Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings

WITNESS STATEMENT OF DR PETER ROB GORDON

I, Dr Peter Rob Gordon OAM of [redacted], in the State of Victoria, Clinical Psychologist, [redacted], do solemnly and sincerely declare that:

1. I make this statement in a personal capacity.

2. I make this statement on the basis of my own knowledge, save where otherwise stated. Where I make statements based on information provided by others, I believe such information to be true.

BACKGROUND AND QUALIFICATIONS

3. I have the following qualifications:

   (a) Bachelor of Arts (with Honours) from Adelaide University;

   (b) A PhD from the University of Melbourne on the topic of "A Study of Group Psychotherapy"; and

   (c) Fellow of the College of Clinical Psychology, Australian Psychological Society.

4. I have worked as a clinical psychologist since 1976 and have over 35 years of experience in the areas of trauma, emergencies and disasters. Since 1983, I have worked with children and adults in relation to over 50 large scale natural disasters (including bushfires, floods, droughts, and wind storms) and community-level traumatic events (such as shootings and suicides), as well as large scale sexual abuse, including within youth detention, child protection and disability organisations. Part of my work has involved working with affected staff of such organisations, as well as supporting the organisation to recover.

5. I have been a member of the Australian Association of Group Psychotherapists for thirty years and president on two occasions. I have been director of training for eight years.

6. Attached to this statement and marked **PRG-1** is a copy of my curriculum vitae, which includes a list of academic works published by me, alone or in collaboration with other persons, as well as further information about my professional experience.

PROFESSIONAL BACKGROUND IN DISASTER RECOVERY

7. I first became involved in disaster recovery in 1983 in response to the Ash Wednesday fires, where I was part of the Royal Children's Hospital team working in the Macedon area in Victoria. After providing services in several other fires, the Queen Street Shootings (1987) and the Manresa Kindergarten Siege (1989), I was asked to take a role with the then Department of Health as a psychological consultant for disaster recovery in 1989. I have retained this role with various successors of that department, including the former Department of Health and Human Services **(DHHS)** and the now Department of Families, Fairness and Housing (**DFFH**). Since the Department of Health has now become separate from DHHS and I have consulted on health emergencies, the most recent being the recovery program following the Thunderstorm Asthma crisis in 2017. In this role, I have advised on how to assist individuals and whole communities as they rebuild and recover from disasters.

8. I have also been a consultant to the Emergency Services Department of Australian Red Cross since 1995. This work has involved advising on emergency recovery programs and providing services as part of recovery programs offered by the Red Cross. These activities included design and implementation of community recovery programs, training of recovery workers from various agencies and leading community meetings to inform affected community members about the nature of stress and trauma during recovery and to provide advice on therapeutic strategies.

9. Since 1983, my work has included the following:

   (a) Involvement in most Victorian emergencies since that time and in many other events throughout Australia and New Zealand under the auspices of Australian Red Cross or local recovery agencies. These roles have included preparedness and planning, training, advice and consultation on services and the provision of community consultation and education and information sessions to affected communities throughout their recovery.

   (b) As part of my consultation to the then DHHS, I participated in the Medical Displan, later the Field Emergency Medical Service to advise on psychosocial aspects of mass casualty events. This role included

various public health emergencies. In 2006-08 I was involved in pandemic preparation and training and planning regarding the psychological effects of chemical, biological and radiological incidents and associated recovery services.

(c) I was heavily involved in the Victorian and Tasmanian recovery from the Port Arthur shootings, the Bali bombing, the East Asian Tsunami and the Bourke Street tragedy among numerous other emergencies. I was involved with bushfire recovery after Black Saturday and worked with Emergency Management Victoria, DHHS, the Australian Red Cross, as well as with flood recovery after 2010 in Victoria and Queensland and recovery programs associated with the Morwell Coal Mine Fire and the Victorian Thunderstorm Asthma event.

(d) I also often receive referrals to my clinical practice of people affected by large and small traumatic events and disasters, whom I treat if possible.

BASIC PRINCIPLES OF DISASTER PSYCHOLOGY

10. The principles of how to assist people who have experienced a disaster or emergency arise from the body of knowledge around trauma and post-traumatic stress disorder (**PTSD**). Psychologists have developed a broad set of understandings about the social implications of a disaster and the extended stress state that people are in, both during the disaster itself and in the recovery process.

11. A lot of psychological problems which people who have been involved in a disaster experience are related to their being in a state of extended stress in a socially disrupted environment which presents multiple, simultaneous problems. Being involved in a disaster (like a fire or flood) is very different to a discrete traumatic event which affects one aspect of life but leaves the rest intact. For instance, a car accident is distressing but it is only one event and the home, family and ordinary patterns of life remain intact around the affected person while they deal with the effects of that one event. This is very different to an event which forces a person out of their home and their ordinary routines and completely disrupts their life.

12. A significant emergency, therefore, is a social as well as a psychological event and has social as well as psychological stress effects.

TRAUMA ASSOCIATED WITH HUMAN-CAUSED EVENTS

13. The word ‘trauma’ in medicine literally means an injury or a wound. Human-caused traumatic events involve intentional acts at the hands of humans, such as deliberate negligence or criminal offending. These events can have a much greater destructive potential for the persons involved compared to events that are accidental or involve natural disasters. For example, while people generally understand the destructive potential of extreme weather, a traumatic experience resulting from a human-caused event can destroy the important assumptions and expectations about human behaviour that provide us with a sense of safety in the world. In most cases, people are not aware of these assumptions and expectations until they are shattered.

14. For example, while we know that criminals exist in our society, we generally assume that the people we encounter are well-disposed, caring and civilised people. When we encounter a person who is not like that, our assumption is challenged and might be damaged or destroyed. This can leave us feeling like our world doesn’t hang together. It can create a psychological wound that doesn’t heal. It can also undermine trust in society and its institutions. This damage to a person’s assumptive world often commences a chain reaction of anxiety and a state of high arousal.

15. When you are assessing a community that has experienced a human-caused trauma, you are essentially observing fractured relationships and assumptions of trust, including assumptions about society and institutions. This extends to assumptions about people in charge of institutions and the professionals within them. Disrupted relationships within institutions can lead people to question whether they can trust managers if they complain to them; whether managers will be professional and take action. This can then drift into a distrustful view of things where people don’t trust anyone.

16. Affected persons must be supported by trained experts in this field who are able to restore fundamental assumptions, such as “I am in an environment where people care about me, I am valuable, what has happened to me is bad and everyone around me is trying to help me”. To use the wound analogy, we need to stop the bleeding which is the continuing disorganisation of lost

assumption and provide proper treatment, otherwise we risk further and ongoing problems. Restoration of a person's assumptions serves to limit the perception of threat to the person who caused the injury, so that it does not extend to persons and circumstances beyond the injury.

17. Child sexual abuse has features which define the damaging potential of this trauma. If the abuse is perpetrated in a violent and aggressive way, then fear, pain and sense of danger are associated with the sexual behaviour and the perpetrator is felt to be a threat. In many cases, however, children are groomed and drawn into sexual behaviour by offering inducements especially to children in institutional settings experiencing deprivation. The perpetrator often presents as a friend and woos their trust. When sexual activity begins, if the child is pre-pubertal, and especially with young children, they lack experience or understanding of sexual activity. The genitals and sexual regions of the body have been associated with excretion and they have been taught they are dirty and to be avoided. The inability to make sense of adults' interest in sex and in particular to understand the responses associated with arousal and orgasm leads them to associate it with the only experience that is familiar in such states of arousal which is either fear or violence. Although young children are usually unable to describe these responses, their reactions and behaviour indicate confusion and identification of sexuality to either anxiety or aggression. Early association of these emotions may lead to serious disorders in the development of healthy sexuality in adulthood. It is common that in sexual penetration or oral sex, children and youth lack understanding of what is happening, and they feel in danger of being seriously damaged or death. Often these experiences are associated with the perpetrator showing indifference or disregard for their feelings or needs. This causes serious damage to the sense of identity whereby the child feels of no account as though they are prey being consumed by a predator. It damages the assumptions we wish all children to have: that their experience is important and has a value to be respected. Another form of damage is that stimulation of the sexual organs are likely to emit sensations for which they are designed in the form of sexually arousing sensations. However, they occur in the presence of danger, devaluing and disregard of them as a person. Then the body is experienced as though it has betrayed them and responded to stimulation when they felt in danger and devalued. This creates the seeds of disgust,

hatred of the body and aversion to what in the right circumstances should be pleasurable experiences. Instead of sexual activity being a form of private, intimate emotional communication, it becomes a frightening, disgusting and repellent activity to be either avoided or indulged in and then associated with guilt or remorse. When young children or youth are in situations of pain, helplessness and emotional vulnerability without supports and must submit to unwanted sexual activity there is nothing they can do and may activate the psychological defence of last resort which is to violate the integrity of their experience and dissociate from what is happening. This may lead to disorders of dissociated identity, or detachment, numbness and disconnection from their own emotional experiences and from people who show them affection or interest. Grooming or seductive behaviour often associated with child sexual abuse may lead to distrust of adults and if occurring in an institutional setting to distrust of institutions and all forms of adult authority. Where the abuse is associated with coercion or aggression it may lead to feelings of humiliation and degradation. Children usually take away from such experiences the impression they are somehow to blame, are bad, worthless or deserve what is being done to them. Such experiences lead to disorders of identity, damaging their ability to form loving relationships and predisposing them to depression and other disorders. Sexual abuse always occurs in a social setting. Where it cannot be told because the child does not trust the adults around them, or even worse they are not believed or are told they are lying, they feel alienated from the social world and this prevents them finding their way into experiences that would enable them to recover. There are serious threats to the child's psycho-social being resulting from sexual abuse since sexual experience goes to the core of the sense of self, the relationship to the body, to one's capacity for pleasure and enjoyment and to the capacity to form warm, loving and trustful relationships. These capacities underpin the whole of future social and psychological development. Therefore, it is common that particularly in a depriving institutional setting, sexual abuse causes pervasive disturbances of social relationships and personal development.

18. Research has established that about one third of people who experience trauma, are likely to go on to experience chronic post-traumatic stress disorder (PTSD). In my experience, people who suffer from chronic PTSD often exhibit two interrelated risk factors. Firstly, they usually have a background of

significant emotional deprivation, which means they do not have a good foundation for recovery. Secondly, they usually only seek trauma assistance after a considerable period of time has passed. People who are in this category may take 10 years or more to seek assistance. This is because their early traumatic experiences did not encourage them to feel valued and heard. Also, as a previously functional person, they may not understand the therapeutic value of speaking about trauma.

19. We have to be very open-minded in the aftermath of traumatic events, because people react in different ways. A person's level or distress may seem disproportionate to the objective impact of the event on them, especially when compared to others. Often, a person's history, explains the sense of their responses. It is important to take care to avoid being opinionated or judgmental about who is "entitled" to be upset by an event, and to what extent.

20. What responsible human beings do (or do not do) can support recovery, or compound the damage caused by an event. Typically, organisations learn how to respond to a traumatic event "the hard way" – that is, by experiencing such an event and learning from mistakes.

BEST PRACTICE RESPONSES TO HUMAN CAUSED EVENTS

21. The three fundamentals to establish trauma recovery are:

    (a) appropriate and effective management;

    (b) psychological intervention for the persons involved (for example, psychological first aid, de-briefing or acute trauma treatment); and

    (c) creating an environment for people to recover over time, including by integrating their understandings of the traumatic events.

22. These processes, and related concepts, are discussed below.

High arousal states and decision-making

23. A disturbing, tense and threatening event will place a person in high arousal. When a person is flooded with energy and adrenaline, they will likely lose their capacity for systemic and lateral thinking, resulting in an inability to look at the whole picture. Neuroscience has demonstrated an inverse relationship between a person's level of arousal and their ability to use the prefrontal

cortex. This results in increased reliance on the hypothalamus or the instinctive parts of the brain.

24. When an organisation experiences a traumatic event, all people within the organisation will be affected. One of the effects of arousal under threat is to cause Managers to go into self-protection mode, perceiving the event as a threat to themselves and to their organisation. This creates a conflict between the concerns of the individual manager or organisation which feels threatened by the event, and the concerns of persons directly impacted. As long as the threat persists it continues the state of high arousal, which can limit the ability of a manager to look at a decision systematically, and morally.

25. Unless managers are trained in crisis management and are able to disengage from a state of high arousal, they are unlikely to make the best decisions in these circumstances. Hurried or "knee-jerk" reactions that cannot be sustained are common in these situations. The basis for these reactions are to respond to the unprecedented situation by adapting familiar strategies from other crisis situations. For example after the Port Arthur shootings, the manager told all staff they must use the organisation's Employee Assistance Program (**EAP**) (contracted to an interstate provider) and must not use the community recovery services being developed. This resulted in local residents, who were employees, using the service while other members of their family used the community supports and the two services did not communicate. Other responses are often to inhibit or forbid communication outside the organisation thus preventing effective management of information and social support. It is often the case that strategies advised to limit legal liability (such as not apologising or acknowledging anything has happened) undermine credibility and the sense that management don't care about anyone except themselves and protection of the institution. This severely disrupts recovery since support from the agency responsible cannot be replaced by other forms of support.

26. It should be acknowledged that traumatic events are unusual, and there is no reason why a manager in that situation would automatically know what to do unless they are well-trained in crisis management. Often, they will seek advice from lawyers, whose focus can be on limiting liability, rather than limiting arousal. The high levels of arousal experienced during a crisis can be transmitted to others; this is a form of emotional contagion. What is really

needed is to establish trust by providing factual information that acknowledges the event. This can be done in a way that doesn't incur unnecessary liabilities rather than a blanket denial or a refusal to acknowledge.

27. Clear policies and procedures for dealing with crisis events can help to mitigate the impact of arousal on decision-makers and managers. Such policies tend to exist for emergency events like fires, but they could also be developed for human-caused traumatic events like child sexual abuse. That said, I would be surprised if many organisations have an explicit policy on how to manage organisational recovery following sexual assault by staff on a person cared for by an organisation.

28. In the absence of formalised policies and procedures that can be implemented in a crisis situation, it is critical that people outside the "circle of arousal" (such as people outside the organisation) are engaged in confidential consultative relationships to support clear thinking and assist in the formulation of a response.

29. High-arousal states also increase the intensity of a traumatic event for other members of the organisation. Organisations can seek to reduce arousal by creating a supportive environment and providing opportunities for regular, caring and unsolicited communication, as well as opportunities for people to give feedback and communicate their needs.

The importance of support and communication

30. In the aftermath of a traumatic event, people must feel that they are not alone. A sense of support is often a by-product of a certain means of communication. If people communicate with each other in a way that conveys a commonality of experience and a shared understanding and respect for each other's reactions, that will produce a sense of togetherness. If an organisation restricts communication (e.g. by instructing staff not to discuss a particular person or event or not contact a staff member), staff cannot access the sense of togetherness or support they need. Social support has been shown to be the number one protective factor for any mental or physical illness. Without access to social support the affected person feels alone and if it is a traumatic event, it is by definition outside their previous experience. Therefore, they lack a frame of reference or past experience to effectively evaluate what has happened, their role or the meaning given by the institution. In the absence of support to

ground the experience is the care and respect of others, their emotional reactions become unstable and are likely to exaggerate the situation and create possibilities that are not real. Without supportive relationships, the person concerned will lack the capacity to judge or evaluate the situation and they will feel alone, rejected and therefore as though it is their fault and they are to blame. It is a very common experience for victims to feel they are the problem, especially for sexual trauma. Effective support by peers or even more effectively by people in authority strengthens the affected person so they feel their dignity is preserved and their suffering is limited. It enables them to draw on their own capacities to think, plan and solve problems as well as manage their emotional reactions.

31. Trauma can be exacerbated if people are suddenly ordered around by unfamiliar authorities or treated as a nuisance, or if they are disbelieved or dismissed by authorities. If this continues without a person receiving support, the injury is no longer confined to the event: the whole system becomes the threat.

32. Affected people also need to process, digest, interpret and define the trauma they have experienced. It is important for people to receive factual information about what has happened, via a clear and consistent flow of information up and down the hierarchy. Managers don't have to have all the answers straight away, but they should explain what they are doing to obtain those facts. There is no such thing as 'no information' - if people are denied information in traumatic situations, they will start to fill the gap and create information for themselves. This often leads to fantasies, speculation and rumours that can compound distress.

33. Where there are reasons why managers cannot talk about the details or intricacies of the event itself (for example, due to a police investigation), they can still bring people together to explain how trauma works and give them strategies for caring for themselves and pathways to appropriate professional support without discussing the specific situation or people involved. That can often be enough for people to feel connected and part of a supportive network.

Initial organisational responses

34. A good organisational response involves managers and decision-makers acknowledging and establishing that they understand what has transpired and

what it means for the persons affected. This serves to establish trust with the affected community.

35. Debriefing sessions should be held with affected persons, to convey information and contain emotions. As explained above, statements of fact as to what has happened play an important role in dispelling fantasies around an event. Managers and decision-makers should be briefed to communicate fundamental messages in a consistent way and empowered to offer appropriate messages of regret and support, without wandering into admissions of legal liability. Communications to affected persons can acknowledge that an unusual and distressing event has happened, that it will be investigated, and the first priority is to support and care for those involved. The services available can be enumerated and arrangements made to provide follow up and when further information will be provided. It is of great psychological importance that the information is provided before it has to be asked for. This shows affected people that the authorities understand how crucial it is to their recovery. Broad timelines should be given, and they will often be longer than people expect so opportunities for people to identify representatives of the organisation who can be a contact person who can take up specific issues on their behalf. Clear preservation of boundaries of privacy and confidentiality are important and recognition that many people look to their employer to support them as a first step after a crisis. Where managers feel uncomfortable, they can identify a professional or other person who can be given the role of communicating with affected people. Messages that everyone's rights will be respected, to discourage rumours and speculation and to identify who will make decisions and judgements and when they are likely – even if it is a long way off. It is valuable to acknowledge the commitment and dedication of workers for the institution.

36. Regular communication with affected persons is essential – both to update them on information as it becomes available and, if there is no new information, to let them know that too. Advising when people can expect to hear information next will encourage them to wait before 'filling in the gaps', thereby limiting the scope for fantasies to take hold in people's minds. Also, where you provide people with information but ask that they don't make it public until a formal announcement, they will usually respect that - particularly if they understand why. This approach will often produce a sense of 'we're in this together.'

37. Based on my experience working in Tasmania, my impression is that it is similar to a smaller rural community, where some people may struggle to verbally express what they are feeling. People may also feel reluctant to speak openly about their experiences in a smaller community because of the feeling their privacy is being violated.

38. In smaller communities like this, it is critical that information is provided in a clear and succinct way and that people are given safe and structured opportunities and help to speak about their experiences.

Group debriefings or review sessions in the immediate aftermath of a traumatic event

39. One of the most crucial components of recovery is for people to be able to discuss the event with colleagues who understand the workplace environment. For this reason, peer support is important to establishing ongoing recovery within an organisation.

40. A sense of group belonging will also reduce an individual's sense of responsibility for a traumatic event. Giving affected community members permission to have a group identity can reduce the load on each individual member of the group and enhance their ability to cope with the complex emotions they feel in response to the event. It can also help to normalise their feelings and reactions, if others are feeling the same way.

41. In my experience of working with people immediately after traumatic events, I have found that many people need to talk about it, to feel supported, and to begin to make sense of what has happened. Rather than discuss their feelings, people affected by traumatic events often first need to discuss their memories and understandings, to clarify their perceptions and to assist them to form judgments that are reasonable in the circumstances. When this occurs, emotions inevitably follow and, ultimately, settle. The physiological and psychological effects of the arousal state that occurs in any unusual, shocking or threatening situation have the effect of creating a narrowed attention and intense focus on details that are perceived to be distressing. The effect of this is to create an incomplete and often distorted understanding of the event because the full facts have not been taken into account. For example if something bad has happened to someone then anyone who had recent contact with them is likely to feel guilt and responsibility as though they might have

known it was going to happen. Another example is that often people act in an emergency and if they are not successful in what they are trying to do, they gather other information to reveal that something else might have been better. However this is uncertain and if they are asked why they did act as they did it will mobilise neglected memories of the observations and judgements they made to guide their actions often showing that given their training, experience and what they knew of the situation they did the best they could. In this sense clarifying the facts and understanding, asking for information in memory that is not being used allows the person to make a more accurate judgement about their actions. It often occurs that after this process (which is central to the concept of debriefing) when they are asked about their feelings, they are likely to say “well I have been feeling very guilty and self-critical but now I realise I did the best I could” showing that the changed meaning has changed the emotional response that is activated. It is often the case in a tragic event people judge themselves for what they did not know as though they should have. This process is valuable with a group and will often create a strong supportive network, but it is equally valuable and effective for individuals who experience events in isolation or who have a role separate from the others involved. It relates to a technique of working with the experience of the event rather than the emotional reaction to it which is appropriate for a clinical intervention.

42. It is important to create an environment for ordered productive talk - to limit possibilities for false judgements and misinformation. Organisations are generally reluctant to get everyone together, but there are very simple steps that can be taken to contain such meetings to ensure they remain constructive. They can be convened by a neutral or responsible person, with a clearly defined agenda which does not allow any issues to come up as long as they are deferred to such other time or situation as they can be dealt with. They need to be clearly chaired or managed by a person who has skills and credibility for all involved. The agenda is published, the meeting is identified as part of a broader recovery or incident management program and members of the meeting are allowed the opportunity to express their views and needs. Where they are critical with management, criticisms do not need to be answered immediately, they can be taken on by management and if necessary contextual information can be supplied or the meeting can be given a follow up

opportunity in which the criticisms will be further discussed. This slows down the cycle of action and reaction and gives a process for the issues causing the emotion to become the focus rather than the emotions themselves.

43. A properly trained de-briefer will be aware of how valuable it is for people to review and reflect on their experience in order to try and piece together events in an orderly and trauma informed way, rather than in a state of high arousal. Training in the area requires an understanding of trauma and how people respond in states of high arousal, which is basic knowledge for mental health clinicians. However the sensitivity of the immediate aftermath of traumatic events may also require skills in de-escalation and managing group process which are also skills for mental health practitioners but are likely to involve some degree of specialisation. Crisis Intervention And Management Australia is an organisation that provides specialist training in this area.

44. The de-briefer would be able to assist the affected persons to interpret the events and articulate what those events mean to them. Only then would the de-briefer turn to the emotions and ask the person how they are feeling. It is at this point that affected persons tend to acknowledge and express prior feelings of guilt but then make the shift to realising that the situation was out of their control, having reflected on all the information presented to them. The shift away from emotional connections, particularly guilt, is an important shift to make early on to avoid problems in the long term.

45. Addressing trauma effectively at the early stages can stop guilt and shame from compounding the harm.

46. Debriefing interventions are designed for people working in workplaces where some degree of emergency or trauma situations are likely. People in this kind of situation have training and experience and are actively fulfilling responsibilities in responding to events. All of these factors have a protective effect and unless the event involves multiple deaths and mutilating injuries should be helpful for people who have a shared involvement. People with different levels of involvement or exposure may be better served by having sessions for their own. However these assumptions do not hold where members of the public are involved in an event. They lack training, experience, a role or perhaps and active relationship to the situation. In this case Psychological First Aid is the appropriate method which involves providing the

opportunity for the person to speak about the experience in order to indicate their needs, gain information and advice about how to take care of themselves and to link them to their loved ones and opportunities for ongoing support. Vicarious trauma may be a hazard to consider in how services are provided for incidents with high exposure to traumatic stimuli. Nothing can replace the role of a careful assessment and planning for interventions after such an event.

Opportunities to process the event with someone trained in trauma after the immediate situation has passed

47. One of the learnings of trauma psychology is the importance of opportunities to review and process the experience after the trauma has passed. The hope is that this builds on the work done in the immediate aftermath. Such opportunities ideally occur a few days or a week after the event. Experiences during a state of high arousal are not registered in an even and connected way. They are often recorded in memory as a series of disconnected and emotionally charged moments. Often details and memories of moments continue to emerge in memory for some days or weeks or even longer after the event. This material needs to be integrated into the understanding of the event. If a person does not get an opportunity to integrate these memories into a coherent narrative, they tend to remain emotionally charged and easily evoked. This work can be done among the group of involved individuals if they are able to meet and talk together but it is more advantageous to provide a trauma trained mental health professional to conduct such sessions.

48. Many people benefit from the opportunity to go back over traumatic experiences, and to reflect on the emotions they experienced and what they discovered about themselves during the period of stress. Often they represent unique experiences in the person's experience and there is always the opportunity for people to learn about themselves under these circumstances. This work takes time and often involves adjustment to sense of identity, values, perhaps even the purpose and direction of their life. In this sense the person is likely not to be the same as before and it may take time to clarify how they integrate these experiences into their life. This if often spoken of as Posttraumatic Growth and is associated with being part of a supportive environment which it can be talked and through about with others.

49. In a state of extended stress, a person mobilises themselves to deal with it but can then be vulnerable once the stress has passed. This can be likened to the decompression response in a deep-sea diver whose body is able to cope deep down in the ocean, but is vulnerable to “the bends” if they surface too quickly. While the crisis is occurring, people cope and make many large and small adjustments in mind, body, emotions and social interactions. Many of these changes are reflexive and made without full awareness.

50. Once the crisis has passed, these adjustments can make it difficult for people to adjust back to “normal life”. Professional support may be required. Providing people with opportunities to reflect and consider what they did for themselves to adjust and manage the stress period brings those changes to mind and provides an opportunity for them to be reversed and for the otherwise fragmented high-arousal memories to be linked into a more coherent narrative.

51. It is also possible that, for a small number of people, the experience may have activated previous traumatic experiences involving a loss of control and feelings of helplessness. The situation may have derived from early childhood, in which case strong emotion may be evoked without clearly defined memories. Although it is likely to be a small number of people, the provision of some form of standardised post incident debriefing, information session or reflective session would allow such needs to be identified and followed up.

Addressing moral injury

52. A moral injury occurs when fundamental assumptions about morals and values are injured. Such injuries are common in human-caused events. Where such an event occurs in an organisational context, members of the organisation will often ask how it is that an organisation they believe in and belong to could have allowed the event to occur in the first place. An important part of moral injury is when a person finds themselves in situations that violate their own or society’s moral code. Perhaps they were too afraid to help someone who needed it or misunderstood something which caused someone harm. Not only does this lead to feelings of guilt, remorse, and anger but may be at risk for changing the person’s self-concept resulting in lasting self-criticism and self-judgement. An example is a person who feels they had responsibility for preventing an event and failed to do so. There are cases in which people responsible for children who were killed or injured have subsequently

completed suicide. This shows moral injury to be a serious consequence of traumatic events.

53. In these circumstances, the organisation needs to assist people to work through their sense of moral injury; to retrieve a sense of the organisation's fundamental values and purpose, and to be proud of the work they do, in spite of the fact that the injury occurred in the organisation, perhaps perpetrated by a colleague.

54. Where, say, someone you know and had coffee with over the weekend abuses a child, it's hard not to feel somehow implicated. So it's important to come back to ideas about how this person has deliberately deceived people around them and to recognise that we tend to give people the benefit of the doubt unless we get evidence to the contrary.

55. Again, it is important for people to be able to talk about and process the moral injury at various stages. It is particularly useful for people to talk to their peers, who understand their work, their workplace and who don't need it all explained to them. It can often be a group ethos (such as those of a profession) that can be offended, not just a personal one. The opportunity to consider everything from training and education to organisational policies, supervision and monitoring arrangements that incorporate the threat of traumatic events and abuse into the areas of professional responsibility that have to be protected against allow people to feel that the profession or organisation grow and develop and become more effective safe and representative of the ethical qualities inherent in it.

56. One way to think about addressing the moral injury done to an organisation or its relationship to its community is to think in terms of a recovery process for the injury. This might be approached by considering the assumptions, values and expectations that have been injured and to consider the sort of procedures that will remedy the gaps or problems that have led to the event or events. Publicising the processes of review and change that flow from it provide an opportunity for harnessing sentiments to positive change. Consideration to symbols and rituals meets a level of emotional experience that cannot be attained in other ways. Memorials, gardens, artistic objects or events are all ways to remember what has happened and express what is wanted to arise from it. People involved in trauma and tragedy often express a deep

satisfaction where others learn and benefit from their pain. In this sense to invite the community through representatives to shape and participate in the recovery process rebuilds the relationship of trust that is inherent in the very notion of institutions.

Learning from a traumatic event

57. Once the crisis has passed, the organisation should review its response to the crisis and establish or improve its internal processes for communicating to staff and others about future traumatic events.

58. All members of the management team should be involved in this process. I would also encourage the organisation to get the managers together to ensure they form a coherent group that can be given all the information and be helped to understand how they might best communicate with their staff.

59. Depending on the nature of the event, the internal process for communicating with staff may be a dedicated communication system, including a staff meeting, a lounge where an EAP representative or alternative support will be in attendance, and/or a newsletter to disperse any essential information. It is critical that the organisation ensures that its staff feel as though they are a part of an open communication process.

60. Similarly, I would encourage the organisation to set up a communication process to the wider community. This may involve several approaches, including articles in a newspaper or speaking to a local radio network. It may involve community meetings, noting the various ways the community more broadly may be impacted by the event. There can be a lot of apprehension about such meetings, but where they happen, if planned and conducted on the principles enumerated in paragraph 42 above they can be managed in a safe and effective manner and the community will appreciate the senior people from within the organisation attending. This is an important symbol of the organization respecting the community it serves.

61. Ultimately, the organisation needs to commit to its principles in these communications, to demonstrate its support to people affected by the events. Part of the importance of taking these steps is to communicate that the organisation cares about its clients, its staff and its community. Sometimes, these initiatives do not feel very effective (for example, you might have a low

turnout at a community meeting) but it's important that it happens because it demonstrates a commitment to care and to rebuilding trust and many people who do not attend will be reassured by the fact it is happening.

I make this solemn declaration under the *Oaths Act 2001* (Tas).

This document was signed and witnessed in accordance with the Notice made by the Premier under section 17 of the COVID-19 *Disease Emergency (Miscellaneous Provisions) Act* (Tas) 2020 on 4 September 2021

Declared at [redacted]
on 23 June 2022

[redacted]

.....
Peter Rob Gordon

Before me

[redacted]

Sophie Louise Uhlhorn
An Australian legal practitioner within the meaning of the Legal Profession Uniform Law (Victoria)