

# Hiding in plain sight: Vulnerability, public administration, and the case of Covid-19 hotel quarantine

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## Abstract

I examine how failures surrounding a quarantine detention program for returned travellers from overseas brought a deadly second wave of the Covid-19 virus into existence in Victoria, Australia. In addition to providing insights into the ways in which public administration organizations (PAO) can plan for and respond to wicked problems, I propose that they can learn to manage latent failures and equivocal circumstances before, during, and after such crisis events. This is important as locally and globally PAO face emergencies, crises, and disasters triggered by natural and non-natural hazards which remind us that we need to find new ways of learning while living in challenging times.

## KEYWORDS

accidents, crisis, failures, learning, public inquiries, wicked problems

Hotel Quarantine *cannot be made risk free*. Hotels are built for tourists *not* for managing infectious diseases. *We cannot eliminate risk in this environment*. (Acting Premier of Victoria James Merlino on Channel 7, 2021)

## 1 | INTRODUCTION

Accidents happen. Sectors such as aviation, mining, defense, energy, and manufacturing have advanced initiatives to safeguard against organizational failure (Roberts & Bea, 2001), yet surprisingly public administration organizations (PAO) continue to be the focal point of accidents (see

Whitford, 2021). Indeed, recent times have reminded us that PAO attempts at solutions to wicked problems (Rittel & Webber, 1973) in relation to the Covid-19 can actually prompt accidents which have all too often exacerbated the transmission of the virus. One example of this is the first attempt by the Victorian government to implement a Covid-19 hotel quarantine program in 2020 (Covid-19 HQ) and is the focus of this paper.

PAO remain under-researched in terms of how lessons from organizational failures are translated into knowledge, which enables them to foresee and prevent future accidents (Dwyer et al., 2021). Accordingly, this paper seeks to develop insights into ways they can learn from such experiences by examining the failures surrounding the initial Covid-19 HQ. By doing so, I make three contributions to existing gaps in public administration literature.

First, I present an empirical case study of the Covid-19 HQ that allows for observations which show the different ways in which latent failures become active in PAO (Perrow, 1961; Reason, 2016; Reason & Hobbs, 2017). Second, I show that although PAO manifest different characteristics of safety systems (see Exhibit 1), they have a tendency to fail when they encounter the novelty of wicked problems, as actors struggle to get to grips with failures, which results in their actions exacerbating existing accidents and even bringing new ones into existence (Maitlis & Sonenshein, 2010). This is important as a reminder that accidents and failures are inevitable. By accepting this, the narrative surrounding the role of PAO in community safety shifts from being retrospective after failure to being prospective which seeks to identify and manage latent failures in ways that prevent them becoming active.

My third contribution focusses on public review processes and how they can often hinder learning in PAO. To date, public inquiry recommendations rarely focus on ways in which community actions bring harmful circumstances into existence (Dwyer, 2021). Instead, they have repeatedly blamed the leadership of managers and functional experts in PAO for accidents which could have been avoided if community behaviours and actions were heedful of safety advice surrounding Covid-19 and other hazards (Dwyer et al., 2021; McLennan et al., 2014). With ever increasing levels, types, and complexities (Perrow, 1961, 1967) associated with events such as pandemics and natural hazards, I propose that it is timely to modernize public review processes in a way which re-interprets and reframes accountability as a shared responsibility of PAO, society, and community. By doing so, learning becomes a focus and more importantly, a responsibility of everybody.

## 2 | CASE STUDY: COVID-19 HQ

Covid-19 HQ, with its focus on preventing the spread of the virus by quarantining returned overseas travellers in hotels in the city of Melbourne, was announced on 27 March 2020 and implemented on 29 March 2020. Despite the low number of positive tests from returned travellers, it was failure to secure containment lines from these hotels that brought a second wave of the virus into existence in Victoria. Consequently, the program ceased operation on 30 June 2020 and prompted the Premier of Victoria to establish a public inquiry into the failures surrounding the program on 20 July 2020.

In this section, I present a timeline of key events surrounding Covid-19 in the Victorian context (Table 1), which enabled me to reconstruct a chronology of key events as a case study from briefings by the Premier of Victoria between January and July 2020, publicly available commentaries, and 'official publications' (Whitford, 2021, p. 3) such as the reports of findings from the Covid-19 HQ inquiry. This was an important way of developing a theoretical understanding that

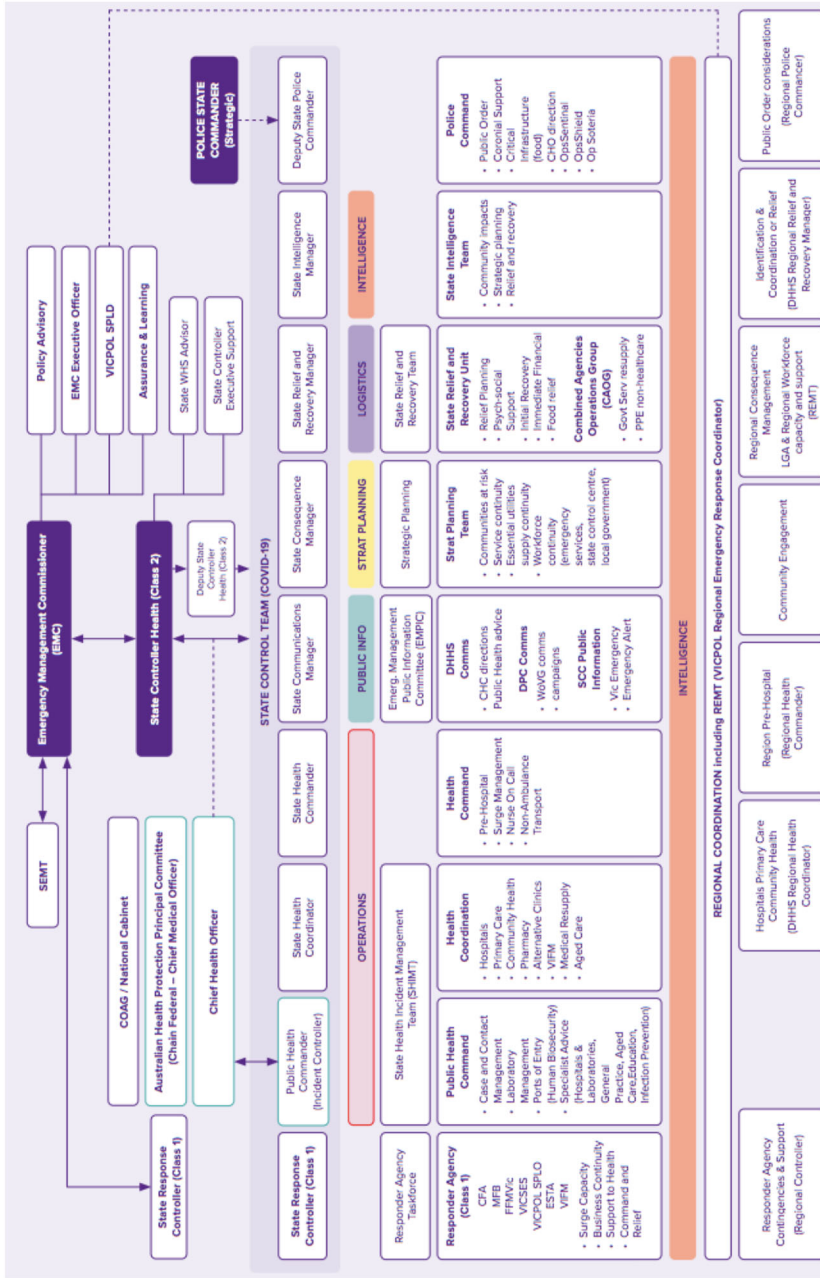


EXHIBIT 1 Governance structure for the COVID-19 health emergency (COVID-19 Hotel Quarantine Inquiry, 2020a, p. 265) [Colour figure can be viewed at wileyonlinelibrary.com]

**TABLE 1** Chronology of key events surrounding Covid-19 HQ

Key date(s)	Relevant event
25 January 2020	Australia's first confirmed case of Covid-19.
16 March 2020	Victoria declares a State of Emergency. Returned overseas travellers required to undergo mandatory 14 days quarantine through stay home orders. Public events cancelled/restricted.
20 March 2020	Australian borders closed to all non-residents. Hotel quarantine announced from 27 March 2020.
27 March 2020	Australian Defence Force (ADF) enlisted to ensure that returned travellers are quarantined appropriately.  Initial responsibility for setting up Covid-19 HQ in Victoria was given to the Department of Jobs, Precincts and Regions (DJPR) through a telephone discussion between Secretary of the Department of Premier and Cabinet (DPC) and the Secretary of DJPR despite having no expertise in quarantine detention programs. DJPR understood assistance would be needed from Department of Health and Human Services (DHHS) for managing people's well-being while being detained in quarantine.
	Within a few hours of that call to the Secretary of DJPR (and without prior knowledge of the above decision and phone call), the Emergency Management Commissioner (EMC) and the State Controller – Health at DHHS were setting up a meeting to establish a State Control Centre (SCC) on the understanding that this Program would be operated using the emergency management framework (Australasian Inter-Service Incident Management System (AIIMS)).
28 March 2020	Victoria's Covid-19-related death toll reaches an all-time high at 111. Meeting of a number of agencies at the SCC, The EMC, in conjunction with the DHHS State Controller – Health, declared that DHHS was in charge as the control agency of the operation surrounding Covid-19 HQ, whereas DJPR was a support agency.
29 March 2020	Victorian government establishes Covid-19 HQ, which admits about 2000 returned travellers in its first week. Victoria unlike other States and Territories uses private security guards rather than Victoria Police, ADF, and DHHS to triage returned travellers and enforce the mandatory 14-day quarantine period.
12 April 2020 to 31 May 2020	State of Emergency is extended in Victoria as the State begins an ambitious program of Covid-19 testing. On 31 May, State of Emergency extended as new cases are recorded at 4 with restrictions eased from 1 June. Evidence emerges of a security guard at a hotel quarantine site being infected with Covid-19.
6 June 2020 to 17 June 2020	No new cases recorded in Victoria. Restrictions eased but reach 21 on 17 June.
17 June 2020 to 26 June 2020	Detainees in Covid-19 HQ (about 30%) have been refusing testing which means that government cannot determine accurately who is infected. Hotel quarantine breaches are linked to new outbreaks of the virus.
29 June 2020 to 7 July 2020	A number of suburbs in Melbourne's northwest are returned to lockdown as cases continue to rise with all international flights to Melbourne cancelled.
2 July 2020	Victorian Premier announces Covid-19 HQ public inquiry.
4–19 July 2020	Border between Victoria and New South Wales is closed and nine public housing towers in Melbourne are locked down. New cases are spiral to 191. Victorian government repeatedly asked to clarify rationale for using private security guards to implement Covid-19 HQ.

(Continues)

TABLE 1 (Continued)

Key date(s)	Relevant event
20 July 2020	Review of Covid-19 HQ begins with Victoria in the grip of a second wave of outbreaks. The focus of the inquiry was on the decisions and actions of government agencies, hotel operators, and private contractors; communication between government agencies, hotel operators, and private contractors; contractual arrangements; information, guidance, training, and equipment provided to personnel in hotels; and policies, protocols, and procedures.

captured ‘the richness, dynamism and complexity of the data’ surrounding key events of relevance surrounding Covid-19 HQ (Langley, 1999, p. 695).

### 3 | FAILURES AND ACCIDENTS

Concerns surrounding failures and accidents (such as those outlined in Table 1) shape organizational systems, processes, and procedure design (Perrow, 1967). Moreover, they often define the attitudes, values, and norms of actors at all hierarchical levels across and between organizations (Perrow, 1994). In this section, I review four theories, which have been developed as mechanisms for preventing, managing, and ameliorating the effects of failures and accidents (Reason, 2016). By doing so (in conjunction with Exhibit 1 and Table 2), I show that although the PAO responsible for administering the Covid-19 HQ had characteristics of safety systems, they were still vulnerable to failure and accidents.

#### 3.1 | Normal accident theory

Normal Accident Theory (NAT) proposes that accidents are an inevitable and normal part of organizational life because of the complexity, which surrounds the design of electronic, mechanical, and/or social systems (LaPorte & Consolini, 1991). That said, NAT also proposes that unexpected failures will not usually cause an accident as long as different actors across and between hierarchies have the ability to make sense of equivocal events unfolding in their organizational environment (Weick, 1993). However, all too often, tight coupling exists within organizational hierarchies where there is a complex reliance or interaction between processes within a system (Perrow, 1967). When process components are misaligned or break down, system de-coupling can bring failures and accidents into existence which can have tragic and catastrophic consequences (Perrow, 1994).

Essentially, the claims of NAT are that accidents are inevitable because of the interconnected nature of components and their propensity to decouple when the operational environment of organization becomes discrepant or equivocal (Perrow, 1961, 1994). This means that low-probability failures and accidents are likely to have a higher likelihood of disastrous consequences because ‘of unfamiliar sequences, or unplanned and unexpected sequences’ which are ‘either not visible or not immediately comprehensible’ (Perrow, 1984, p. 78). However, scholars have claimed that NAT is only relevant to practitioners operating within systems, which are tightly coupled (Roberts, 1990). Therefore, it offers little guidance in terms of failure or accident prevention. Furthermore, other critiques have surfaced arguing that NAT has been used to analyse an array of accidents which have little to do with system failure. Moreover, scholarly debate remains

TABLE 2 Safety management systems in Victorian PAO

Evidence of a safety management system	Action	Inaction	Failure type
<p>HRO</p> <p>PAO show an explicit commitment to a safety culture. AIIMS was at the core of Covid-19 HQ which provides for a hierarchy of leadership and collective action across a range of organizational systems. AIIMS promotes a safety culture through collective mindfulness which monitors the changing nature of the incident being managed.</p>	<p>Covid-19 HQ systems were established and managed by private security personnel. Covid-19 HQ was established hastily without containment lines, which were robust and fit for purpose. Covid-19 HQ was established and operationalized without leaders being mindful of the risks.</p>	<p>Covid-19 HQ arrangements failed to develop a clear delegation of responsibility for managing the quarantine program. Covid-19 HQ leaders chose to decline Australian Defence Force Assistance to manage containment lines at Covid-19 HQ sites.</p>	<p>HRO failures: Covid-19 HQ became space and place from which the virus spread into the community. Covid-19 HQ was left to operate without clear and transparent public administration ownership within command and control organizations.</p>
<p>NAT</p> <p>PAO show an explicit commitment to the prevention of accidents. PAO manage Covid-19 HQ risk through AIIMS. AIIMS creates tightly coupled systems between PAO when planning for and responding to emergencies.</p>	<p>Covid-19 HQ systems were established but not managed in a unified way across complex hierarchical organizations. Covid-19 HQ established without role clarity and responsibility for risk management.</p>	<p>Covid-19 HQ leaders were unable to make sense of failures in a way that meant they could keep pace with the breaches of containment lines occurring at Covid-19 HQ sites. Covid-19 HQ leader were unaware of the failures that were occurring in relation to containment lines at Covid-19 HQ sites.</p>	<p>NAT failures: Covid-19 HQ systems decoupled without any PAO having ownership for the program. Covid-19 HQ systems were established with little appreciation for the complexity of operation and systems which comprise the PAO.</p>

(Continues)

TABLE 2 (Continued)

Evidence of a safety management system	Action	Inaction	Failure type
<p>Error modelling</p> <p>PAO develop hierarchical levels. AIIMS create hierarchical levels within systems to ensure that latent risks do not become active.</p>	<p>Covid-19 HQ was established based on assumptions which meant latent risks were not identified.</p> <p>Covid-19 HQ was established with no contingency and crisis planning which meant that latent failures became active and gave rise to harm.</p>	<p>Covid-19 HQ leaders established a system whereby they were blind to the weaknesses that would arise if containment lines were breached.</p> <p>Covid-19 HQ leaders were passive in delegating responsibility for the support systems surrounding the quarantine program.</p>	<p>Error modelling failures: Covid-19 HQ systems were established in such a way that latent failures upstream in processes aligned with latent failures downstream in processes.</p> <p>Covid-19 HQ defence systems were passive in the way they were aligned which enabled risks and hazards to pass through processes across and between PAO.</p>
<p>AIIMS</p> <p>PAO allocate command and control responsibilities for responding to Covid-19 through a State Control Centre.</p> <p>AIIMS defines the leadership roles of PAO.</p>	<p>Covid-19 HQ was established by the DJPR as a program for detaining and quarantining returned travellers.</p> <p>Covid-19 HQ was established using private security contractors that were not within the State Purchase Contract (standard agreements from which government purchases commonly used goods and services).</p> <p>Covid-19 HQ was enforced by private security contractors which were allocated to hotels.</p>	<p>Covid-19 HQ commenced on its first weekend of operation (28 and 29 March 2020) with no enforcement personnel.</p> <p>Covid-19 HQ was established with no assessment of the risks associated with the program.</p> <p>Covid-19 HQ was established with no clear focus about whether it was a response to an emergency incident or a pandemic.</p> <p>Infection control was neglected giving rise to a new wave of virus transmission.</p>	<p>AIIMS failures: Covid-19 HQ systems were established with a focus on allocation of resources which would enforce quarantine and detention rather than infection control.</p> <p>Covid-19 was managed as a response to the pandemic as an emergency incident rather than a focus on community safety.</p>

uncertain about what actually constitutes complexity, which has implications for whether NAT offers practitioners assistance as they plan for and respond to accidents (cf. Hopkins, 1999).

### 3.2 | High reliability theory

High Reliability Theory (HRT) sits at the core of High Reliability Organizations (HRO) which operate in environments where the potential for danger and harm is high but is managed effectively and efficiently through processes which are guided by a safety culture (La Porte, 1996; Weick et al., 2008). Such organizations have the capacity and capability to self-correct when they encounter equivocal circumstances (Landau, 1973). They have a safety culture that is typically operationalized by leaders with their teams being acutely aware of changes in the operational environment of their organization (Roberts & Bea, 2001). This is achieved by individuals across and within hierarchies having shared responsibility for safety and being willing to adapt to circumstances in a way which ensures risks do not become crises and subsequently disasters (Roberts, 1990). Accordingly, HRO are characterized by a collective mindfulness where systems can be adjusted before, during, and/or after disruptions to achieve reliable outcomes, which prevent accidents coming into existence (Weick, 1987). However, low-probability equivocal events have been found to have significant impacts on HRO insofar as there is little adaptive capacity and capability to deal with novelty in their operational environment (Maitlis & Sonenshein, 2010).

### 3.3 | Error modelling/Swiss cheese model of system accidents

Like HRO and NAT, error modelling places a strong emphasis on a systems approach to defending organizations against latent failures (failures which lie dormant until triggered) becoming active in a way that causes damages and losses (Reason, 2016). Error modelling places an explicit focus on the ways in which human factors interact with systems across and within organizations. Essentially, organizational systems are managed by human actors who are prone to errors of misinterpretation, which can bring accidents into existence (Reason, 1990). However, error modelling recognizes the accident-prone nature of human actors with what is an equivocal environment in everyday life. Accordingly, error modelling proposes system design on a series of in-built checking mechanisms from upstream (inputs) to downstream (outcomes and outputs) stages of processes (Reason, 2000). By doing so – theoretically – errors are caught through in-built defences which prevent them from aligning with latent risks and/or failures that may become active if circumstances and happenings align in such a way that brings harm into existence. Where defences fail, errors will flow through system processes and increase the likelihood that latent risks can become active and prompt an accident and accordingly harm (Reason & Hobbs, 2017). This approach is often explained using the metaphor of Swiss Cheese. According to this metaphor, hazards will occur when the holes of slices align because there is scope for latent failures to connect with each other, with the consequences usually being an accident.

### 3.4 | The Australasian Inter-Service Incident Management System

Australasian Inter-Service Incident Management System (AIIMS) is a well-developed practitioner-based system, which has been developed in Australia and is used to manage



a range of emergencies and incidents through organizational principles and structures (cf. Conway, 2012). These include:

1. Management by Objectives: where incident personnel work towards one set of objectives.
2. Control: where incident personnel manage activities to bring about a successful resolution to an incident.
3. Planning: where incident personnel manage the provision of information and warning to the community.
4. Operations: ensuring that resources are allocated in a way that provides for effective incident management.
5. Logistics: deployment of resources to support the incident action plan.

Each of the five incident management areas will have a designated leader with a span of control, which is flexible insofar as it can be increased or decreased depending on the severity of an incident. Such flexibility has been found to be important in the effective management of incidents particularly in times of crises (Boin & 't Hart, 2010).

Despite Victorian PAO manifesting many of the characteristics of risk management systems through a governance structure, the Covid-19 HQ failed (see Table 2 and Exhibit 1). Consequently, the Victorian government established a public inquiry to review what happened and why.

## 4 | COVID-19 HQ INQUIRY

Public inquiries are a typical response by governments to establish an authoritative account of what occurred after failures and crises which have given rise to significant damages and losses (Dwyer, 2021; Whitford, 2021). They seek to explain what happened and why (single loop learning) as a basis for re-establishing legitimacy, improving and transforming the operating assumptions of procedures and systems (double loop learning) of organizations in the future (Dwyer & Hardy, 2016; Stark, 2019). This was the focus of the Covid-19 HQ Inquiry.

The following section draws on my analysis from Table 1 and the salient findings of the Covid-19 HQ Inquiry to present a version of events, which explains why the Covid-19 HQ failed. By doing so, I show that understanding failures and accidents in a public administration context is as complex as it is complicated, which is important because it shows that even authoritative mechanisms such as public inquiries will struggle to make sense of wicked problems retrospectively.

## 5 | FINDINGS AND ANALYSIS

It was clear that the novel and discrepant circumstances under which Covid-19 HQ was established placed extraordinary demands on PAO. Simply put, there were no facilities available that were fit for quarantining returned travellers. This was noted by counsel assisting the inquiry when they observed: 'An enormous immediate, unenviable burden was placed on those in public service to establish not one but a succession of infection control facilities in buildings clearly not designed for quarantine purposes' (Neal, Transcript of Day 26, 2020b: P-2196).

The Covid-19 HQ Inquiry found that a series of actions and inactions surrounding decisions by politicians, practitioners, and policymakers with responsibilities for public administration portfolio areas gave rise to accidents which brought failures and subsequently a crisis into existence.

The major failure of the program centred on enforcement and security. Despite the cross examination of many of the key leaders in Victoria's public administration, the inquiry failed to delineate who made the decision to use private security guards to enforce the detention which ultimately had disastrous consequences. In essence, '... no one turned their mind to whether they remained a suitable workforce because no one understood themselves to have made the decision about their use in the first place' (Ellyard, Transcript of Day 26, 2020b: P-2212). As counsel assisting the Covid-19 HQ Inquiry noted: 'This decision ended up employing thousands of people and costing tens of millions of dollars and as a matter of proper governance we ought to be able to say who is accountable for that decision' (Ellyard, Transcript of Day 26, 2020b: P-2208). Despite the efforts of well-meaning actors across systems of public administration hierarchy, the Covid-19 HQ prompted a second wave of Covid-19 which eventually claimed 768 lives.

Despite the collective competencies of PAO, the leadership and functional expertise at group as well as individual levels was unable to take meaningful action to ensure that the program was fit for purpose. Moreover, their inaction as suggested by the counsel assisting the inquiry was just as harmful: 'A multitude of decisions, actions and inaction, many of which compounded the effect of the other, ultimately expressed itself in the outbreaks which subverted the very reason for the existence of a hotel quarantine program' (Neal, Transcript of Day 26, 2020b: P-2197). Consequently, the program never had a clarity of focus which it needed as a health response to managing the transmission of Covid-19: '[Hotel Quarantine] remained a program for keeping people detained in hotels rather than a health response' (Ellyard, Transcript of Day 26, 2020b: P-2200).

## 6 | DISCUSSION

Although counsel assisting acknowledged the challenges faced by the PAO in relation to establishing Covid-19 HQ, they were unable to deliver authoritative findings on who was in charge of the program in terms of key decision-making related to enforcement. Despite very defined leadership roles within the system of hierarchies, which comprise PAO, there was no individual decision maker. None of the leaders such as The Premier, the Minister for Health, the Minister for Coordination of Jobs, Precincts and Regions, the Chief Health Officer, the Emergency Management Commissioner, and Police Commissioner, as well as the executive management of PAO, were able to recall who was responsible for making the decision to use contracted security guards to enforce the program (see Exhibit 1). Consequently, there was what counsel assisting referred to as a 'creeping assumption' about who was responsible for managing the program (Ellyard, Transcript of Day 26, 2020: P-2211). It seems as though leaders relied on their interpretation about what was happening rather than the governance structures which surround Victorian public administration and the hierarchy which supports it.

## 7 | CONTRIBUTIONS

My study makes a number of contributions to risk management in a public administration context. First it shows that by reconstructing case studies of failures and accidents, which arise as a result of the collective action and indeed inaction of PAO, we become aware of latent failures which are translated into harmful circumstances by wicked problems such as Covid-19. This is important because analysis shows that, essentially, an amalgam of risk management systems (which I found to sit at the operational core of PAO in this study – see Exhibit 1 and Table 2) in and of

themselves will not necessarily facilitate an effective outcome when planning for and responding to wicked problems such as stopping the spread of a virus such as Covid-19. This is important if we are to begin to understand wicked problems and to ameliorate their harmful effects. This is not to say that ameliorating wicked problems requires novel responses. Rather, a cognitive shift is needed which focuses on the core competencies developed from what we already know – accidents/failures will happen (are even inevitable). This case study reminds us that latent failures are more likely to align and become active as organizations seek to ameliorate the effects of wicked problems.

Although the Covid-19 HQ program shares some commonalities with other failures in an Australian context, I stop short of referring to it as a policy fiasco (Bovens & 't Hart, 2016) because there was (and continues to be) much which is unknown about the transmission of Covid-19. By framing Covid-19 HQ as a fiasco, we run the risk of a continued retrospective focus, which dominated learning approaches in PAO (see Dwyer & Hardy, 2016). To date, in an Australian context this has given rise to unnecessary blaming (and even scapegoating) of emergency management practitioners when the nature of risk means that there is a need to learn in a manner which is prospective (Dwyer, 2021). By doing so, policy can be more sophisticated as a mechanism for preventing accidents coming into existence in the first place rather than emphasizing management failures which have to date been a dominant focus of studies of learning from crises and disaster (see Dwyer, 2021). Much has been made in public discourse surrounding the use of the private security contractors to enforce the containment lines of Covid-19 HQ. Yet time has shown that the virus continues to be transmitted from hotel quarantine programs nationally. Moreover, such discourses have remained silent on the fact that private security contractors secure many of the State's and Territories parliaments, public buildings, airports, banks, and so forth as well as Covid-19 vaccination sites every day without incident. The obsessive nature of the focus on private security guards has at best blinded and at worst paralyzed government, as well as society, in terms of learning from experiences related to Covid-19 HQ.

Recent work by Whitford (2021) has been able to delineate that the *Robodebt* Crisis (an Australian government initiative designed to recover payments made to social security recipients) was a fiasco insofar as PAO failed in a manner which was at best unethical and at worst unlawful. My study, however (albeit exploratory), suggests that when a wicked problem arises in the context of a grand challenge, it becomes much more difficult to foresee failures and assign accountability for what are novel and unprecedented circumstances. My study fully acknowledges the failures and accidents and the harm that was caused as a result of Covid-19 HQ but it also sheds light on complexities that sit deep at the core of responding to wicked problems. This is highlighted by the Covid-19 HQ public inquiry being unable to conclusively determine why the failure occurred and what should be done differently in the future.

The continued breaching of hotel quarantine containment lines in Australia suggests that lessons surrounding wicked problems are difficult to learn. In essence, we have much to learn about how we can learn from novel and equivocal circumstances (Dwyer, 2021; Dwyer & Hardy, 2016). Accordingly, my study suggests that future research should examine the cues and frames which comprise both failures and fiascos so that we can examine them in a much more meaningful way which reframes them through a wicked problem lens.

My second contribution shows the distinct nature of risk management in a public administration context. To date, studies have focussed on the ways in which risk management fails and brings accidents into existence within single organizations within a specific sector (see Perrow, 1984). My study shows that managing risk in a public administration context is uniquely complex as it will inevitably involve an array of large bureaucratic organizations and statutory authorities

with different portfolio responsibilities (see Table 1 and Exhibit 1). Multiple organizations also bring multiple actors at senior management, middle management, and functional expert levels (see Exhibit 1), which creates its own equivocal circumstances when collective action is required to manage risk (Perrow, 1994; Roberts, 1990). My findings clearly show that this becomes all the more complex when failures begin to occur and accidents come into existence. Accordingly, when we examine risk management, failures, and accidents in a public administration context, we must recognize that responding to wicked problems such as Covid-19 is fraught with challenges at every turn. Therefore, it is my hope that this study can provide a basis for future studies, which will examine risk management, failures, and accidents with a distinct focus on the dynamic complexity, which surrounds PAO as they grapple with wicked problems. This is important as it is one way that scholarly work can facilitate practitioners to develop more meaningful lessons from experiences of failures and accidents, which recent times remind us are inevitable regardless and irrespective of the systems organizations have in place to prevent them (Lagadec, 1993).

My third contribution relates to public review processes and inquiry myopia. Studies of significant public review processes such as the Royal Commission which occurred after the Black Saturday Bushfires in 2009 (where poignantly 173 lives were lost) show that these processes have had a tendency to blame and even vilify emergency management practitioners for events that have, over time, been shown to be beyond their control while also presenting findings which fail to represent the complexity of what occurred on the day (Brown, 2004; Dwyer, 2021; Holmes, 2010). Like previous review processes, the Covid-19 HQ public inquiry has been somewhat myopic insofar as it failed to produce authoritative evidence about what happened and why. Surprisingly, inquiry deliberations ignored the fact that it was returned travellers who breached the containment lines (despite knowing that they were required to quarantine) and brought harm to many in the Victorian community – not those who were scrutinized during the public inquiry who had actually worked successfully to eradicate the virus up until containment lines were breached. Accordingly, my study suggests that there are grounds for new ways of conducting public inquiries, which reinterprets accountability for community safety as ‘everybody’s’ responsibility. This is particularly important in the Australian context where scientific evidence shows that not only are bushfire seasons starting earlier and lasting longer but that challenges remain with preventing the transmission of Covid-19. Moreover, it is likely that policy fiascos such as *Robodebt* will continue to occur which inevitably will absorb the resources of PAO. Under current circumstances, public inquiries in an Australian context run the risk of producing recommendations that are in and of themselves latent failures insofar as they are developed through authorial strategies, which often omit important information (Brown, 2000, 2004). The community are to a large degree absolved of responsibility despite being aware that their behaviours can bring harm into existence (Dwyer, 2021). Even though we know that latent failures have their origin in the errors of high-level decision makers (Reason, 2016; Reason & Hobbs, 2017), there is still a focus on conducting quasi-judicial public inquiries where commissioners are far removed from the accidents, failures, and disasters which they are tasked with reviewing. I argue that such formats of public review and the recommendations they propose represent a form of latent failure insofar as they keep government and society focussed on a perception of failure which may have little relevance to what actually happened in situ. Accordingly, such review processes may not necessarily provide practitioners with lessons about how to prepare for future events. Therefore, the opportunity for a more prospective focus is lost and we run the risk of re-living the same failures again (Dwyer et al., 2021).

Without reform, public inquiries with a focus on learning from accidents, failures, and disaster run the risk of producing recommendations which make safety systems less effective and

efficient than they should be because important stakeholder groups are omitted. With this in mind, I propose that public review processes are reformed to ensure that accountability for safety is shared. This would allow for broader input into the development of lessons learned and an awareness of the how community actions and behaviours can translate into accidents with tragic outcomes (Hardy & Maguire, 2020). In essence, we cannot expect that accidents and failures surrounding Covid-19 quarantine detention programs will not continue to occur irrespective of whether private security contractors are used or not. Without reform that broadens the responsibility and accountability of all stakeholders in community safety, we run the risk of repeated accidents, failures, and disasters.

## 8 | CONCLUSION

As we continue to live with Covid-19, it is important to accept that failures and accidents will inevitably continue to occur particularly as public administration practitioners continue to understand it and learn from their experiences. Although practitioners (many who were also involved in responding to the Black Summer Fires 2019–2020) addressed numerous challenges associated with Covid-19, it is unrealistic to expect that their approach to managing it can and/or will always be right first time.

[I]t seemed to me that a dedicated team of people at that very much operational level ... would be able to do as they had done many times before, they could rise to a challenge like this and that they would be able to stand the system up within the time-frame (Premier of Victoria, pg. 117 of Hotel Quarantine Public Inquiry, Final Report).

It is important that we begin to learn for the future by acknowledging we are still learning about the novelty that surrounds Covid-19 so much so that it is difficult to understand where the incubation period for accidents begin and indeed, ends (Turner, 1978). Although learning from experience will occur, it is unrealistic to expect that we can reach a future perfect scenario as different variants of the virus emerge over time. As one medical advisor cautions:

The understanding of Covid-19 continues to develop. I am not convinced that we yet fully understand how it is transmitted (Dr Simon Crouch, a senior medical adviser, DHHS, p. 25 of Covid-19 HQ, Final Report).

By accepting what we already know, it may begin to prompt the process of moving from retrospective public inquiries which to date have had a tendency to blame, towards a more prospective approach, which may facilitate more meaningful learning with respect to wicked problems – not only for Covid-19 but for other natural and non-natural hazards which continue to recur in a Victorian, Australian, and indeed global context.

## 9 | KEY POINTS

- This paper examines how accidents surrounding a quarantine detention program for returned travellers from overseas brought a second wave of the Covid-19 virus into existence in Victoria, Australia.

- Analysis provides insights into the ways in which public administration organizations (PAO) can plan for and respond to wicked problems by re-framing narratives around accidents and failures.
- Much remains unknown about the transmission of Covid-19, therefore it is unrealistic to expect that accidents and failures will not occur in the future.
- Findings suggest that it is timely to consider modernizing public review processes to re-interpret and reframe accountability as a shared responsibility of PAO, society, and community which adopt a prospective approach to learning.
- It is important that PAO, society, and community are provided with public review mechanisms which seek to learn for the future by acknowledging we are still learning about the novelty that surrounds Covid-19.

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## CONFLICT OF INTEREST

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