

Report summary — investigation into the detention and treatment of public housing residents arising from a COVID-19 ‘hard lockdown’ in July 2020

Why we investigated

1. At approximately 4:00pm on 4 July 2020, Victoria’s Deputy Chief Health Officer (Communicable Disease) (‘Deputy CHO’) issued public health directions to residents and other people located at nine public housing towers in the inner-Melbourne suburbs of Flemington and North Melbourne.
2. These directions — at the time, the most restrictive imposed in Australia in response to an outbreak of COVID-19 — detained approximately 3,000 people to their homes in an immediate ‘hard lockdown’.
3. The Ombudsman received more than 85 complaints from residents, community advocates and concerned Victorians relating to the treatment of people living at the public housing towers during the lockdown.
4. Ombudsman investigators also attended the North Melbourne public housing estate and spoke with community advocates, emergency services staff and representatives of the Department of Health and Human Services (‘DHHS’) — the social landlord and authority responsible for the operation.
5. On 16 July 2020, the Ombudsman decided to investigate the treatment of people during the lockdown, focusing on 33 Alfred Street, North Melbourne — the public housing tower subject to the longest period of restrictions.
6. The investigation looked at whether imposition of the lockdown complied with the *Charter of Human Rights and Responsibilities Act 2006* (Vic), and also considered:
 - the conditions under which people were detained at 33 Alfred Street
 - official communications with residents and advocates
 - the restrictions upon people’s access to fresh air, exercise, medical care and medical supplies while detained.
7. The Ombudsman recognised the outcomes of her investigation of the lockdown at 33 Alfred Street would also be relevant to other Melbourne public housing estates.

What we found

Imposition of the lockdown

8. The outbreak of COVID-19 associated with 33 Alfred Street was first identified on 2 July 2020, in the early stages of Victoria’s ‘second wave’ of COVID-19 infections.

9. Prior to the outbreak, DHHS had not prepared a specific Outbreak Management Plan for the Flemington and North Melbourne public housing estates or Melbourne's high-density public housing settings more generally. Both State and Federal guidelines relating to other 'sensitive' and 'high risk' settings recommended the preparation of such a document.
10. By late in the evening of 3 July 2020, almost two dozen recently confirmed cases of COVID-19 had been connected to three public housing towers located at the Flemington and North Melbourne estates.
11. Following discussion, an inter-agency meeting was convened at 11:00am on 4 July 2020 to consider a possible response to the outbreak. Under this proposal, residents of the affected public housing towers would be required to quarantine at home for an initial period of five days.
12. Senior DHHS officers leaving the meeting, including the Deputy CHO, expected these arrangements would not commence for approximately 36 hours.
13. Later, during the early afternoon of 4 July 2020, the Deputy CHO was informed that a decision had been made to bring forward the operation. Directions were to be made under the *Public Health and Wellbeing Act 2008* (Vic) and would commence that same afternoon.
14. This decision appeared to have been made by the Crisis Council of Cabinet, a special forum of Victorian Government Ministers chaired by the Premier.
15. This was to be the first use of emergency detention powers to manage an outbreak of COVID-19 within the Victorian community, and the first 'hard lockdown' of a high-density residential building anywhere in Australia in response to the global pandemic.
16. Yet the Deputy CHO was provided just 15 minutes to consider the human rights implications of the decision before the lockdown was scheduled to be announced.
17. While convinced of the need to impose additional public health restrictions at the outbreak sites, the Deputy CHO said she would have preferred an opportunity to consult with multicultural community leaders and further time to discuss the available options.
18. Although she signed the directions, the Deputy CHO told the investigation she was not convinced delaying the lockdown by a day would have made a 'hugely significant' difference to containing the outbreak.

Implementation

19. Those planning for the lockdown needed to urgently develop and implement arrangements to provide food relief, as well as health and social supports, for the thousands of people likely to be affected by the intervention.

20. Public servants and qualified interpreters needed to be sourced on short notice. Those operating on the ground required advice on appropriate infection prevention and control protocols. Meanwhile, there was need to develop a community engagement strategy and brief multicultural community leaders about the intervention.
21. Despite the dedicated efforts of those coordinating the operation, many of these matters remained outstanding or only just under development when the lockdown commenced.

Treatment of people at 33 Alfred Street

Notice of the lockdown and safeguards

22. Copies of the Detention Directions – the English-language instrument setting out the purpose and terms under which people were being detained – were not distributed when the lockdown commenced. DHHS did not provide some households with a copy of this document until the third day of the intervention. Other attempts to notify residents of the purpose and terms of the lockdown were also delayed or lacking.
23. DHHS was unable to produce any records demonstrating the detention of residents at 33 Alfred Street was formally reviewed each day, in apparent breach of section 200(6) of the Public Health and Wellbeing Act.
24. Information distributed to residents also did not refer to the ability to make complaints about the lockdown under section 185(1) of the Public Health and Wellbeing Act.

Fresh air and outdoor exercise

25. Residents at 33 Alfred Street were not provided access to outdoor exercise until the second week of the lockdown, increasing risks to health and wellbeing during this period.
26. People participating in a trial of the fresh air and exercise program on 11 July 2020 were escorted by Victoria Police officers to an outdoor area enclosed by temporary fencing. This was clearly degrading and inhumane.
27. Other restrictions associated with the fresh air and exercise program, including requirements that residents be escorted through the building and supervised by health staff, aligned with public health advice and were not unreasonable in the circumstances.
28. Yet imposition of the fresh air and exercise program was initially inconsistent with the public health directions in force during the second phase of the lockdown. These and other restrictions imposed on residents during this period did not appear to comply with the Public Health and Wellbeing Act.

Enforcement

29. The involvement of large numbers of uniformed Victoria Police officers in implementing the lockdown was described by residents, advocates and some health workers as both unnecessary and insensitive to the experiences of many people living at 33 Alfred Street.
30. This aspect of the lockdown did not appear to have been the subject of noteworthy inter-agency discussion or debate, nor was it based on direct advice from the Deputy CHO. Overall, DHHS as the authority responsible for the operation and the social landlord appeared to have given insufficient consideration to how the significant police deployment was likely to be perceived and experienced by residents.

Health and wellbeing

31. The investigation was generally satisfied appropriate arrangements were put in place for residents at 33 Alfred Street to access medical care during the lockdown, including emergency treatment where necessary.
32. Yet there were significant problems with the provision of medication and other medical supplies to residents.
33. The investigation identified several cases where fulfilment of seemingly urgent requests for medication was delayed or neglected by authorities administering the lockdown. Residents were in some cases forced to rely upon family or community volunteers to collect and deliver essential supplies.
34. Resolving requests for medical supplies would have benefited from a centralised case management system and greater coordination and oversight from DHHS.
35. A more structured, comprehensive approach to monitoring resident welfare would also have decreased risks to health and wellbeing associated with the lockdown.

Cultural and linguistic diversity

36. The decision to impose the lockdown was not informed by consultation with multicultural community leaders.
37. Consultation by DHHS with multicultural communities after the lockdown started was initially reactive and non-collaborative in nature but improved with time.
38. There were nevertheless significant delays in preparing and distributing materials about the lockdown in community languages. Of most concern, translated materials explaining the purpose and terms of the lockdown were not distributed until the fifth and sixth days of the intervention.
39. There was also an unacceptable absence of qualified interpreters at the Flemington and North Melbourne public housing estates during the critical first evening of the lockdown, leaving some residents to rely upon the assistance of neighbours and community advocates to understand what was happening.

Compatibility with human rights

40. While the temporary detention of residents at 33 Alfred Street may have been an appropriate measure to contain the outbreak of COVID 19 at the building, the imposition of restrictions so quickly on 4 July 2020, without further preparation or specific health advice recommending such an approach, was not reasonably necessary and did not appear compatible with the right to humane treatment when deprived of liberty.
41. Indeed, many of the problems associated with the lockdown appeared attributable to the immediacy of the intervention.
42. The investigation was also not satisfied proper consideration was given to the human rights of those affected by the lockdown when restrictions were introduced, noting the Deputy CHO was provided less than 15 minutes to consider this issue.
43. It was also clear that greater effort could have been taken to reconcile aspects of how the intervention was implemented and perceived with its overall public health objectives. In many cases, residents' concerns about implementation of the lockdown were wholly understandable.
44. Ultimately, there was a common view, voiced by many of the residents and senior DHHS officers who shared their experiences with the investigation, of the need to restore trust following the lockdown.

Opinion

The Ombudsman formed the following opinions under section 23(1)(a) of the *Ombudsman Act 1973* (Vic):

1. The detention of people at 33 Alfred Street on 4 July 2020, without further preparation, appears contrary to law, because it:
 - was incompatible with human rights recognised in the *Charter of Human Rights and Responsibilities Act 2006* (Vic)
 - did not result from proper consideration of relevant human rights.
2. The detention of people at 33 Alfred Street following revocation of the *Detention Directions (33 Alfred Street)* was incompatible with the right to liberty and appears contrary to the *Charter of Human Rights and Responsibilities Act 2006* (Vic).
3. DHHS's failure to ensure the detention of residents at 33 Alfred Street was reviewed at least once per day appears contrary to the *Public Health and Wellbeing Act 2008* (Vic).
4. The requirement that people at 33 Alfred Street exercise in an area surrounded by temporary fencing on the evening of 11 July 2020 was degrading and inhumane, and appears contrary to section 38(1) of the *Charter of Human Rights and Responsibilities Act 2006* (Vic).

Further, pursuant to section 23(1)(g) of the Ombudsman Act:

5. DHHS acted in a manner that was wrong, in:
 - (a) failing to provide people at 33 Alfred Street with timely information about their detention, including in community languages
 - (b) failing to notify people at 33 Alfred Street of their ability to complain about their treatment
 - (c) failing to provide people at 33 Alfred Street with access to fresh air and outdoor exercise between 4 July and the evening of 11 July 2020
 - (d) failing to take proper steps to ensure people at 33 Alfred Street were provided reasonable access to medication while detained.

Recommendations

Among other things, the Ombudsman recommended that the Victorian Government:

- apologise for harm or distress caused by the immediate lockdown
- amend the *Public Health and Wellbeing Act 2008* (Vic) to include greater safeguards around the use of emergency detention powers.

The Ombudsman also recommended that DHHS:

- ensure appropriate COVID-19 outbreak prevention, preparation and response measures are in place for all other sensitive accommodation settings administered by the Victorian Government
- consult with the Victorian Multicultural Commission and work with community leaders and public housing residents to strengthen trust and engagement
- consider other measures to improve relationships between DHHS and residents of the Flemington and North Melbourne public housing estates, such as forming one or more tenant representative bodies.

The Ombudsman's full investigation report in English can be accessed at:

www.ombudsman.vic.gov.au

If you require more information about this report you can contact us. Call (03) 9613 6222 (between 10am-4pm Monday-Friday), or if you need an interpreter call 131 450 (between 10am-4pm Monday-Friday).