the considered acceptance by this Commission of the genuine engagement by all the public health officials whose conduct has been examined in this Inquiry, in the difficult and multifarious tasks and challenges posed by COVID-19, of which the cruise ship program, and the Ruby Princess on 18-19 March, was but one integer of one part.

- 1.42 Other systemic details of the decision-making on 18-19 March are described and assessed in the body of the Report. One theme common to some of them warrants noticing in these general reflections. When legal power is being exercised, including when a legal duty is being performed, a modicum of formality probably helps rather than hinders. This is not at all a plea from a lawyer for more red tape – perish the thought. Rather, it suggests that tasks such as considering whether to grant pratique (ie permission to disembark or unload a ship or aeroplane) lend themselves to deliberate, explicit mental consideration of all relevant matters. Understood as a servant and not as a master, it is a suggestion for an ordered approach akin to a checklist. If more than one officer participates, the redundancy enhances the prospect of avoiding critical errors. Part of such an ordered approach will usually be a near contemporaneous written (or digital) record, including of informative communications. All the crucial steps on 18-19 March 2020 in relation to the Ruby Princess would have been improved, most likely, and for the public benefit, had this traditional formality been more thoroughly observed. No decrement in speed of process, or appreciable increment in administrative burdens on busy officials, would have resulted. And, most likely, a slip like the out-of-date epidemiological criterion would not have gone undetected had members of the Health staff and of the Expert Panel expressly checked off an item eg of consistency with current CDNA requirements.
- 1.43 As the body of the Report exhaustively sets out, the governmental powers and responsibilities brought to bear on the matter of responding to the threat of COVID-19 on board the Ruby Princess on 18-19 March 2020 are by no means straightforward to describe. The legislative drafting is, unfortunately, touched with the puzzle-making flair that is a part of our national legal genius. And, above all, the scheme (if it deserves that label) is explicitly an essay in co-operative federalism – Commonwealth and State officials all playing a part in an overall combined endeavour. At the outset, it is worth remembering that procedures for protecting us from health risks when passengers disembark from cruise ships are a very good example of useful and sensible co-operative federalism: because quarantine, overseas trade and immigration are Commonwealth powers and intrinsically national (quarantine, not only national), and because health regulation in the territory of a State is, naturally, among the most pressing of the so-called police powers (constitutional, not constabulary) of the State. In any event, this Commission sees no reason to deprecate the concurrent operation, in particular, of the Commonwealth's *Biosecurity Act 2015* and the State's *Public Health Act 2010*.
- 1.44 The carpentry of delegated legislation and statutory instruments involved in the steps leading up to and comprising the grant of pratique is described and somewhat criticised in the body of the Report: the criticisms are not major. The administrative arrangements by which the Commonwealth's Department of Agriculture, Water and Environment (DAWE) interacts with the State's Department of Health are also described and evaluated, not entirely favourably: but again without major flaws. Overall, the system on 18-19 March was workable. Unfortunately, it did not work completely as intended, for the Ruby Princess, in the various respects identified in the body of the Report.

- 1.45 The relevant legislative provisions make it crystal clear that the Australian Border Force (ABF), despite its portentous title, has no relevant responsibility for the processes by which, by reference to health risks to the Australian community, passengers were permitted to disembark from the Ruby Princess, as they did, on 19 March 2020. The absence of any such duty no doubt explains why the ABF is not granted specific powers in relation to pratique, and why there are no appropriate postings of medical practitioners or epidemiologists in the ABF ranks.
- 1.46 The position is not so plain with respect to DAWE, to whose officers the final decision on pratique is committed by the *Biosecurity Act*. What is clear, albeit after careful perusal of dense statutory language, is that a so-called Biosecurity Officer, a member of DAWE staff, will grant pratique for a cruise ship like the Ruby Princess on 18-19 March only on the favourable word of a so-called Human Biosecurity Officer – here an officer of the State's Department of Health. This sharing (or division) of functions to achieve one administrative outcome (ie pratique) so as to advance the shared social goal of protecting the Australian community from the pandemic is, by and large, not too bad – intended as faint praise. Ways in which, mostly administratively and co-operatively, it could be improved are suggested in the body of the Report. The Government should try to persuade the Commonwealth authorities to participate in that project of very feasible improvement.
- 1.47 Given its lack of medical or epidemiological expertise, it is well for the public good that the ABF (and, for that matter, the Department of Home Affairs) do not bear any responsibility for the Ruby Princess mishap. As this Report was being finished, some interesting journalism was published that advanced the notion that a basic misreading by an ABF officer of negative influenza results as meaning negative COVID-19 results, had somehow contributed to the decision to let the passengers go as they did on 19 March. As the body of the Report spells out, that is not correct. It was the State's Expert Panel that made the operative decision, relayed accurately (if by a clumsy means) to the DAWE Biosecurity Officer who granted pratique. That seems by far to be the most likely understanding of what happened, by dint of administrative conduct that undoubtedly could have been more crisp and formal. To repeat, neither the ABF nor any ABF officers played any part in the mishap.
- 1.48 Part of the purpose of the Commission publishing as much of the evidence, other material and submissions in as close to real time as possible was to inform the public and, therefore in particular, journalists. It is a pity that serious journalism, as both the broadcast and press stories were, seems to have proceeded on this erroneous basis of a part played by the ABF. No doubt the procedures and the narrative are not easy to analyse, and no doubt the ABF officer's error was a striking one to have made (if anything, vindication of a system keeping the ABF well clear of the public health assessment).

- 1.49 Occasionally during this Inquiry, there has been political and public comment to the effect that this Commission should question the State Minister for Health about the grant of pratique and associated public health administration. This Commission would certainly have done so, concerning public health administration, if questions of substance had arisen about the law, the organisation of the Department, its resourcing (including recruitment of appropriately expert officers), or the like. Nothing of those kinds did arise. Perhaps those making calls for the Minister to appear at a Commission hearing during the Inquiry had in mind some version of the rather nebulous so-called Westminster theory of ministerial responsibility. This report is not the place to expatiate on the unsatisfactory nature of this idea, that does not really warrant being called a doctrine. Of course a Minister should resign in some circumstances, but as this Commission sees it, without wading into the partisan politics, this case would not appear to fit that outcome. The failures were professional – failures in decision-making by experts. They are not, as to their expert judgements, subject to Ministerial direction. Nor should they be, unless our system of government were to become farcical. Respectful as this Commissioner is of political accountability, especially in the parliamentary chambers, this Commission saw no aspect of Ministerial conduct that amounted to any action or inaction of any relevance to be investigated in this Inquiry – let alone by calling the Minister as a witness.
- 1.50 The running of this Inquiry could not have proceeded without the assistance of the represented parties and the witnesses. Without exception, their industry and frankness, respectively, were of the highest order. I am most appreciative of these efforts, professional and personal.
- 1.51 The Commissioner of Police, and his staff, were of great assistance, not only in providing the product of much prior investigation, but also in facilitating the unexpected early hearing of the Commission when the Ruby Princess's departure from Australian waters was delayed.
- 1.52 There were concerns raised during the Commission's hearings directed to grievances raised by published statements by the Commissioner of Police that could be understood as critical of other parties, such as Carnival employees. Those statements have not influenced any of the findings in this Report. Addressing them is not, on balance, necessary within the Terms of Reference.
- 1.53 The one fly in the ointment so far as assistance to this Commission goes, is the stance of the Commonwealth. I hasten to exclude the lawyers for the Commonwealth, whose written assistance and production of materials are very much appreciated, in the circumstances. Those circumstances are dominated by the assertion on the Commonwealth's part of an immunity from any compulsory process of a State's Special Commission of Inquiry. A Summons to a Commonwealth officer to attend and give evidence about the grant of pratique for the Ruby Princess was met with steps towards proceedings in the High Court of Australia. Quite how this met the Prime Minister's early assurance of full co-operation with the Commission escapes me.

- 1.54 This waste of time and resources, when time, in particular, was always pressing, was most regrettable. As the quality and helpfulness of the voluntary submissions by the Commonwealth demonstrated, there was no problem of resources or governmental embarrassment conducting against the Commonwealth fully co-operating with this Commission, by providing one of its officers to give evidence. It may even be that, had this happened, the confusion about the ABF noted in [1.47] above could have been avoided. It seems that this practical approach was swamped by a determination never to concede, apparently on Constitutional grounds, the power of a State Parliament to compel evidence to be provided to a State executive inquiry (such as a Royal Commission or a Special Commission of Inquiry) by the Commonwealth or any of its officers, agencies or authorities.
- 1.55 This is also not the place to set out arguments for and against this Commonwealth position. As a South Australian Royal Commissioner, I have previously expressed views contrary to the Commonwealth's stated position. I maintain those views. Further, I continue to believe that this difference about something as fundamental as a State's legislative power to bind the Commonwealth to assist in a State inquiry just as every other legal person in Australia would be obliged to do, disfigures the area of co-operative federalism. For example, in this case, it is of great governmental significance to New South Wales to study and inform the public health arrangements by which the risk of COVID-19 on the Ruby Princess was addressed. One hopes the Commonwealth also perceives that significance. But until this constitutional impasse is cleared, the State should re-consider its arrangements such as under the *Biosecurity Act*, so as to procure advance approval for mutual access to information by the co-operating polities. Meanwhile, perhaps the *Special Commission of Inquiry Act 1983* should itself be reviewed and modernised (along Victorian lines, perhaps) so as to clear the decks for argument only about the alleged Commonwealth immunity.
- 1.56 It remains to recognise as prominently as possible the merits and efforts of the small and splendid team who assisted me in this Inquiry. Valentina Markovina and Susan Kent provided indispensable and high-quality support. James Loosley and Luke Teo have shown excellent legal acumen and very impressive research, investigation and reporting skills: they imbue real confidence in their new generation of lawyers. And in Jennifer Hoy, the Commission has had unfailing insight, industry and constant support: her writing is at the heart of this Report. Nicolas Kirby has done all, and more, that could be asked of counsel assisting, with an energy and application of great benefit to the public. Finally, and again, my thanks to and admiration for the central part taken by Richard Beasley SC are difficult to convey without gushing. I thank all the Commission's staff, and commend each of them for the public service they have done.

SPECIAL COMMISSION OF INQUIRY INTO THE RUBY PRINCESS

2

Key Findings and Recommendations

Key Findings

Chapter 9

- 2.1 On 10 March 2020, the CDNA amended its Guidelines, such that all persons on board the Ruby Princess with an ARI or ILI became suspect cases for COVID-19: meaning they should all have been tested for the disease. The Expert Panel did not have this suspect case definition in mind when they conducted their risk assessment on 18 March. This was a serious and material error.¹
- 2.2 The Expert Panel was not helped by the drafting of the risk assessment form, which was not updated with the new “suspect case” definition. This too was a serious error.²
- 2.3 The risk assessment form should have been drafted so as to clarify for the Expert Panel whether persons on this ship who had symptoms of respiratory illness were told in advance of assessment at the onboard medical centre that the consultation would be free of charge.³
- 2.4 The ARD Log should have been read by all members of the Expert Panel. They should have noticed the “significant spike” in ARI/ILI rates on the ship, particularly on 17 March. They should have requested an updated log either late on 18 March, or early on 19 March. These are all serious errors.⁴

1 [9.7](h), [9.9]-[9.15], [9.23]-[9.24], [9.112].

2 [9.16]-[9.22], [9.113].

3 [9.32]-[9.41], [9.114].

4 [9.42]-[9.57], [9.115].

- 2.5 A graded risk assessment approach may at times provide a useful framework for public health risk assessments. It did not here, either before 10 March, or after. It was a distraction from the real questions: what are the consequences of the risk eventuating, and what are the appropriate precautions to take in light of such consequences?⁵
- 2.6 An ILI rate of 1% or more had some utility for the assessment of whether COVID-19 was circulating on the Ruby Princess during the 8 March voyage. That utility was limited. The more important question was: are there suspect cases of COVID-19 on board the ship?⁶
- 2.7 NSW Health should have ensured that cruise ships were aware of the change to the definition of a “suspect case” for COVID-19 made on 10 March. This would have resulted in the identification of such cases on the Ruby Princess. 101 persons fell within the suspect case definition by 18 March, and 120 by the time the ship docked. NSW Health should also have ensured that such persons were isolated in cabins. These were serious mistakes by NSW Health.⁷
- 2.8 The failure to ensure that swabs were collected by an onboard health assessment team in accordance with the requirements of the 9 March Enhanced Procedure was a serious failure by NSW Health.⁸
- 2.9 The delay in obtaining test results for the swabs taken from the Ruby Princess on the morning of 19 March is inexcusable. Those swabs should have been tested immediately.⁹
- 2.10 In light of all the information the Expert Panel had, the decision to assess the risk as “low risk” – meaning, in effect, “do nothing” – is as inexplicable as it is unjustifiable. It was a serious mistake.¹⁰

Chapter 12

- 2.11 In relation to the insufficient supply of swabs available to the medical staff on the 8 March voyage of the Ruby Princess, no criticism is made of Dr von Watzdorf.¹¹
- 2.12 Dr von Watzdorf gave a truthful answer to the question on the pre-arrival risk assessment form as to whether health assessments in relation to respiratory illness were provided free of charge.¹²

5 [9.58]-[9.79], [9.116].

6 [9.80]-[9.87], [9.117].

7 [9.88]-[9.93], [9.118].

8 [9.94]-[9.107], [9.119].

9 [9.105]-[9.106], [9.110], [9.120].

10 [9.108]-[9.111], [9.121].

11 [12.16]-[12.17], [12.19], [12.43]-[12.50] and [12.71].

12 [12.51]-[12.53], [12.72].

- 2.13 No criticism is made of Mr Little for not informing NSW Health of the “significant spike” in ARI/ILI numbers that he perceived on the Ruby Princess as at 17 March because that information was provided to NSW Health in the ARD Log on 18 March.¹³
- 2.14 Dr von Watzdorf ought to have notified NSW Health of the additional passengers and crew diagnosed with an ARI or an ILI on 18 and 19 March 2020. However, this was an oversight by her, which did not amount to a failure to comply with policies and procedures in place at the time.¹⁴
- 2.15 Carnival should have ensured that Dr von Watzdorf was made aware of the change to the CDNA “suspect case” definition on 10 March 2020. They should also have ensured that passengers and crew aboard the Ruby Princess were informed that there were suspect cases of COVID-19 on board. Those persons meeting the definition of a suspect case should have been required to isolate in their cabins.¹⁵

Chapter 13

- 2.16 Passengers were incorrectly advised by the ABF during the cruise that their 14-day period of self-isolation would commence from the date of departure from the last overseas port visited by the Ruby Princess, being Napier on 15 March. This inaccuracy was later clarified during disembarkation at the OPT on 19 March, when passengers were provided with a fact sheet published by the Commonwealth Department of Health which relevantly instructed them to self-isolate for 14 days from their arrival in Sydney.¹⁶
- 2.17 The directive to allow passengers to onward travel interstate and internationally after disembarkation on 19 March did not appropriately contemplate or comply with the terms of the Public Health Order that came into effect on 17 March, which required all cruise ship passengers entering the State from any other country to isolate themselves in suitable accommodation for 14 days. Under the terms of the Public Health Order, the State Government should have arranged suitable accommodation for all passengers who were not residents of the State.¹⁷
- 2.18 The fact sheet linked to an email sent to passengers at 10:46am on 20 March incorrectly advised that they were permitted to continue with onward travel, despite being identified as “close contacts” of a confirmed COVID-19 case. Although this advice was corrected by NSW Health by the evening of 21 March, it was at that stage too late to prevent a considerable number of interstate and international passengers from onward travelling, including some passengers who were symptomatic during transit.¹⁸

13 [12.41]-[12.42], [12.54]-[12.57] and [12.73].

14 [12.66]-[12.70], [12.75].

15 [12.60]-[12.64], [12.74].

16 [13.2]-[13.7], [13.63].

17 [13.8]-[13.14], [13.64].

18 [13.29], [13.49]-[13.54], [13.65].

Recommendations

Chapter 11

- 2.19 That the NSW HBO Guideline should be reconsidered in light of the criticism made at [11.13], namely that it regards a grant of pratique as the default position, and indicates that pratique should only ever be withheld where there is a compelling reason to deny it, for example, where a HBO has a “genuine belief” that other passengers “were exposed” to a LHD. The current HBO Guideline does not appear to satisfactorily reflect an appropriately precautionary public health approach.
- 2.20 That Human Biosecurity Officers, DAWE, the Commonwealth Department of Health and NSW Health develop:
- a) better awareness of their own and each other’s roles and responsibilities for human biosecurity; and
 - b) more formal protocols for their interaction and communication. This includes, but is not limited to, the grant of pratique.
- 2.21 That human health reporting within MARS be reviewed with a view to:
- a) improving its ability to be readily adapted to novel circumstances and suggested improvements (see, eg, [11.52]);
 - b) improving its clarity of expression and the coherence and intelligence of the format of its design and presentation (see, eg, [11.54] to [11.60]); and
 - c) improving access to other agencies (such as the Port Authority) with a legitimate interest in receiving the data for their own operations.
- 2.22 That any future review of the *Biosecurity Act* consider the utility and possible expansion of human biosecurity control orders so as to be applicable to persons or groups.¹⁹
- 2.23 That the *Biosecurity Act* make explicit a requirement to update superseded human health information.²⁰

19 [11.76]-[11.77].

20 [11.78].

SPECIAL COMMISSION OF INQUIRY INTO THE RUBY PRINCESS

SPECIAL COMMISSION OF INQUIRY INTO THE RUBY PRINCESS

3

Chronology of the COVID-19 pandemic

Detection of a new coronavirus in China

- 3.1 On 31 December 2019, the World Health Organisation's (WHO) Country Office in the People's Republic of China became aware of a series of cases of "pneumonia of unknown etiology"¹ detected within the population of Wuhan, the capacity city of Hubei Province.²
- 3.2 On 3 January 2020, researchers at the Chinese Centre for Disease Control and Prevention (CCDC) identified a novel coronavirus within bronchoalveolar samples taken from a pneumonia patient receiving treatment at Wuhan Jinyintan Hospital.³ The coronavirus was provisionally designated as 2019-nCoV. It would later be renamed by the International Committee on Taxonomy of Viruses as "severe acute respiratory syndrome coronavirus 2" (SARS-CoV-2).⁴ The disease caused by SARS-CoV-2 would become known around the world as COVID-19.⁵

1 "Pneumonia of unknown etiology" is a surveillance definition established following the outbreak of Severe Acute Respiratory Syndrome (SARS) in China in 2003. It is defined as an illness without a causative pathogen identified which fulfils the following clinical criteria: fever ($\geq 38^{\circ}\text{C}$), radiographic evidence of pneumonia, low or normal white-cell count or low lymphocyte count and no symptomatic improvement after antimicrobial treatment for three to five days following standard clinical guidelines. See further: Qun Li et al, 'Early Transmission Dynamics in Wuhan, China, of Novel Coronavirus-Infected Pneumonia' (2020) 382(13) *The New England Journal of Medicine* 1199, 1200.

2 World Health Organisation, *Timeline of WHO's response to COVID-19* (29 June 2020) World Health Organisation <<https://www.who.int/news-room/detail/29-06-2020-covidtimeline>>.

3 Wenjie Tan et al, 'A Novel Coronavirus Genome Identified in a Cluster of Pneumonia Cases – Wuhan, China 2019-2020' (2020) 2(4) *CCDC Weekly* 61.

4 Alexander Gorbalenya et al, 'The species *Severe acute respiratory syndrome-related coronavirus*: classifying 2019-nCoV and naming it SARS-CoV-2' (2020) 5 *Nature Microbiology* 536.

5 Dr Tedros Adhanom Ghebreyesus, 'WHO Director-General's remarks at the media briefing on 2019-nCoV on 11 February 2020' (Speech delivered at the World Health Organisation, Geneva, 11 February 2020) <<https://www.who.int/dg/speeches/detail/who-director-general-s-remarks-at-the-media-briefing-on-2019-ncov-on-11-february-2020>>.

- 3.3 Of 59 suspected pneumonia cases transferred to Wuhan Jinyintan Hospital on 31 December 2019, 41 were subsequently confirmed to be infected with SARS-CoV-2. The symptom onset of the first patient identified was 1 December 2019.⁶ Epidemiological investigations conducted by the National Health Commission and CDCC determined that a majority⁷ of these cases in Wuhan had direct exposure to the Huanan Seafood Wholesale Market.⁸
- 3.4 On 9 January 2020, the WHO announced that Chinese authorities had determined that the pneumonia outbreak in Wuhan had been caused by SARS-CoV-2.⁹
- 3.5 On 10 January 2020, Chinese state media reported the first known fatality of a patient suffering from COVID-19.¹⁰ The 61-year-old man had continuous exposure to the Huanan Seafood Wholesale Market and was admitted to hospital following a week-long history of fever, coughing and difficulty breathing. Five days after the onset of his illness, the man's wife, a 53-year-old woman with no known exposure to the Huanan Seafood Wholesale Market, was also admitted to hospital suffering from pneumonia.¹¹
- 3.6 On 13 January 2020, the Ministry of Public Health in Thailand confirmed the first case of COVID-19 detected outside of China, following the hospitalisation of a traveller from Wuhan on 8 January 2020.¹² Three days later, the Japanese Ministry of Health, Labour and Welfare informed the WHO of a detected case of COVID-19 in a person who had travelled to Wuhan. The WHO noted that "considering global travel patterns, additional cases in other countries are likely".¹³

6 Chaolin Huang et al, 'Clinical features of patients infected with 2019 novel coronavirus in Wuhan, China' (2020) 395 *Lancet* 497, 500.

7 Of 41 admitted hospital patients identified as having contracted 2019-nCoV on 2 January 2020, 27 (66%) had been exposed to the Huanan Seafood Wholesale Market. See *ibid* 498.

8 Li et al, above n 1, 1202.

9 World Health Organisation, 'WHO Statement regarding cluster of pneumonia cases in Wuhan, China' (Media Statement, 9 January 2020) <<https://www.who.int/china/news/detail/09-01-2020-who-statement-regarding-cluster-of-pneumonia-cases-in-wuhan-china>>.

10 Amy Qin and Javier Hernandez, 'China Reports First Death From New Virus', *The New York Times* (online), 10 January 2020 <<https://www.nytimes.com/2020/01/10/world/asia/china-virus-wuhan-death.html>>.

11 Huang et al, above n 6.

12 World Health Organisation, 'WHO statement on novel coronavirus in Thailand' (Media Statement, 13 January 2020) <<https://www.who.int/news-room/detail/13-01-2020-who-statement-on-novel-coronavirus-in-thailand>>.

13 World Health Organisation, 'Novel Coronavirus – Japan (ex-China)' (Media Statement, 16 January 2020) <<https://www.who.int/csr/don/16-january-2020-novel-coronavirus-japan-ex-china/en/>>.

- 3.7 By 20 January 2020, 282 confirmed cases of COVID-19 had been reported to the WHO across four countries including: China (278 cases), Thailand (2 cases), Japan (1 case) and the Republic of Korea (1 case).¹⁴ On the same date, Chinese authorities determined that COVID-19 would be included in the notifiable report of Class B infectious diseases and border health quarantine infectious diseases, resulting in the enforcement of temperature checks, health care declaration and quarantine at transportation depots.¹⁵
- 3.8 On 21 January 2020, the Commonwealth Chief Medical Officer (CMO), in his capacity as Director of Human Biosecurity, made a written determination, pursuant to s 42 of the *Biosecurity Act 2015* (Cth) (*Biosecurity Act*),¹⁶ that COVID-19 (designated “human coronavirus with pandemic potential”) should be included as a “listed human disease”. The effect of this determination was, *inter alia*, to authorise the Commonwealth Health Minister to impose enhanced border screening measures for all travellers entering and departing Australia.
- 3.9 Soon after that determination, on 25 January 2020, Australia confirmed its first imported case of COVID-19, identified as a man from Wuhan, who had flown from Guangdong to Melbourne on 19 January 2020.¹⁷ In response, the Australian Government raised the level of travel advice for Wuhan and Hubei Province to “Level 4 – Do Not Travel” and introduced precautionary measures to ensure all passengers arriving in Australia from China were met and provided with information about COVID-19 and instructions on what to do if they developed any symptoms.
- 3.10 On 30 January 2020, the WHO Director-General, Dr Tedros Adhanom Ghebreyesus, convened a meeting of the Emergency Committee pursuant to the International Health Regulations (2005). The Emergency Committee was informed that there were at that time 7,711 confirmed COVID-19 cases in China and 83 cases reported in 18 other countries. Confirmed cases of human-to-human transmission were reported in 3 countries outside China.¹⁸ Following the meeting of the Emergency Committee, the Director-General declared that the global outbreak of COVID-19 constituted a Public Health Emergency of International Concern (PHEIC).¹⁹

14 World Health Organisation, *Novel Coronavirus (2019-nCoV) Situation Report 1* (21 January 2020) 1 <https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200121-sitrep-1-2019-ncov.pdf?sfvrsn=20a99c10_4>.

15 World Health Organisation, *Report of the WHO-China Joint Mission on Coronavirus Disease 2019 (COVID-19)* (16-24 February 2020) World Health Organisation 14 <<https://www.who.int/docs/default-source/coronaviruse/who-china-joint-mission-on-covid-19-final-report.pdf>>.

16 *Biosecurity (Listed Human Disease) Amendment Determination 2020* (Cth). The Director of Human Biosecurity may determine that a human disease is a “listed human disease” if he or she considers the disease may be communicable; and cause significant harm to human health.

17 The Hon Greg Hunt MP, ‘First confirmed case of novel coronavirus in Australia’ (Media Release, 21 January 2020) 1 <<https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/first-confirmed-case-of-novel-coronavirus-in-australia>>.

18 World Health Organisation, ‘Statement on the second meeting of the International Health Regulations (2005) Emergency Committee regarding the outbreak of novel coronavirus (2019-nCoV)’ (Statement, 30 January 2020) <[https://www.who.int/news-room/detail/30-01-2020-statement-on-the-second-meeting-of-the-international-health-regulations-\(2005\)-emergency-committee-regarding-the-outbreak-of-novel-coronavirus-\(2019-ncov\)](https://www.who.int/news-room/detail/30-01-2020-statement-on-the-second-meeting-of-the-international-health-regulations-(2005)-emergency-committee-regarding-the-outbreak-of-novel-coronavirus-(2019-ncov))>.

19 Dr Tedros Adhanom Ghebreyesus, ‘WHO Director-General’s statement on IHR Emergency Committee on Novel Coronavirus (2019-nCoV)’ (Speech delivered online from the World Health Organisation, Geneva, 30 January 2020) <[https://www.who.int/dg/speeches/detail/who-director-general-s-statement-on-ihremergency-committee-on-novel-coronavirus-\(2019-ncov\)](https://www.who.int/dg/speeches/detail/who-director-general-s-statement-on-ihremergency-committee-on-novel-coronavirus-(2019-ncov))>.

- 3.11 On 1 February 2020, the Australian Government extended its “Level 4 – Do Not Travel” advisory to cover all of mainland China. On the same date, the Prime Minister of Australia, in response to updated advice from the CMO and the Australian Health Protection Principal Committee (AHPPC), announced additional travel restrictions to prevent the spread of COVID-19. Principally, this included a temporary prohibition on all foreign nationals (excluding permanent residents) departing mainland China from entering Australia for 14 days from the time they departed, or transited through, mainland China.²⁰

Virology and clinical characteristics of SARS-CoV-2

- 3.12 Coronaviruses are associated with a number of infectious disease outbreaks in humans, including two large scale pandemics in the past two decades: severe acute respiratory syndrome (SARS) in 2002-03, and Middle East Respiratory Syndrome (MERS) in 2012.
- 3.13 SARS-CoV-2 is the seventh coronavirus known to infect humans.²¹ Although SARS-CoV-2 has been confirmed as a zoonotic virus, the origin of its outbreak has yet to be precisely identified.²² Estimates of the timing of the most recent common ancestor of SARS-CoV-2 suggest the emergence of the virus in humans in late November to early December 2019.²³
- 3.14 Virological research has also suggested that, due to the similarities between SARS-CoV-2 and coronaviruses detected in mammals since 2005, bats may have served as the host for the progenitor of SARS-CoV-2.²⁴ The nature of the intermediate host (or hosts) for the virus, however, remains unclear.²⁵

20 The Hon Scott Morrison MP, ‘Updated Travel Advice to Protect Australians from the Novel Coronavirus’ (Media Release, 1 February 2020) <<https://www.pm.gov.au/media/updated-travel-advice-protect-australians-novel-coronavirus>>.

21 Kristian Andersen et al, ‘The proximal origin of SARS-CoV-2’ (2020) 26 *Nature Medicine* 450, 450.

22 World Health Organisation, above n 15, 8.

23 Andersen et al, above n 21, 451.

24 Andersen et al, above n 21.

25 World Health Organisation, above n 15, 8.

- 3.15 Evidence of human-to-human transmission of SARS-CoV-2 emerged almost immediately following the discovery of the virus in Wuhan in early January 2020.²⁶ The WHO discovered that the virus is transmitted via droplets and fomites during close unprotected contact between infected and non-infected persons.²⁷ For that reason, the primary route of human-to-human transmission, particularly during the early stages of the pandemic, was through family or household contacts.²⁸ Recently, aerosol transmission, implicating the importance of enclosed spaces and ventilation, has become seriously suspected.²⁹
- 3.16 Generally, people infected with SARS-CoV-2 develop signs and symptoms, including mild respiratory symptoms and fever, around five to six days following infection.³⁰ There have also been reported cases of asymptomatic³¹ infection of SARS-CoV-2 across a number of countries,³² although information on the history and progression of asymptomatic infection remains scarce.³³ The WHO also noted during a relatively early period of the pandemic that asymptomatic cases did not appear prevalent, nor did they appear to contribute significantly to secondary transmission of SARS-CoV-2.³⁴ The science has since moved on and nothing like confident categorical statements can be made about this topic, let alone by a Special Commission of Inquiry constituted by a lawyer. As to asymptomatic (or pre-symptomatic) transmission, it can confidently be regarded as a real possibility, at all times material to this Commission.
- 3.17 When a person is infected with SARS-CoV-2, the virus finds an optimal binding with a human receptor known as angiotensin-converting enzyme 2 (ACE2).³⁵ The binding with ACE2 allows SARS-CoV-2 to enter other cells, initially in the pharyngeal passageway. Once inside, the “virus hijacks the cells’ machinery, making myriad copies of itself and invading new cells”.³⁶

26 Li et al, above n 1, 1203.

27 World Health Organisation, above n 15, 8.

28 Jasper Fuk-Woo Chan, ‘A familial cluster of pneumonia associated with the 2019 novel coronavirus indicating person-to-person transmission: a study of a family cluster’ (2020) 395 *Lancet* 514-523.

29 Elizabeth Anderson et al, ‘Consideration of the Aerosol Transmission for COVID-19 and Public Health’ (2020) 40(5) *Risk Analysis* 902-907.

30 Li et al, above n 1, 1203.

31 Asymptomatic transmission may also be understood in this context as including pre-symptomatic transmission.

32 See Camilla Rothe et al, ‘Transmission of 2019-nCoV Infection from an Asymptomatic Contact in Germany’ (2020) 382(10) *The New England Journal of Medicine* 970-971; Anne Kimball et al, ‘Asymptomatic and Presymptomatic SARS-CoV-2 Infections in Residents of a Long-Term Care Skilled Nursing Facility’ 69(13) *Morbidity and Mortality Weekly Report* 377-381.

33 Aki Sakurai et al, ‘Natural History of Asymptomatic SARS-CoV-2 Infection’ (2020) *New England Journal of Medicine* 1 <<https://www.nejm.org/doi/pdf/10.1056/NEJMc2013020>>.

34 The WHO asserts that the majority of people who test positive to COVID-19 while asymptomatic will subsequently go on to develop a mild form of the disease.

35 Andersen et al, above n 21.

36 Meredith Wadman et al, *How does coronavirus kill? Clinicians trace a ferocious rampage through the body, from brain to toes* (17 April 2020) *Science* <<https://www.sciencemag.org/news/2020/04/how-does-coronavirus-kill-clinicians-trace-ferocious-rampage-through-body-brain-toes>>.

- 3.18 This phenomenon has distinguished SARS-CoV-2 from other human coronaviruses such as SARS. Typically, peak viral load concentrations for SARS have been detected around seven to ten days following the onset of symptoms and did not occur until the virus had entered the lower respiratory tract. Conversely, peak concentrations in SARS-CoV-2 have been detected before day five of the onset of an infected person's symptoms and calculated at more than 1,000 times higher than SARS. These findings indicate a much more efficient transmission pathway of SARS-CoV-2, at a time when symptoms are either absent or still mild and typical of conventional upper respiratory tract infections.³⁷
- 3.19 According to findings made by the WHO following its Joint Mission to China in February 2020, approximately 80% of patients with COVID-19 have mild to moderate disease, around 14% develop severe disease, and 6% become critical.³⁸ Patients who become critically ill with COVID-19 can suffer a devastating range of conditions. Although COVID-19 is mostly commonly seen to attack a person's lungs, the virus' reach can also extend to many other organs including the heart and blood vessels, kidneys, stomach and brain.³⁹ As with all attempts to describe COVID-19, even this understanding is provisional.
- 3.20 Due to the rapidly evolving understanding of SARS-CoV-2, calculation of the mortality rate for COVID-19 has been a particularly challenging exercise for epidemiologists worldwide. The latest studies estimate that between five and ten people will die for every 1,000 confirmed COVID-19 diagnoses; an Infection Fatality Rate of 0.5-1%.⁴⁰ A significant difference between COVID-19 and other pandemic diseases, however, is the age distribution of patients who are severely ill. It is now widely accepted that the mortality rate in people infected with COVID-19 increases steeply with age and deaths are predominantly seen in patients older than 50 years.⁴¹

37 Roman Wölfel et al, 'Virological assessment of hospitalized patients with COVID-19' (2020) 581 *Nature* 465, 467-468.

38 World Health Organisation, above n 15, 12.

39 Wadman et al, above n 36.

40 Smriti Mallapaty, 'How deadly is the coronavirus? Scientists are close to an answer' (2020) 582 *Nature* 467.

41 Analysis of the COVID-19 outbreak in Italy shows that the fatality rate was 0% for age group 0-39 years, 0.1% for 40-49 years, 0.6% for 50-59 years, 2.7% for 60-69 years, 9.6% for 70-79 years and 16.6 for ≥80 years. See Eskild Petersen et al, 'Comparing SARS-CoV-2 with SARS-CoV and influenza pandemics' (2020) *Lancet Infectious Diseases* <<https://www.thelancet.com/action/showPdf?pii=S1473-3099%2820%2930484-9>>.

CDNA National Guidelines

- 3.21 The Communicable Diseases Network of Australia (**CDNA**), a subcommittee of the AHPPC, provides national public health coordination and leadership and supports best-practice for the prevention and control of communicable diseases. The body comprises all State and Territory Directors of Communicable Diseases, representatives of the Commonwealth and other health experts.⁴²
- 3.22 The CDNA has developed a Series of National Guidelines (**SoNGs**) for the surveillance and response to a number of nationally notifiable diseases. The SoNGs are generally endorsed by the AHPPC and published by the Commonwealth Department of Health. The objective of each guideline is to define a minimum public health standard that should be adopted in the management of and response to notifiable diseases.⁴³
- 3.23 Since 23 January 2020, the CDNA has published SoNGs specifically in relation to the management and response to COVID-19 for Public Health Units in Australia (the **CDNA Guidelines**).⁴⁴ These guidelines provide contemporary information about infection, definitions for “confirmed” and “suspected” COVID-19 cases, testing procedures, public health management of confirmed COVID-19 cases (including self-isolation and quarantine measures), the management of close contacts and responses to outbreak situations.⁴⁵
- 3.24 During the early stages of the outbreak of COVID-19 in Australia, multiple versions of the CDNA Guidelines were published, as the international community’s understanding of the novel coronavirus continued to rapidly evolve. In February to March 2020, 21 iterations of the CDNA Guidelines were publicly released, including 3 versions that were in place between the departure of the Ruby Princess from Sydney on 8 March 2020, and its return on the morning of 19 March 2020.⁴⁶

42 Exhibit 57, Statement of Dr Jeremy McNulty (15 June 2020) [13].

43 Exhibit 57, Statement of Dr Jeremy McNulty (15 June 2020) [13].

44 A consolidated bundle of the various iterations of the CDNA National Guidelines in force from February–March 2020 is contained at Exhibit 32.

45 Exhibit 57, Statement of Dr Jeremy McNulty (15 June 2020) [15].

46 Version 1.17 (published on 5 March 2020), Version 1.18 (published on 10 March 2020) and Version 2.0 (published on 13 March 2020).

Suspect case definition

- 3.25 As at February and March 2020, the CDNA Guidelines broadly defined a “suspect case” as a patient satisfying identified epidemiological and clinical criteria. As was the case with other parts of the guidelines, the applicable criteria was continually evolving during this period as further information became available to public health authorities in Australia.
- 3.26 On 8 March 2020, a “suspect case” of COVID-19 was defined as follows:
- Epidemiological criteria:*
- Travel to (including transit through) a country considered to pose a risk of transmission in the 14 days before the onset of illness
- OR
- Close or casual contact in the 14 days before illness onset with a confirmed case of COVID-19
- Clinical criteria:*
- Fever
- OR
- Acute respiratory infection (e.g. shortness of breath or cough) with or without fever
- 3.27 Countries considered to pose a risk of transmission included mainland China, Iran, Italy and South Korea (higher risk) and Cambodia, Hong Kong and Indonesia (moderate risk).
- 3.28 By 10 March 2020, the epidemiological criteria for a “suspect case” of COVID-19 had been updated and significantly broadened to include all international travel in the 14 days before the onset of illness. Accordingly, this updated “suspect case” definition had been in place for in excess of one week prior to the risk assessment of the Ruby Princess by an expert panel formed by NSW Health.⁴⁷

⁴⁷ Discussion of the notion of a “suspect case” and its significance to the assessment of passengers on the Ruby Princess is discussed in further detail at Chapters 8, 9 and 12 of this Report.

Infectious period

- 3.29 From 21 February 2020, the CDNA Guidelines provided the following advice regarding the understanding of the infectious period of COVID-19:

"5. Infectious period

Infectious period of COVID-19 remains unknown, however there is some evidence to support the occurrence of pre-symptomatic or asymptomatic transmission. As a pre-cautionary approach, cases are considered to be infectious 24-hours prior to onset of symptoms. Cases are considered to pose a risk of onward transmission and require isolation until criteria listed in the release from isolation section have been met."

- 3.30 The relevant criteria for a confirmed COVID-19 case to be released from isolation included:
- The person has been afebrile for the previous 48 hours;
 - Resolution of the acute illness for the previous 24 hours;
 - At least seven days after the onset of the acute illness; and
 - Polymerase chain reaction (PCR) negative on at least two consecutive specimens collected 24 hours apart after the acute illness has resolved.

Advice for cruise ships

- 3.31 The CDNA Guidelines also provide specific advice for "Special Situations". On 21 February 2020, the CDNA Guidelines extended its advice for "Special Situations" to managing the risk of COVID-19 outbreaks on cruise ships.⁴⁸ Specifically, the CDNA Guidelines recommended the following precautions for embarkation and disembarkation procedures:

"After all suspect and confirmed cases have been managed appropriately and the Human Biosecurity Officer has determined that no other passengers or crew have symptoms consistent with COVID-19, remaining passengers and crew will be allowed to disembark. The vessel may be permitted to commence embarking once it is certain there is no risk of ongoing transmission."⁴⁹

48 Exhibit 32, CDNA National Guidelines for Public Health Units re 2019-nCoV, Version 1.9 (21 February 2020).

49 Exhibit 32, CDNA National Guidelines for Public Health Units re 2019-nCoV, Version 1.9 (21 February 2020) at p 12.

Communicable Diseases Intelligence Reports

- 3.32 *Communicable Diseases Intelligence (CDI)* is a peer-reviewed scientific journal published by the Office of Health Protection in the Commonwealth Department of Health. The journal is an authoritative source of information on the epidemiology, surveillance, prevention and control of communicable diseases of relevance to the Australian community.
- 3.33 Following confirmation of the first case of COVID-19 in Australia on 25 January 2020, the CDI commenced the release of a weekly epidemiological report addressing COVID-19 (**CDI Report**).⁵⁰ Each report included data on confirmed COVID-19 cases in Australia reported in the week prior, as well as an overview of the international situation and any updated information on the severity, transmission and spread of SARS-CoV-2.
- 3.34 The CDI Report for the week ending 14 March 2020 provided the following updates:⁵¹
- Internationally, there were 142,539 reported cases of COVID-19, with 5,393 deaths
 - In Australia, there were 295 confirmed cases (including three deaths) of COVID-19, 152 (51%) of which had been reported in NSW;
 - The median age of all 295 reported Australian COVID-19 cases was 47 years, with the highest proportion of cases aged 50-59 and 60-69 years; and
 - Of the 166 confirmed overseas-acquired COVID-19 infections in Australia; 36 (22%) had a directed link to the United States, 18 (11%) had a direct link to Italy and 13 (8%) had a direct link to the United Kingdom.
- 3.35 The subsequent CDI Report for the week ending 22 March 2020 indicated the following developments in Australia and internationally for COVID-19:
- Internationally, there were 292,142 reported cases of COVID-19, with 12,784 deaths;
 - In Australia, there were 1,765 confirmed cases (including seven deaths) of COVID-19, 766 (43%) of which had been reported in NSW;⁵²
 - The median age of all reported Australian COVID-19 cases was 48 years, with the highest proportion of cases aged 20-29 and 60-69 years; and
 - Virus genome sequences analysed from Australian cases indicated introduction of SARS-CoV-2 from China, Iran, Europe and the United States.

50 A consolidated bundle of the CDI Weekly Epidemiology Reports from January to March 2020 is contained at Exhibit 33.

51 Exhibit 33, Epidemiology Reports re COVID-19 of Communicable Diseases Intelligence, Department of Health - Numbers 1 to 9, CDI Report week ending 14 March 2020.

52 This reporting period accounted for 65% of reported cases in Australia.

The Diamond Princess

- 3.36 Emerging evidence of the rapid transmissibility of COVID-19 within close contact environments gave rise to significant public concerns regarding the potential for the spread of the novel coronavirus on cruise ships. By mid-February 2020, this concern was brought sharply into focus by the case of the Diamond Princess, a stricken cruise ship that was quarantined at Yokohama Port in Japan.
- 3.37 On 20 January 2020, the Diamond Princess, a cruise ship owned and operated by Princess Cruise Lines, departed Yokohama Port on a 16-day round trip itinerary, travelling to: Hong Kong on 25 January 2020; Chan May Port, Vietnam on 27 February 2020; Cai Lan, Vietnam on 31 January 2020; and Naha, Japan on 1 February 2020. The cruise had 3,711 passengers (2,666 guests and 1,045 crew) on board.⁵³
- 3.38 On 1 February 2020, the first case of COVID-19 connected with the Diamond Princess was confirmed by health authorities in Hong Kong. The ill passenger, an 80-year-old male, had earlier disembarked in Hong Kong on 25 January 2020. At disembarkment, the ill passenger had only developed minor respiratory symptoms, but on 1 February 2020, he was hospitalised with fever and soon tested positive to COVID-19.⁵⁴
- 3.39 At the time of the announcement from Hong Kong, the Diamond Princess was docked at Okinawa, Japan and had been issued a provisional quarantine certificate. The ship was immediately directed to return to Yokohama Port, where it arrived on 3 February 2020 and re-commenced its quarantine.⁵⁵ Two days later, on 5 February 2020, ten passengers tested positive to COVID-19, with the result that all passengers were isolated in their cabins, although crew continued to work.⁵⁶ Japanese health authorities consequently announced that the ship's quarantine period would be extended by at least 14 days.⁵⁷
- 3.40 In the early stages of the COVID-19 outbreak onboard, testing was limited to passengers presenting with fever or respiratory symptoms and their close contacts. All passengers who tested positive to COVID-19 were disembarked and hospitalised. This testing procedure was soon after expanded to any high-risk passengers; prioritising elderly passengers, those with pre-existing medical conditions and those in internal cabins with no access to outdoor areas on the ship.⁵⁸

53 Eisuke Nakazawa et al, 'Chronology of COVID-19 Cases on the Diamond Princess Cruise Ship and Ethical Considerations: A Report From Japan' (2020) *Disaster Medicine and Public Health Preparedness* 1.

54 Ivan Fan-Ngai Hung et al, 'SARS-CoV-2 shedding and seroconversion among passengers quarantined after disembarking a cruise ship: a case series' (2020) *Lancet Infectious Diseases* 1, 2 <<https://www.thelancet.com/action/showPdf?pii=S1473-3099%2820%2930364-9>>.

55 Nakazawa et al, above n 53.

56 Leah Moriarty et al, 'Public Health Responses to COVID-19 Outbreaks on Cruise Ships - Worldwide, February-March 2020' 69(12) *Morbidity and Mortality Weekly Report* 347.

57 Shuichi Doi, Daisuke Yajima and Shingo Tsuru, 'Cruise ship put under 2-week quarantine as 10 cases confirmed', *The Asahi Shimbun* (online), 5 February 2020 <<http://www.asahi.com/ajw/articles/13102622>>.

58 Moriarty et al, above n 56.

- 3.41 On 15 February 2020, the Japanese Ministry of Health, Labour and Welfare determined to expand its testing policy to ensure that every passenger onboard was tested for COVID-19. On that date, the number of passengers who had tested positive had grown to 285. By 20 February 2020, confirmed COVID-19 cases onboard the ship had surged to 634, representing more than half of the confirmed cases outside of China at the time.⁵⁹
- 3.42 Over the next few days, governments from a number of countries around the world announced their intentions to repatriate their citizens who were passengers on the ship.⁶⁰ On 17 February 2020, the Prime Minister of Australia announced that all Australian passengers onboard the Diamond Princess would be repatriated to Australia, where they would compulsorily be required to observe a further 14-day quarantine period at the Howard Springs Facility in Darwin.⁶¹
- 3.43 On 20 February 2020, 164 passengers arrived at the Howard Springs Quarantine Facility to begin their 14-day quarantine period. All passengers had been health screened before being permitted to disembark the Diamond Princess. None had tested positive for COVID-19 or had any symptoms associated with the disease. Following their arrival, six people identified as having minor respiratory symptoms or fever. Those passengers were immediately separated from others at the airport and put directly into isolation. The following day, the CMO confirmed that two of the isolated passengers had tested positive for COVID-19. Dr Murphy further stated: “[g]iven there was continued evidence of spread of infection on board the Diamond Princess in recent days, the development of some positive cases after return to Australia is not unexpected, despite all of the health screening before departure”.⁶²
- 3.44 Ultimately, of 3,711 passengers onboard the Diamond Princess, 712 (19.2%) tested positive for COVID-19. Of those positive cases, 331 (46.5%) were asymptomatic at the time of testing. Of the 381 symptomatic patients, 37 (9.7%) required treatment in an intensive care unit and nine (1.3%) tragically died.⁶³ There were also three reported instances of secondary transmission among Japanese public responders, including one nurse, one quarantine officer and one administrative officer.⁶⁴

59 Kenji Mizumoto et al, ‘Estimating the asymptomatic proportion of coronavirus disease 2019 (COVID-19) cases on board the Diamond Princess cruise ship, Yokohama, Japan, 2020’ (2020) 25(10) *Euro Surveillance* 1.

60 Nakazawa et al, above n 53, 3.

61 The Hon Scott Morrison MP, ‘Press Conference – Melbourne, VIC’ (17 February 2020) <<https://www.pm.gov.au/media/press-conference-melbourne-vic-0>>.

62 Dr Brendan Murphy, ‘Two Diamond Princess passengers positive for COVID-19’ (Media Release, 21 February 2020) <<https://www.health.gov.au/news/four-more-diamond-princess-passengers-test-positive-for-covid-19>>.

63 This included 78-year-old James Kwan, who on 1 March 2020 became the first Australian to die due to COVID-19.

64 Moriarty et al, above n 56, 348.

The Grand Princess

- 3.45 In the wake of the Diamond Princess, public concerns surrounding the evident transmissibility of COVID-19 on cruise ships were further compounded by the journey of the Grand Princess off the Californian coast.
- 3.46 From 11 to 21 February 2020, the Grand Princess, another cruise ship owned by Princess Cruise Lines, sailed on a roundtrip itinerary from San Francisco, California. A second voyage, carrying 3,751 passengers (2,460 guests and 1,111 crew), departed San Francisco on 21 February 2020, with a planned return on 7 March 2020. A majority of the 1,111 crew and 68 passengers from the first voyage remained onboard for the second voyage.⁶⁵
- 3.47 On 4 March 2020, the Centers for Disease Control and Prevention (CDC) in the United States was informed of a passenger from the first cruise who had tested positive for COVID-19 in California. The CDC notified Princess Cruise Lines, which commenced cancelling all social activities planned for the remainder of the second voyage. Since that notification, more than 20 additional confirmed cases of COVID-19 have been identified from the first voyage of the Grand Princess, including one death.⁶⁶
- 3.48 On 5 March 2020, specimens taken from 45 passengers were collected from the ship by a response team.⁶⁷ The following day, United States Vice President Mike Pence confirmed during a briefing with members of the White House Coronavirus Task Force that 21 passengers (2 guests and 19 crew) had tested positive for COVID-19. All guests and symptomatic crew members were requested to isolate in their cabins.⁶⁸
- 3.49 Following discussions between the White House Coronavirus Task Force, the CDC and authorities in the State of California, the Grand Princess was directed to port at a non-commercial dock in Oakland, California, where it arrived on the afternoon of 8 March 2020.⁶⁹ On 9 March 2020, all passengers from California were transferred to Travis Air Force Base in Miramar for a 14-day quarantine period. The remaining passengers⁷⁰ from the United States were transported to military bases in Georgia and Texas for their respective 14-day quarantine periods.⁷¹
- 3.50 By 21 March 2020, of 469 passengers with available results, 78 had tested positive for COVID-19.⁷²

65 Moriarty et al, above n 56, 348-349.

66 Moriarty et al, above n 56, 348-349.

67 Moriarty et al, above n 56, 348-349.

68 Mike Pence, Vice President of the United States, 'Press Briefing by Vice President Pence and Members of the White House Coronavirus Task Force' (Transcript issued on 6 March 2020) <<https://www.whitehouse.gov/briefings-statements/press-briefing-vice-president-pence-members-white-house-coronavirus-task-force-3/>>.

69 Mike Pence, Vice President of the United States, 'Remarks by President Trump, Vice President Pence, and Members of the White House Coronavirus Task Force in Press Briefing' (Transcript issued on 9 March 2020) <<https://www.whitehouse.gov/briefings-statements/remarks-president-trump-vice-president-pence-members-white-house-coronavirus-task-force-press-briefing/>>.

70 All passengers from Canada (242) and the United Kingdom (113) were repatriated by direct charter flights following their disembarkment in Oakland.

71 Pence, above n 69.

72 Moriarty et al, above n 56, 348-349.

Pandemic declaration and escalating public health responses

- 3.51 On 11 March 2020, the WHO Director-General reported a 13-fold increase in the number of COVID-19 cases detected outside of China in the previous fortnight. By that stage, there were in excess of 118,000 reported infections spanning 114 countries, with 4,291 deaths recorded. Dr Tedros acknowledged that “in the days and weeks ahead, we expect to see the number of cases, the number of deaths, and the number of affected countries climb even higher.”⁷³ In recognition of what Dr Tedros described as “the alarming levels of spread and severity”, as well as the “alarming levels of inaction”, the WHO made the assessment that COVID-19 could be described as a pandemic.⁷⁴
- 3.52 The WHO’s pandemic declaration would ultimately herald an unprecedented shift in the Australian public health response to COVID-19. From 13 to 19 March 2020, the newly formed National Cabinet, consisting of the heads of the Commonwealth and State and Territory Governments, endorsed a series of increasingly restrictive public health measures geared towards reducing transmission of COVID-19 within the Australian community. These measures included as follows:
- On 13 March 2020, a restriction on non-essential, organised public gatherings of more than 500 people;⁷⁵
 - On 15 March 2020, a 14-day self-isolation requirement on all international arrivals and a ban on international cruise ship arrivals;
 - On 18 March 2020, an immediate ban on all non-essential indoor gatherings of greater than 100 people;⁷⁶ and
 - On 19 March 2020, the closure of Australian borders to non-citizens and non-residents, effective as at 9:00pm.

73 Dr Tedros Adhanom Ghebreyesus, ‘WHO Director-General’s opening remarks at the media briefing on COVID-19’ (Speech delivered at the World Health Organisation, Geneva, 11 March) <<https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020>>.

74 Ibid.

75 This restriction was subsequently legally enforced by the NSW Minister for Health following the *Public Health (COVID-19 Public Events) Order 2020*.

76 This restriction was legally enforced by the NSW Minister for Health following the *Public Health (COVID-19 Mass Gatherings) Order 2020*.

SPECIAL COMMISSION OF INQUIRY INTO THE RUBY PRINCESS

SPECIAL COMMISSION OF INQUIRY INTO THE RUBY PRINCESS

4

Legal Framework for Cruise Ship Arrivals

Introduction and key legislation

- 4.1 As a cruise ship approaches an Australian port, it is subject to an array of statutory regimes and a number of administrative processes which purport to fulfil those statutes' requirements.
- 4.2 There are, of course, immigration considerations in relation to the people – both passengers and crew – who are entering or re-entering Australia. Additionally, there are customs considerations relating to the importation of goods into Australia, and there are biosecurity considerations in relation to both goods and people.
- 4.3 This chapter focusses particularly on the human biosecurity arrangements relevant to international cruise ship arrivals.

The Constitution

- 4.4 The *Constitution* provides the Commonwealth Parliament with the power to make law with respect to quarantine (s 51(ix)) and immigration and emigration (s 51(xxvii)).

The Commonwealth Statutes

- 4.5 Without attempting to be exhaustive, the following Commonwealth statutes are relevant to an incoming cruise ship:
 - *Biosecurity Act 2015*
 - *Migration Act 1958*
 - *Customs Act 1901*
 - *Australian Border Force Act 2015*
- 4.6 Of these statutes, the *Biosecurity Act 2015* (Cth) (*Biosecurity Act*) is central to this Commission.

Biosecurity Act

Relevant objects and definitions

- 4.7 The objects of the *Biosecurity Act* relevantly provide for the management of the risk of Listed Human Diseases (LHD) or any other infectious human diseases entering Australia, or emerging, establishing themselves or spreading in Australia.
- 4.8 The Director of Human Biosecurity (DHB) may determine that a human disease is a LHD if he or she considers the disease may be communicable; and cause significant harm to human health: s 42. A determination under s 42 is a legislative instrument. The *Biosecurity (Listed Human Diseases) Determination 2016* was amended on 21 January 2020 to include human coronavirus with pandemic potential at s 4(h).
- 4.9 A “biosecurity risk” is defined as the *likelihood* of a disease or pest entering or establishing itself in Australian territory, and the potential of the disease or pest to:
 - a) cause harm to human, animal or plant health, or the environment; or
 - b) have economic consequences associated with the entry, establishment or spread of the disease or pest.

Responsibilities for administration and enforcement

- 4.10 The responsibility for administering the *Biosecurity Act* is divided between the Department of Agriculture, Water and the Environment (DAWE) and the Commonwealth Department of Health. This results in a bifurcation of administrative and enforcement powers and responsibilities. DAWE has primary responsibility for most provisions of the *Biosecurity Act*. DAWE’s responsibilities are referred to, simply, as “biosecurity”. The Commonwealth Department of Health’s responsibilities are referred to as “human biosecurity”. At the apex of each of these administrations, under each of the Ministers, is the Director of Biosecurity and the DHB. They are responsible for, respectively, “Biosecurity Officers” and “Human Biosecurity Officers” (HBO) (including, in relation to the latter category, a Chief Human Biosecurity Officer (CHBO) appointed for each State and Territory).
- 4.11 This Commission is concerned with a cruise ship which entered Australia carrying SARS-CoV-2, a LHD which was, by that time, sufficiently serious and widespread to carry the designation of a pandemic. This Commission is, thus, focussed on questions which are referred to in the *Biosecurity Act* as relating to ‘human biosecurity’.
- 4.12 Chapter 4 of the *Biosecurity Act* provides that DAWE has the responsibility for vessels, including cruise ships, entering Australia. That responsibility is reflected in the power to grant pratique.

Pratique

- 4.13 The *Biosecurity Act* provides for the grant of “pratique”. Pratique is relevantly defined by the World Health Organisation’s International Health Regulations 2005 (IHR) as “permission for a ship to enter a port, embark or disembark...”. Giving effect to the IHR is one of the objects of the *Biosecurity Act*.
- 4.14 The provisions concerning pratique are located in Part 2 of Chapter 2 of the *Biosecurity Act*. Chapter 2 deals with managing human biosecurity. Part 2 of Chapter 2 is entitled “Preventing risks to human health”. Part 2 seeks to achieve its object by providing the Commonwealth Health Minister with the power to require individuals to provide information about his or her health or undergo screening (s 44).

Positive and negative pratique

- 4.15 The *Biosecurity Act* provides for pratique in one of two ways. Automatic pratique is given by force of s 48(2). This is known as “positive pratique”. Section 49 provides for “negative pratique”. Negative pratique is, essentially, pratique in relation to certain classes of vessels which is granted on a case-by-case basis. It is negative in the sense that the vessel will not have permission to dock, disembark or unload until a Biosecurity Officer affirmatively grants pratique.
- 4.16 The default position is automatic (positive) pratique. Section 49(1) enables the DHB to make a legislative instrument which specifies classes of aircraft and vessel to be excepted from the positive pratique arrangements and stipulates the requirements those excepted conveyances must satisfy for pratique to be granted. Cruise ships fell into such a class, depending on factors explained below.

DAWE controls the grant of pratique

- 4.17 The *Biosecurity Act* provides that once the conditions prescribed in the DHB’s legislative instrument are satisfied, a Biosecurity Officer may grant pratique (s 49(4)).
- 4.18 Notwithstanding that pratique concerns the management of human biosecurity, the grant of pratique is vested in a Biosecurity Officer (a DAWE officer) rather than a HBO. This may be because DAWE has general control of biosecurity in relation to vessels (Chapter 4) including their pre-arrival reporting obligations (s 193). DAWE manages vessels’ pre-arrival reporting through a system called the Maritime Arrivals Reporting System (MARS).

Biosecurity (Negative Pratique) Instrument 2016

- 4.19 The relevant legislative instrument promulgated by the DHB is the *Biosecurity (Negative Pratique) Instrument 2016* (Cth) (***Biosecurity Instrument***). Pursuant to s 49 of the *Biosecurity Act*, that instrument excludes certain classes of conveyance from the default arrangements of positive pratique. Relevantly, cl. 5, item 2 of the *Biosecurity Instrument* excludes vessels that have provided a pre-arrival report that disclosed that an individual has or had, during the voyage, signs or symptoms of a LHD.
- 4.20 Therefore, once a ship has declared even just one individual (passenger or crew) who has (or who has had during the voyage) signs or symptoms consistent with a LHD, that ship does not have automatic (positive) pratique and requires consideration of the grant of pratique by a biosecurity officer.
- 4.21 By virtue of cl. 5, item 2 of the *Biosecurity Instrument*, the Biosecurity Officer is not to grant pratique unless permission has been granted by a CHBO, HBO or Biosecurity Officer.
- 4.22 Submissions on behalf of Carnival that, in the context of the *Biosecurity Instrument*, any of the persons listed in cl. 5, item 2 should be construed to be a Biosecurity Officer for the purposes of s 49 of the *Biosecurity Act* should be rejected. The *Biosecurity Act* defines “biosecurity officer” to mean a person appointed pursuant to s 545. That section relates only to the appointment of DAWE Biosecurity Officers. It does not relate to the appointment of HBOs or CHBOs.
- 4.23 Accordingly, the *Biosecurity Instrument* permits a Biosecurity Officer to grant pratique without recourse to advice from a CHBO or HBO.

Chapter 10 of the Biosecurity Act – governance and officials

- 4.24 The Director of Biosecurity is the person who is (or acting as) the Secretary of the Department administered by the Agriculture Minister, in this case, DAWE: s 540.¹
- 4.25 The DHB is the Commonwealth Chief Medical Officer: s 544(1).
- 4.26 The Commonwealth Health Minister may enter into an arrangement with a State or Territory body for an officer or employee of the body to be authorised as a CHBO or a HBO for that State or Territory: s 564.
- 4.27 Additionally, the DHB may authorise a person to be a CHBO or a HBO for a State or Territory: s 562. The DHB must be satisfied that the person to be appointed as CHBO or HBO has appropriate clinical experience before appointing them to the role. The Commonwealth Department of Health has Standard Operating Procedures for the appointment of CHBOs and HBOs. Such authorisation must not be made unless an arrangement under s 564 is in place.

1 Previously known as the Department of Agriculture and Water Resources (from 2015 to 2019).

The arrangement between the Department of Health and the State of NSW

- 4.28 There was, at all relevant times, an arrangement in place pursuant to s 564, between the Commonwealth and NSW Health in relation to provision, by the latter, of a CHBO, HBOs and biosecurity services.
- 4.29 The Schedule to a Standing Funding Agreement (**Agreement**) with the Commonwealth Department of Health names the relevant “programme” as “*Agreement with the States and Territories for the provision of Human Quarantine Services*.” The “activity” is described as “Human Biosecurity Services”. The Agreement is expressly made pursuant to s 564 of the *Biosecurity Act*.² The Agreement provides that the State will ensure that a CHBO and HBOs are appointed. The CHBO’s activities will be subject to the direction of the DHB and a HBO’s activities will be subject to direction of the State’s CHBO.
- 4.30 The services that are to be provided by the Agreement are as follows:
- Routine, day-to-day human biosecurity services at the Australian border, including by:
 - screening travellers at Australia’s international border for LHDs; and
 - managing the treatment of travellers at Australia’s international border for LHDs; and
 - Resourcing for human biosecurity emergencies (if required, based on an assessment according to the individual circumstances of each incident).
- 4.31 The Agreement also provides that the CHBO and HBOs will perform certain other activities including:
- 1) the provision of medical advice to Biosecurity Officers assessing ill travellers at Australia’s international points of entry;
 - 2) integration into State public health systems of particular travellers;
 - 3) imposing Human Biosecurity Control Orders (**Control Orders**) on individuals who may have a LHD;
 - 4) providing advice to DAWE Biosecurity Officers concerning measures to be taken to treat a vessel or other biosecurity measures to be performed if a vessel is suspected to have a communicable disease onboard;
 - 5) to act as a conduit between Commonwealth and State on human biosecurity matters;
 - 6) to support the assessment of travellers who are at higher risk of developing a listed human disease; and
 - 7) maintaining regular contact with First Points of Entry in the State to ensure that response procedures to health emergencies are documented in the [seaport] emergency planning as required under the IHR.

² Exhibit 114, Voluntary Statement of the Commonwealth of Australia (12 June 2020), Document 8.

- 4.32 The Agreement recites that the Commonwealth has constitutional responsibility for quarantine including biosecurity. It further recites that the Commonwealth's objective in relation to human biosecurity matters "is to protect the Australian public from serious communicable diseases, particularly new, exotic and re-emerging infectious diseases through human biosecurity activities."
- 4.33 The Agreement notes that the Commonwealth Department of Health is responsible for administering the human health aspects of the *Biosecurity Act* which is a key element of the Commonwealth's biosecurity programme. The Agreement also notes that the Commonwealth Department of Health does not have officials at Australia's First Points of Entry to perform human biosecurity services, and that "These activities are performed by [DAWE Biosecurity Officers] supported by State and Territory health departments and the Department of Health."
- 4.34 NSW Health had developed a policy to assist the CHBO and HBOs with how to assess and manage a suspected case of a LHD.³

Chapter 2 of the Biosecurity Act – managing biosecurity risks in relation to human health

Human Biosecurity Control Orders

- 4.35 One way which the *Biosecurity Act* seeks to actively manage human biosecurity risks, once such risks are identified, is through Control Orders. Control Orders may be made by CHBOs, HBOs and Biosecurity Officers: s 60.
- 4.36 A Control Order may be made where someone has signs or symptoms of a LHD or if they have been "exposed" to someone who has such signs or symptoms. "Exposed" is defined as including physical contact or close proximity: s 17. It may be assumed that everyone on a cruise ship is likely to have been "exposed" to one another.
- 4.37 The administrative processes relating to Control Orders are fairly demanding. Consequently, it is impractical to issue Control Orders to large numbers of individuals. The contents of the Control Order are prescribed by s 61. Those contents are comprehensive in their requirements to notify persons subject to Control Orders about the nature and justification of the Control Order. The Control Order must be given to the individual within 24 hours of it having been made or it is of no effect: s 63.

³ Exhibit 93, Second statement of Dr Sean Tobin (19 June 2020), Annexure SNT-5.

- 4.38 The biosecurity measures which may be included in a Control Order include: home self-isolation (s 87); undergoing an examination (s 90); requiring body samples (s 91); and isolation measures. An isolation measure is a requirement that an individual remain isolated at a specified medical facility. "Medical facilities" are defined to be places where medical assessments are conducted. Those facilities may be either permanent or temporary. Accordingly, a designated hotel would meet the definition of "medical facility" as long as medical assessments were conducted there. These powers were not invoked in relation to the passengers who disembarked the Ruby Princess on 19 March 2020.
- 4.39 On 16 March 2020, the NSW Health Minister gave a ministerial direction (commencing 17 March 2020) that a person arriving in NSW who had been in a country other than Australia within 14 days before that arrival must isolate themselves for a period of 14 days: *Public Health (COVID-19 Quarantine) Order 2020*. On 28 March 2020, Minister Hazzard made a further direction requiring all international maritime arrivals to attend a "quarantine facility" for 14 days: *Public Health (COVID-19 Maritime Quarantine) Order 2020* (amended 3 April 2020). The latter direction effected the "mandatory hotel quarantine" regime for international arrivals which has applied since that time.

Chapter 4 of the Biosecurity Act – conveyances

- 4.40 Chapter 4 deals with "conveyances", including cruise ships. Section 191(2) provides that a vessel becomes subject to "biosecurity control" when it enters Australian territory.

Pre-arrival reporting

- 4.41 Section 193 requires the operator of an aircraft or vessel entering Australia to furnish a pre-arrival report (PAR). The form and content of the PAR are prescribed by s 48(2) of the *Biosecurity Regulation 2016* (*Biosecurity Regulation*), most relevantly at cl 48(2)(l) which requires the vessel to provide:
- "details of any person on board who has, or had, during the voyage signs or symptoms of a listed human disease, or signs or symptoms of any other disease that are, or were, not due to: (i) a pre-existing physical condition; or (ii) an injury; or (iii) inebriation; or (iv) the effects of a drug other than alcohol; or (v) motion sickness".
- 4.42 The report must be submitted to MARS 12-96 hours before the estimated time of arrival at an Australian port: cl. 48(6)(a) of the *Biosecurity Regulation*. Section 194 of the *Biosecurity Act* requires vessel operators to update the report if they become aware that the information in the report is incomplete or incorrect. Section 194 is expressed in a way which creates an obligation to correct a report which is found to be incomplete or incorrect. The section does not convey a clear obligation to update case numbers if and when those case numbers increase: ie the number of cases reported at a specified time does not make that report "incomplete or incorrect" when the number of cases later increases. Consequently, it is doubtful whether updating is required by s 194.

Commonwealth Policies

- 4.43 There are four Commonwealth biosecurity-related policies which apply to an incoming passenger ship:
- 1) DAWE Work Instruction – *Undertake a Routine Vessel Inspection*;⁴
 - 2) DAWE Work Instruction – *Undertake a Human Health Inspection on board international vessels*;⁵
 - 3) DAWE Guideline – *Death or illness of a traveller on board an international vessel*;⁶ and
 - 4) Commonwealth Health – *Assessing Ill Travellers at Australia’s International Border*.⁷

DAWE Work Instruction: Undertake a Routine Vessel Inspection

- 4.44 The Maritime National Coordination Centre (MNCC) is described as the “central contact point for Agencies, Masters and the inspectorate for advice on vessel clearance activities.” One of its responsibilities is the provision of documentary risk-assessments of all pre-arrival information.
- 4.45 Biosecurity Officers are, pursuant to this Work Instruction, responsible for physical vessel inspections, assessing documentation, assessing crew and taking appropriate action when a biosecurity risk is identified.
- 4.46 MARS will queue a Routine Vessel Inspection (RVI) when, relevantly, a biosecurity risk has been reported by a vessel in a PAR, or MARS has assessed the risk on a vessel and determined that a RVI is required.
- 4.47 A RVI is divided into various components including: an interview with the Master of the vessel; a Human Health Assessment and various other assessments including in relation to ballast water and ship sanitation. Where a Human Health Assessment is required, Biosecurity Officers must follow the procedures set out in the *Death or illness of a traveller on board an international vessel* Work Instruction (dealt with from [4.56] below). The *Undertake a Routine Vessel Inspection* Work Instruction notes “Important: it is the Department of Health Policy that the TIC [Traveller Illness Checklist] be administered face to face.”
- 4.48 The Work Instruction provides that a Biosecurity Officer must board a vessel with various documents including a Traveller with Illness Checklist (TIC); the *Death or illness of a traveller on board an international vessel* Work Instruction; and a HBO contact list. They must also ensure that the ship’s medical log is available for review by the Biosecurity Officer in order to compare it to the disclosure provided in the ship’s PAR.⁸

4 Exhibit 114, Voluntary Statement of the Commonwealth of Australia (12 June 2020) [78], Document 23.

5 Ibid [78], Document 24.

6 Ibid [78], Document 25.

7 Ibid [78], Document 26.

8 Ibid Document 23, p 17.