TRANSCRIPT OF PROCEEDINGS

INQUIRY INTO THE COVID-19 HOTEL QUARANTINE PROGRAM

BOARD: THE HONOURABLE JENNIFER COATE AO

DAY 20

2.00 PM, FRIDAY, 18 SEPTEMBER 2020

MELBOURNE, VICTORIA

MR A. NEAL QC appears with MS R. ELLYARD, MR B. IHLE, MR S. BRNOVIC and MS J. MOIR as Counsel Assisting the Board of Inquiry

MR D. STAR QC appears with MS J. DAVIDSON, MR T. GOODWIN and MR J. HARTLEY for the Chief Commissioner of Victoria Police

MS J. FIRKIN QC appears with MS S. KEATING for the Department of Environment, Land, Water and Planning

MS C. HARRIS QC appears with MS P. KNOWLES and MR M. McLAY for the Department of Health and Human Services

MS J. CONDON QC appears with MS R. PRESTON and MR R. CHAILE for the Department of Jobs, Precincts and Regions

DR K. HANSCOMBE QC appears with MS H. TIPLADY for the Department of Justice and Community Safety

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MR R. ATTIWILL QC appears with MS C. MINTZ for the Department of Premier and Cabinet

MS S. McNICOL QC appears with MR E. NEKVAPIL and MR D. PORTEOUS for the Hon. Lisa Neville MP, Minister for Police and Emergency Services

MS A. ROBERTSON appears with MS E. GOLSHTEIN for MSS Security Pty Ltd

MR A. WOODS appears for Rydges Hotels Ltd

MR A. MOSES SC appears with MS J. ALDERSON for Unified Security Group (Australia) Pty Ltd

MR R. CRAIG SC appears with MR D. OLDFIELD for Wilson Security Pty Ltd

MS D. SIEMENSMA appears for Your Nursing Agency (Victoria) Pty Ltd

CHAIR: Yes, Ms Ellyard.

MS ELLYARD: Good afternoon, Madam Chair. Before I call this afternoon's witness, now is a convenient time, in my submission, for me to provide a summary of the evidence that's been called over the past six days.

CHAIR: Thank you.

STATEMENT BY MS ELLYARD

MS ELLYARD: Thank you. Over the last six days, the Board has heard evidence about Victoria's emergency response to the COVID-19 pandemic, the health aspects of the Hotel Quarantine Program and the role played in that program by the Department of Health and Human Services. Much of that evidence came from people within Government Departments and agencies, including Victoria's Chief Health Officer and the current and former Chief Commissioners of Police. Evidence came from various commanders and controllers, the Deputy Chief Health Officers, as well as those who provided services as part of the Hotel Quarantine Program, including clinical services and cleaning services.

The evidence included evidence about a framework established by the *Emergency Management Act 2013* and that framework having been invoked for the hotel quarantine response to the State of Emergency that had been declared. The evidence was that the State Emergency Response Plan was a plan that was available to, as it were, put meat on the bones of the *Emergency Management Act* and was relevant to the hotel quarantine response.

Within Victoria's emergency management instruments there's a clear distinction, about which we heard evidence from a number of witnesses, between the concepts of coordination, command and control. The evidence was that those terms have special meanings within the Emergency Management Framework, which perhaps differ from the ordinary meaning of those words. Coordination refers to bringing together agencies and resources; command means authority structures operating vertically within an agency; and control means the overall direction of an emergency response operating horizontally across all agencies.

We heard evidence that the COVID-19 pandemic was categorised for emergency management purposes as a class 2 emergency. The State Emergency Response Plan made it clear that for a human disease emergency, the Department of Health and Human Services was the control agency. The role of that, to use a phrase coined by one of the witnesses, "rather large beast" in the Hotel Quarantine Program has been a matter of some disagreement between agencies.

The State Health Emergency Response Plan, a subplan of the overall Emergency Response Plan, describes in more detail the arrangements for responding to health

emergencies and the key roles to be played in that response. Under the State Health Emergency Response Plan, the Secretary of the Department of Health and Human Services appoints a State Controller so as to enable appropriate focus on managing health consequences according to the nature of the emergency. The identity or role of who would ordinarily be appointed the State Controller is set out in the State Health Emergency Response Plan which says that the Public Health Commander will be appointed State Controller for identified public health emergencies. The Public Health Commander function is usually performed by the Chief Health Officer. However, as the evidence showed, in this instance the Chief Health Officer was not the Public Health Commander and nor was he appointed as the State Controller.

As well as hearing about powers that were exercised as part of the response to the Hotel Quarantine Program, the Board heard evidence about powers that were not exercised and options that were not pursued. As well as being Victoria's Chief Health Officer, Professor Sutton is and has at all times through the pandemic been Victoria's Chief Human Biosecurity Officer. He is vested, as he said in evidence, with extensive powers under the *Biosecurity Act 2015* of the Commonwealth. He could have exercised compulsory powers under that Act, including powers requiring the giving of information, of testing and isolating and quarantining, but he didn't use those powers. He is vested with a similar suite of powers under the Victorian *Public Health and Wellbeing Act*. He didn't use those powers. Instead, the relevant powers, which gave effect to the National Cabinet's policy decision to require all people entering Australia to quarantine, were exercised by Dr van Diemen, acting as an Authorised Officer under the *Public Health and Wellbeing Act*.

In Victoria's response to the pandemic and following the decision of National Cabinet on 27 March to require quarantine, there were many options that were not pursued: the option of allowing returned travellers to quarantine in their own home; the option of increased police involvement in the Hotel Quarantine Program; the option of Australian Defence Force boots on the ground.

In their evidence, the witnesses that have been called thus far repeatedly emphasised that all of those various decisions were made by other people rather than by them, and also that those decisions were in any event made at a point in time based on information that was then known. And that's obviously true. But it remains for consideration whether the decisions --- who made the various decisions and why they were made.

The reason why certain options that may have been available weren't taken up will be the subject, potentially, of further evidence. But we do know from the evidence of Deputy Secretary Skilbeck, who gave evidence, that there was a perspective within the Department of Health and Human Services of an importance of public confidence in the management of the virus, and she said that was a very emotionally held requirement.

Thinking about how the evidence shows the response to COVID-19 was characterised, we've heard that it was treated as an emergency but that, from the

perspective of some involved in the Hotel Quarantine Program, the response was largely focused on control and compliance rather than health.

A key theme that emerged from the evidence was that the Department of Health and Human Services, as the control agency, understood its role as one of coordination rather than anything else. It didn't consider the roles it was playing in the Hotel Quarantine Program to be concerned with the direct delivery of health services or the provision of clinical expertise. And so it was that, as the evidence demonstrated, Mr Helps and Ms Spiteri were appointed as State Controllers for Health rather than the Chief Health Officer, Professor Sutton, and you heard evidence that Professor Sutton himself didn't agree with that decision. And then within the Department of Health and Human Services, the Deputy Secretaries who had responsibility for the Hotel Quarantine Program --- Ms Skilbeck, an economist by training, and Ms de Witts, who had significant legal expertise --- both had no health or medical qualifications and no clinical experience.

The evidence was that the Department had one infection prevention and control expert as an employee and shared that employee with another organisation, and so engaged an external consultant, Infection Prevention Australia, to advise on infection prevention and control measures within hotels. The Department similarly engaged nursing agencies to provide nursing services and a newly created company to provide general practitioners. It engaged and provided those services through those mechanisms, but not directly itself.

DHHS team leaders were present at quarantine hotels, but their role was, the evidence suggested, to coordinate and problem-solve. If there was a problem with security, for example, the team leader would raise it with security managers; if there was a problem with the hotel, the team leader would raise it with the hotel manager. If a problem needed to be escalated beyond that level of frontline security in hotels, it would be escalated to the Department of Jobs, Precincts and Regions, which held the contract.

The evidence from DHHS witnesses was that the team leader wasn't responsible for infection prevention and control nor for managing provision of welfare services nor the delivery of clinical care. DHHS was the control agency, but it wasn't in charge of health and human services on the ground at hotels. With the notable exception of the Brady Hotel, about which some evidence was given, it doesn't appear that there was any continuous on-the-ground oversight of the health and medical aspects of the quarantine program.

Indeed, the evidence demonstrates that on 9 April 2020, the Public Health Team within the Department of Health and Human Services raised the "considerable risk that unless governance and plans issues are addressed, there will be a risk to the health and safety of detainees". Both the Chief Health Officer and the Deputy Chief Health Officer said that it was appropriate for those issues to have been raised. There were problems that were brought to their attention at that time which required immediate action. Moreover, they reflected with hindsight before you that it was

reasonable for them to have done so at the time. These people, who were public health experts, explained that they didn't feel at the time that they had adequate line of sight over the operational aspects of the program.

As foreshadowed, the primary objective of any Hotel Quarantine Program is a health objective: preventing the further spread of a disease. The evidence was that there were factors which increased or didn't sufficiently guard against the risk of transmission of COVID-19 at the hotel quarantine environments from which the virus has spread. Amongst other factors, the evidence suggests that outbreak squads identified inadequacies in cleaning, deficiencies in record-keeping and poor comprehension by hotel staff and security contractors of such issues as hand hygiene, personal protective equipment, and infection prevention and control. These were things that were known to be deficiencies before the outbreaks. For reasons that have not been completely explained, they remained issues up to and even after the outbreaks.

On the evidence, it's open for the Board to find that, following the designation of the Rydges Hotel in Carlton as a hot hotel --- that is, a hotel where people who were positive for COVID-19 would be concentrated --- infection prevention and control were inadequate, even on what was known at that time about the virus. It's open to the Board to find that, in addition to factors which increased the risk of transmission from people detained in quarantine to people working in the program, there were additional factors that increased the risk of spread of transmission from workers at Rydges to the community.

In particular, the evidence was that, firstly, there were delays in undertaking a full clean of the Rydges Hotel, which rendered it an uncontrolled site for longer than should have been the case; and, secondly, people who worked at the Rydges Hotel during the relevant period were not initially instructed to self-isolate after workers had tested positive. There was a delay of at least seven days from the likely infection event and some four days from the first awareness of that outbreak.

So it will be open, in our submission, for the Board to find that, although the use of hotels as a setting for mass quarantine may have been unprecedented, factors that played a part in the outbreaks from the Rydges Hotel and the Stamford Plaza Hotel were not unique to hotels as environments and these factors all contributed to an increased risk which sadly eventuated. The Board may well find that these risks were foreseeable and may have actually been foreseen had there been an appropriate level of health focus in the program from the top down to the bottom.

It's important also to say something about the health and wellbeing of people in quarantine. A secondary but no less important health objective of any quarantine program is meeting the physical and mental health needs of those who are detained. The evidence the Board has heard pointed to a tension between keeping healthcare workers separate from detainees, to guard against possible transmission, and the challenges in meeting detainees' health and welfare needs. The evidence is that Safer Care Victoria investigated two serious incidents that occurred in hotel quarantine. It

made several findings and recommendations. Safer Care Victoria's findings included concerns about the frequency of welfare calls, issues with record-keeping, information-sharing, control, communication, and responsibility for the hotel sites and the detainees.

The evidence showed that there were several concerns that were escalated and that many of these fell outside the scope of the Safer Care investigations. Amongst other things, these concerns related to health checks, welfare checks, escalation processes, family violence and incident management. It will be for the Board to determine whether those issues have now been satisfactorily addressed after they were raised by Safer Care Victoria. It also falls to the Board to determine the reasons why such issues may not have been sufficiently addressed.

A contrast can be drawn with the evidence that has been called about the model adopted at the Brady Hotel in the more recent past. The evidence was that Alfred Health put in place additional layers of staff with an ongoing presence at the hotel on a day-to-day basis, including a clinical leadership team, allied health staff, mental health clinicians, infection control staff, regular processes of auditing and improvement, and dedicated cleaners. As well as those staffing differences, the evidence also revealed differences in infection control and culture at the Brady Hotel.

Turning then to the question of the efficacy of the Emergency Management Framework, which as we've heard was utilised for the Hotel Quarantine Program, the evidence the Board heard was that in the opinion of those within the emergency management hierarchy, the Emergency Management Framework is sound, considered, flexible and scalable such that it is appropriate to apply to a response to a COVID-19 pandemic. The evidence is that the arrangements established under the Emergency Management Framework aim to ensure that there's clarity and appropriate accountability for the management of an emergency on the ground.

It's open, though, for the Board to find that those aims of clarity and accountability were not met through Operation Soteria's structure. What's more, this was not what might have been a more familiar form of emergency, like a fire or a major flood, where the Emergency Management Framework has previously been tried and tested. A Hotel Quarantine Program was not a familiar emergency management response activity. Therefore, it will be open for the Board to give consideration to whether the decision to treat the Hotel Quarantine Program as an activity within the Emergency Management Framework might have actually complicated and confused rather than clarifying and bringing certainty to the roles and responsibilities that were to be played within the program.

A serious question arises, too, as to whether the legislative and policy instruments which provided the architecture for the Emergency Management Framework were fit for the purposes that they were used for here --- a health emergency; or, again, whether their use in fact caused confusion.

And that leads to perhaps the most stark example of this issue, the question: who was

in charge? A question that should be able to be easily answered if Emergency Management Frameworks are working as they're designed to work. The evidence before the Board is that DHHS was and was understood to be the control agency and therefore the agency in charge of Operation Soteria and therefore able to control other agencies' activities within the response. DJPR had a significant supporting role in providing logistics support to the control agency as part of Operation Soteria.

But, beyond that, who was responsible for and accountable for what occurred within Operation Soteria remains the subject of inconsistent evidence. No single person, for example, has accepted that they were in control of Operation Soteria. Many who might have been assumed to be in charge have pointed to others. For example, the State Controller, who sits towards the top of the emergency management governance structure, reporting only to the Emergency Management Commissioner, gave evidence that the Chief Health Officer was ultimately in charge of the pandemic response, but the Chief Health Officer's evidence was that his team had no oversight of Operation Soteria. For example, he didn't know about the use of private security in the response.

The Emergency Management Commissioner, Andrew Crisp, gave evidence that it was the deputy State Controller, Mr Eagle, sharing the role with another, who was responsible for Operation Soteria, but Mr Eagle's own evidence was that he didn't exercise control.

And so, in the light of all of that evidence, it will be open to the Board to find that Operation Soteria was a complex inter-agency operation and, whether it's appropriate to say that responsibility was shared or whether it should be described as being diffuse, it's clear that no one has been identified as or has accepted for themselves that they were in charge.

That also raises the question of where public health experience and knowledge sat within Operation Soteria. The Board heard evidence about who held key roles in the public health emergency response and what were the skills, knowledge and experience necessary for those roles. Whereas the State Controller and Deputy State Controllers were emergency management professionals and experts, none of them were health professionals. They had to rely on public health teams within the command structure of DHHS for that knowledge and expertise. And on the evidence, an issue for the Board arises about whether the balance was properly struck between access to public health expertise on the one hand and access to emergency management expertise on the other.

Another issue before the Board is whether other agencies, namely Victoria Police and the Australian Defence Force, could have performed roles which could have been more effective in managing compliance with the purpose and orders which had been put in place for quarantine. The evidence was, although it was somewhat controversial, that there was a preference on the part of Victoria Police that private security would be the first line of security, with Victoria Police responding as required. There was a suggestion about why that might have been Victoria Police's

preference, although other evidence suggesting that it wasn't so much a preference as an acquiescence in decisions made by others. It involved an assumption expressed by former Chief Commissioner Graham Ashton that the role of private security would be limited to ordinary security services rather than infection prevention or control measures that would be better done by a nurse.

The question arises for the Board's consideration about the difference, if any, that might have been made by a 24/7 police response or presence at hotel quarantine sites, perhaps because they were visible as a professional and State-based cohort of workers, perhaps because they had skills that were particularly useful. It's noteworthy, though, that although there were people who thought there should have been such a presence, the evidence is that no formal request was ever made to Victoria Police to provide a 24/7 response across hotels.

The question of whose idea it was to use private security was and remains a vexed one. Former Chief Commissioner Ashton said in a text message that he understood that the Department of Premier and Cabinet had set up such an arrangement. There will be later evidence from the Secretary to that Department on that question. As to the question of an ADF involvement, the evidence seems to be that the Victorian authorities understood that there was the potential access to ADF help, but they considered that they had enough resources for the various phases of an operation so that, as the Emergency Management Commissioner put it, there was no need for ADF boots on the ground. Reasons were given for why he held that view and there's been no evidence to contradict that view.

And it's also relevant to note that, as the evidence shows, the ADF didn't have compliance or enforcement powers that could be used in a Hotel Quarantine Program. There was evidence of a request made for support in late June but then withdrawn because of the availability of alternative arrangements through Corrections Victoria, and that evidence wasn't challenged.

The evidence also shows that there have been changes to the Hotel Quarantine Program since June 2020 and that those changes have included, firstly, the Secretary to the Department of Justice and Community Safety becoming the sole operational controller for Operation Soteria; Corrections Victoria officers involved to enforce quarantine arrangements; and a change in the constitution of the State Control Team. The evidence that the Board has received is that the rationale for this shift was not recognition that previous structures had been inappropriate, but was due to the sheer scale and complexity of COVID-19 responses and activities required of DHHS, and that's a matter that the witnesses to come next week will be asked about.

Against that backdrop, I want to turn to the witness that I'm calling today. To date, witnesses have given evidence and provided information about the impact that quarantine had on them. The self-evident vulnerability of people who are held in designated places against their will has been laid bare through that evidence. The particular impact on people confined in small spaces was noted, as was the significance of removing someone's freedom.

The witness I propose to call momentarily is an expert witness, Dr Rob Gordon. Dr Gordon is a psychologist. He's worked in various capacities in disaster and trauma since the Ash Wednesday bushfires in 1983 and in a number of other Victorian and other disasters since. I'm calling Dr Gordon to give evidence about the foreseeable psychosocial stresses likely to occur in a program like the Hotel Quarantine Program, what is known about those stresses and what is known about how to reduce those stresses. He will speak of the well-known and foreseeable consequences of a program which deprives people of their liberty, especially when set against the fear and uncertainty that accompanies the backdrop of a global pandemic.

Before I call Dr Gordon, it's important to acknowledge that, as part of understanding those psychosocial impacts, the Board received not just evidence but also information from a number of people about their personal experiences. For some people, the experiences were traumatic, and we acknowledge the courage and commitment shown by those individuals in sharing their stories. Some of them appeared before the Board; others have made information available, including two whose statements have been recently obtained and will be made available on the hearing book. All of that information and evidence provides context to the evidence to now be called by Dr Gordon.

And having acknowledged that evidence and in light of what's been heard over the last six days, Madam Chair, I understand Dr Gordon is available online and ready to be called, and I'll invite him to turn on his camera for the purposes of taking the oath.

CHAIR: Good afternoon, Dr Gordon.

DR GORDON: Good afternoon, Madam Chair.

CHAIR: I should acknowledge, in that long list of engagements that Dr Gordon has had, he also is well known to the courts in Victoria and indeed to myself for the work that Dr Gordon has done in engagement with various aspects of the court's work, and I just wish to acknowledge that as well and my personal knowledge of Dr Gordon and my thanks to him for making himself available to assist the Board.

Dr Gordon, I understand that you wish to take the oath for the purposes of giving your evidence?

DR GORDON: Yes, that's correct.

CHAIR: So I will ask my Associate to assist you to do that. Thank you.

DR PETER ROB GORDON, SWORN

CHAIR: Thank you, Dr Gordon. I'll hand you over to Ms Ellyard now.

EXAMINATION BY MS ELLYARD

MS ELLYARD: Dr Gordon, could you please tell the Board your full name?

A. My full name is Peter Rob Gordon.

Q. And you are by profession a psychologist?

A. I am.

Q. You have been asked by the Board to provide a statement, which you've done by way of a document that the Board has numbered WIT.0001.0051.0001. Do you have a copy of that statement with you, Dr Gordon?

A. I do, yes.

Q. And does that statement reflect your opinions about the matters you were asked to opine on, drawn from your expertise as a psychologist?

A. Yes, it does.

Q. Are the opinions you express there true and correct?

A. Yes.

Q. I tender that statement, Madam Chair.

CHAIR: Exhibit 176.

EXHIBIT #176 --- STATEMENT OF DR PETER ROB GORDON

MS ELLYARD: Dr Gordon, perhaps by reference to paragraph 9 of your statement, may I invite you to provide the Board with a short summary of your relevant experience as a clinical psychologist, particularly with reference to what we'll call disasters or emergencies.

A. Yes. Well, I became involved with disasters as a member of the Royal Children's Hospital team working after Ash Wednesday in 1983. It became evident that not a great deal was known about what services people needed after disasters. And following several other events --- another bushfire, the Queen Street shootings and then the Manresa Kindergarten siege --- I was invited to take a role with the then

Department of Health as a psychological consultant for disaster recovery, on the basis that it was recognised that this was a specialist area of knowledge and it was valuable to have somebody who could dedicate some time to collecting knowledge and carrying experience from one event to another. So that --- I still have maintained that consultancy role. The format and arrangements have changed somewhat, but that's been continuous since 1989. And I've had a role as a consultant to Red Cross' emergency services from the early 1990s and through them I've often been asked to support recovery programs in other disasters and other parts of Australia and through New Zealand Red Cross in New Zealand as well. Currently, I'm consulting to the Department of Education and Training and Bushfire Recovery Victoria in regard to the fires in the beginning of this year.

So I've had some involvement with virtually every natural disaster in Victoria since 1989 and a whole range of other events, including some public health events such as the coal mine fire in the Latrobe Valley, the thunderstorm asthma event, some toxic contamination events and various other issues of that sort.

Q. Thank you, Dr Gordon. At paragraph 5 of your statement you identify the two questions in respect of which your professional opinion has been sought; the first being about what the potential psychosocial stressors are that might occur in hotel quarantine; and then, secondly, the question of what would reduce those stressors.

As I understand it, in turning your mind to those matters you turned your mind firstly to some basic principles of psychology known from learnings about those who have experienced a disaster or emergency, and you summarise a couple of them, as I understand it, at paragraph 12 and 13 of your statement and draw a distinction between social and psychological impacts and stressors. Can I ask you to speak a little bit about that, please.

A. Yes. I think what I learnt working in any kind of community-based event, disastrous or otherwise, is that the social dimension of our ordinary lives comes into focus as a key consideration because it's almost inevitable that particularly natural disasters create severe disruption of the social fabric. And what I've observed is this then creates a series of consequences for people. Because we take for granted in normal traumatic events, like a criminal event or a car accident or something of that sort, that there is an intact social environment around the people concerned: their relationships, their houses are still there, transportation and so on. So everyone else is in their social role and it's the affected role who are thrown out of their social position and then they can be supported by other people in their intact role.

When the whole system is disrupted, then that frame for recovery, which is the intact social fabric and the relationships and the services, becomes severely disrupted. The more severe the event, the more widespread the disruption is, and my observations have shown that, because of the non-routine nature of large and unusual events, that disruption often extends into the agencies that have to rapidly gear up to provide services. So therefore recovery in the first instance has to consider the maintenance and reconstruction and management of the social environment. Without that, what

we provide to individuals doesn't really hold as an effective intervention.

Q. As I understand it from paragraph 13 of your statement, you identify that the particular relevance of the disaster experience can be not only that the experience itself is stressful and might be stressful over a period of time, but that, as you've just outlined, people will be without what would ordinarily be the structures within which they could ordinarily process and manage that stress; is that right?

A. That's correct, yes.

Q. And at paragraph 15 and following of your statement, you go into a bit more detail about that and the role that's ordinarily played. You deal at paragraph 19 with the effects of increased arousal or increased stress. And I might ask the operator, if I may, with reference to the document WIT.0001.0051.0001, to bring up page 5 of the document and the graph that is represented there.

That's coming up now. Perhaps if we can focus on the graph. Thank you, Mr Operator.

You identify at paragraph 19, Dr Gordon, a recognised phenomenon of when someone's level of stress goes up for a while, so too does their capacity to perform, but then over time that changes. Could I ask you to explain that by reference to this graph?

A. Yes. I think it's important to --- as I've mentioned there, this was first observed in 1908 and has been observed for a whole range of human functions --- that the more the arousal, and stress creates arousal, the better we perform, up to the top of the graph, which is you could say the comfort zone; the zone of arousal in which our nervous system and our mind and so on work at their optimum level. If we start to push that arousal level beyond that zone, comfort zone, then the system cannot just simply improve, improve, improve. So therefore there's a gradual set of compromises that come into play to manage that arousal, which involve the reduction of performance levels in quite systematic and predictable ways, and this then constitutes the state of stress.

When they get too far down on the right-hand side, it starts to cause damage to the system. And that's what we understand trauma to mean, what I understand trauma to mean, meaning damage or injury. So if it goes to an extreme, the person becomes completely unable to perform, and we would call that shock. When you get into such a high level of stress that you're beginning to create trauma conditions, then in fact the capacity for the system to reverse and come out of arousal back down, back into the comfort zone, becomes compromised or disrupted. And in essence the condition we call post-traumatic stress disorder is a condition where the person is unable to de-arouse from the event, so they oscillate between shutting it down and re-experiencing it.

We could say that that kind of damage is caused by the severity of a particular

traumatic event, but it's also vulnerable to being caused by an extended unremitting state of stress, which in itself might not be too great, but the person doesn't get any opportunity to recover from that stress until damage is then caused.

Q. Thank you, Dr Gordon. Thank you, Mr Operator. That can come from the screen.

Dr Gordon, thinking about the impacts of high stress, at paragraph 20 of your statement you identify a well-researched and common effect of prolonged or high arousal as being an increase in self-centred focus, with a corresponding link then to a desire to reunite with loved ones when in a state of stress. Could I ask you to speak to that issue, please?

A. Yes. There's been a large amount of research in a lot of different contexts, but I think anyone who's had a period of very high stress will know how totally focused you become on the stressor. That's an adaptive reorganisation to maximise your resources, focus your attention, onto the stressor and thereby manage and deal with it. As a result of that, the awareness of contextual factors, systemic systems and so on, is compromised and all of that attention put on this narrow scope of the immediate problem, as I perceive it. So this is the self-focus.

But the other factor really that comes into play in the behaviour of people under threat is this primary need to reunite. And this really is a consequence of the fact that our attachments with our most important people are the fundamental cornerstones of our personality and the most highly valued aspects of our experience and the very basis for security, comfort and everything we need to counteract the stress. So the instinctive thing is to reunite with your loved ones. And we know that this is problematic in, say, bushfires, where people will try to find their children and loved ones and put themselves at great risks. Even though the school might have evacuated their children, they'll rush to the school. So these are very well-established patterns.

So therefore we can say that unless people are well prepared and rehearsed and trained and have a lot of confidence in --- let's say at a school, that the staff will manage their children safely, they are going to want to reactivate that, and anything that stops them doing that is going to increase the stress, increase the arousal, and increase the problem.

Q. So what does that mean in the context of a Hotel Quarantine Program that will require people potentially to remain in quarantine away from loved ones or unable to reunite with loved ones for a prolonged period?

A. So it's such a fundamental, this reunion with loved ones under stress, as a base for security, anything such as the quarantine situation that prevents free access is going to be a stressor in itself, in its own right, which will then be varied, depending on how readily people can feel confident in why this is happening and such things as how well they can manage electronic contact versus, you know, bodily presence, and that will vary. Some people will cope with that better than others. But I think many

people, particularly people of an emotional disposition, will really find electronic a very pale substitute for being with their nearest and dearest.

Q. At paragraph 26 of your statement, Dr Gordon, you reflect on what you would see as being a social psychology issue that arises if there's going to be a quarantine program.

A. Yes. If I could just make mention of a couple of the points that lead into that, and that is that we know that what maintains security, trust, confidence, and counteracts anxiety, sense of threat, is anything that's stable, predictable, familiar. And the mere fact that people are suddenly in a very unfamiliar environment in very unfamiliar conditions is going to undermine their confidence and is going to challenge trust. And therefore the opinion I came to when I was involved in some pandemic planning for the Department back in 2006, 2008, from the reading I did about pandemics and suchlike events, was that the essence of maintaining quarantine or management of the situation is fundamentally an exercise in social psychology, because it means recruiting the confidence and trust in the people needing to be managed that they can actually accept what they're being asked to do and understand it and trust or agree with the reasons and thereby cooperate, and that this --- there were many examples from other events of how people break quarantine for all sorts of emotional imperatives such as going to reunite with loved ones or whatever.

So I formed this view that the management of let's call it the social psychology of the situation is the essential characteristic that's needed to make it work.

Q. And then thinking about the cohort of people who were going to be involved or detained under any Hotel Quarantine Program, you set out at paragraph 27 and following of your statement what I understand to be some well-understood characteristics that can be said to be usually true about any given population, of which the hotel quarantine population is one.

A. Yes. This is a simple observation that it took me quite some years to realise, that when we look at a population of people affected by some kind of disaster or event or suchlike, we have to assume it's more or less a random sample of the community. That's very different from what health agencies, particularly mental health and social welfare agencies, are used to. We're used to dealing with people who have already been identified, either self-identified or identified by other people, as having a significant disability or disorder or health problem. So it became evident to me, working in many events, that there is a quite separate problem in engaging a group of normal people who don't identify themselves as having a problem. And I would assume, therefore, that most people going into hotel quarantine are not at all thinking about, "I'm now about to enter a highly stressful environment where I'm going to be subject to some serious anxieties."

So the formula I came to was this notion that if we look at a normal population, and if we just take these figures as indicative only, that they are based on some research that was done in the Department of Health when I was doing a consultancy late last

century, but around about, you could say, 20 per cent of the normal population either have some kind of health-related problem, disability, welfare need or whatever, that brings them into contact with Government or funded agencies on a regular basis, so they are used to dealing with people in authority and being told what to do or being given advice and carrying it out.

By and large, the other 80 per cent are people who don't really use formal Government or funded agencies to manage their day-to-day life. They manage their lives with their own resources. So my observation is they're quite unused to just dealing with and understanding the language and the way in which Government agencies and funded agencies function. So this is a problem for the people working with what I call the 80 per centers --- that there's a mismatch in communication when, for example, the health people treat them in the same way as people who have identified as patients. They haven't identified as patients. So if they're used to dealing with people who have identified as having welfare needs, they don't see themselves having welfare needs.

So there's a process of engaging people in understanding why they are in this situation, what kind of issues they might have, and that, for the first time in their life, they might have a need to use agencies and take advice.

So that really I think frames the fact that people need to engage in a process with people that is normally taken for granted. So that if a doctor sees a patient, the person has already gone through the process of understanding that they're a patient and they need help, or a psychologist or whatever. So this is again a matter of social psychology, of helping people recognise the position they're in and understand why these various agencies are around and how they might use them.

Q. Another issue that you raise at paragraph 31 of your statement is the way in which the 80 and the 20, to use your phrase, might interact themselves, if given the opportunity, to form a sense of themselves as being a community group in response to a particular disaster or issue?

A. Yes. We see this regularly in natural disaster affected environments, where you can go to a community meeting and you can see that there are a small proportion of the people who probably haven't fully understood why people did what they did during the emergency, who have got very --- they're very highly aroused, so they've got very narrow focus and they're really angry or upset about various issues. And then there is the majority of people, who are there to understand, and when they actually get the information, you can see that the people who are in high arousal and narrow focus can't really take it in, because it's not exactly what they're looking for, and they've got like a letterbox split of attention, and if the information doesn't exactly meet their question, it's sort of disregarded as noise. Whereas the 80 per cent is more sort of open-minded and take the whole thing and say, "Oh, is that why that was happening? I see."

Now, when they talk together in the community then the more emotionally focused

issues come out and the people who have collected the other information then say, "Yes, but that was because of this and that" and "didn't you hear them say," et cetera. And so what you get is something happening in the group that I think is very similar to what we do when we use this jargon "process information in our mind". We've got a primary concern and we think about, "Well, hang on a minute. There's this. How does that change my view?" And we engage in a process of thinking and processing.

I think there are some people who are not used to doing that in very unfamiliar and maybe threatening and unusual circumstances.

So it's a major strategy for recovery from natural disasters and traumatic events --- and we see this even in all sorts of, say, medical conditions --- that one of the first things that people need to do is to get into self-help groups, where they meet with other people that have the condition and they exchange information. And they then really learn and integrate a lot of stuff that the doctor might have told them but they only heard the first bit, which was the diagnosis, and everything else was noise. So therefore, I think, one of the greatest assets to the containment and processing and therefore bringing arousal down of the situation is to help the whole group that's affected communicate together.

And then the other component that that creates is a sense of common identity, which counteracts the sense of isolation, which is one of the most damaging factors in the quarantine situation.

Q. I turn then, in the light of that answer, Dr Gordon, to what you've identified at paragraph 35 and following to be what you would identify as the three key threats or potential sources of stress that a person in quarantine might identify. You've mentioned isolation, which we'll come to in a moment, but the first one you identify is the threat that people would perceive to be posed by the illness itself. And under paragraph 36 and following, you've provided some reflections on the way that threat might be perceived and the difficulties for a person in understanding that threat to be real. Can I ask you to speak to those matters, please?

A. Through working with traumatic events for many years, it becomes very evident that if you take a simple event like a car accident, there is one sort of trauma for the people in the car but there's quite another sort of trauma for the people who are at home, who aren't in the accident. You can't say that people aren't traumatised if you're not present at a dangerous situation. They are affected by virtue of the connection they have to the person or situation. And the difference is that they have no clear sensory imprint of the experience, as those who are there do. And often for those who are there, the traumatic injury is the imprint of the sensory experience that they can't get away from. The people who aren't there have just a bundle of information that they're given, so they need to imagine what happened, and that's often a very subjective and distorted process.

Now, I contrast these two problems as a sensory trauma, if you're there, and the

problem is to deal with those tremendously disturbing sensory traces; but the other people, for want of a better word, I call that an informational trauma. They are traumatised by information about what happened, and it becomes very important then about how you manage the information so they can't develop an imaginary construction of it that becomes more of a problem than the reality.

Now, if we transpose that basic observation into something like an illness, there's no sensory basis for the illness unless you see people dying in the streets or something. But most people would simply, in hotel quarantine, they would actually find out about it, get on a plane, come back, be met, come into the hotel, and most of them would probably have no experience first-hand of illness, and therefore it's just information. In fact, it's just a concept.

And the whole question of, then, what does this mean determines the arousal. So if people have had previous experience of illness or are of great anxiety or have seen lurid media exposés, they may think, "Oh, my God, I'm going to get a terrible illness and die," then they've got a very heightened arousal. But they would probably be, you could say, the 20 per cent of that group who are prone to anxiety and disturbance.

The problem for most people, and we know that the problem in disasters is always not panic, but not taking the problem seriously. And there's a large research literature in this. Whereas inexperienced people always think --- and we've heard President Trump say he didn't want to panic America so he downplayed it. And this is a regularly observed approach from people who are inexperienced. Therefore the problem with the informational trauma is that because it's just a concept and I can't verify it with my senses, I don't really take it seriously. And then the question comes up, why are they doing this to me if it's not so important?

So the social psychology of the situation is, how can you either recruit enough trust in the authorities to say, "Well, I don't really understand it, but they seem to know what they're doing. I'll go along with it" or provide them with enough information, structured in a way that helps them say, "Oh, I get it, that's what a virus is and that's what it does and that's how it works, and that's how we've got to protect ourselves." And it's this linkage between the understanding of the illness and the arrangements that will motivate the adherence to the arrangements and trusting that "It's worth putting up with the stressful and disturbing events, because I can see that people are trying to take care of us and the whole community."

So that becomes really a --- again, I'd say it's a social psychology exercise, about how do we recruit this understanding. So we have --- you know, we've had quite a lot of learnings about this, you know, from things like thunderstorm asthma and various other toxic contaminants, about some of the principles about how we'd do that. But I'd have to say, since it's my first pandemic, that I've got some general principles but I think we've got a lot to learn about how to do this really effectively.

Q. The second specific threat that you identify is the threat that will be posed by

isolation, that is, being isolated in a room potentially by oneself or with one other person. You deal with that in a bit more detail in paragraph 40 and following. Why is isolation a threat and what does it --- how do you manage it?

A. Yes. I work generally with groups of people on a regular basis who work in high-stress situations and what I've had a chance to observe during this period of time is many of these groups have quite suddenly gone to working from home. So they haven't gone into isolation in the sense of, you know, "I'm not allowed to see anyone," but they've gone from a busy, supportive social environment to being virtually alone, at least for their work, at home.

And what I've observed, really, which I think would apply even more intensively to the hotel quarantine situation, is the sudden loss of ordinary spontaneous social interaction, and I sort of think of this as unsolicited communication. When you listen to people who suddenly lose this, they have a sense of disorientation because we don't realise how much a role, for instance, arriving at work and being greeted warmly by several colleagues plays in actually maintaining a sense that, "Well, some people like me, I must be a nice person", and that this is happening in our ordinary daily routines all the time.

When you suddenly take that away, it's as though you're taking away a whole medium of feedback to me about myself from the people around me. Now, if I have a strong internalised stable sense of my own personal identity, I can manage that because I can say, "Well, I've got such a strong body of experience that people like me and I'm a good person, that the fact that there's no one telling me this for a few weeks or months is okay. I'm finding it a bit hard but I don't really lose it." But if I don't have a strong internalised sense of my own identity, I really need that input. And people display evidence of what I've coined for myself "identity erosion", and they use words like I feel "This feels unreal", "I feel odd," "I feel strange", "I feel it's not really me", "I feel I'm invisible," "I feel I've been rejected." And you can see how people will shade this into whatever other pre-existing problems they have. "Have I been rejected because I'm not wanted? Did I have experience of being pushed out in the past?" A lot of these things will be raised in the absence of this constant input.

You know, there's a sort of jargon that's used in the mental health profession of people needing their tyres pumped up. You know, some people's tyres have slow leaks in them and they need regular input to maintain their sense of self; other people have got good tyres and they can maintain it.

So therefore I go back to this 80/20 split and assume that at least 20 per cent of the people in quarantine are going to be seriously challenged by this just simple fact of isolation, and for some of them, electronic media will probably be enough, but for many it's probably not going to be enough and they're going to feel increasingly challenged or threatened by this absence of this kind of support.

Q. The third specific threat that you identify, Dr Gordon, and you deal with it at

paragraph 42 and following, is the threat posed by disruption. We've touched already on the significance of ordinary structures in one's life but you go into a bit more detail in paragraph 42 about the importance of routines and the potential impact if those kinds of things are withdrawn.

A. Yes. This comes from sort of gradually realising what I'm seeing in disaster after disaster, that the disruption of one's life routines, habits, regularities is a destructive influence in itself. And I like to put it this way: that if we ask, "Why do we develop the routines we do?", "Well, we do it in order to give regular, stable expression to our important values." So we spend time with our loved ones, we engage in hobbies, we take care of ourselves; you know, we embody these important things not just occasionally when we think about them but as unthought regularities in our lives. And this creates a fabric of stable taken-for-granted assumptions. And what we see is when people's lives are disrupted, the loss of these routines allows the sort of eruption of anxiety and a whole lot of associated unstable emotional responses.

Therefore, we need to understand that there will always be a loss of resilience, of self-management, of cognitive understanding simply in disruption. And what I've learnt from disasters is that if we look at the long-term outcomes for individuals, we'll find often the point at which the relationship has got so stressful that they eventually decide to separate is not during the event or in the immediate aftermath but it's in the months and years of disrupted lifestyle and chronic stress where they just never spent any time together that the relationship went wrong. In bushfires and natural disasters, people often say that this period is the second disaster.

So therefore what I've been saying to people --- and I think this applies absolutely to people in quarantine --- what I've been saying to people in the bushfire areas is, "Stop and think about what's really most important for your life. Don't worry about rebuilding your house just yet. Stop and think about what's most important. What did you do regularly to embody that in your lives and how will you actually hold those values during your recovery period while you're engaged in a very disrupted environment?

If, for example, I were asked to talk to people in quarantine, I would say to them, "Just stop and think, now that you're here for 14 days, what's really important for you in maintaining your sense of self, if you're alone, or holding your relationship? And then try to build some routines around it so that you do the same things at the same time every day, and you will find that will be enormously helpful and supportive to give you a sense of security and the ability to kind of confront actively this very challenging environment."

I think routines are something we need to bring to people's attention, because they don't realise they've lost them, because they took them for granted when they had them.

Q. You identify in your statement --- you've already touched on the fact that one can't necessarily anticipate from a particular stressor how actually stressed it will make an

individual person because it has to do with their subjective experience of the threat and the weight that they give it. But at paragraph 48 and following, you identify what might be the range of reactions that could be expected to these stressors, and one that you make, that I gather you would attribute more to the 80 per cent, is a resilience reaction; people find ways to cope with it?

A. Yes. And we know that there's a large literature on resilience now and there are quite clearly identified characteristics of resilient people. And these are people who don't respond passively, but actively go out and engage and try to manage. And I'm sure you would find people after a short time would start to build a routine for themselves because they would know they would feel better.

So the other specific threats that I would predict --- and, again, I'm applying knowledge in other areas to this particular challenge --- but one of the problems would be the need for contact. These are people for whom the attachment issues and the need to communicate becomes important. I think these people are likely to experience an increasing sense of urgency to make contact. Therefore, I think, unless that is engaged with in some way, and maybe these people are helped to make better use of the electronic communications possible or whatever, and helped to understand that, since they're there for 14 days, this is going to be a problem they're going to have to deal with, and then get them thinking about what would make a difference there.

Anxiety is going to be a generalised problem because anxiety is going to come from just the simple fact that things are different and unpredictable and uncertain: "I don't understand it all." If people don't have trust in the authorities established --- and some people will come into this setting with having had bad experiences of authorities in the past, whether it be family or Government authorities, so they will be feeling in a very vulnerable state. And we know that anxiety is highly contagious. So one person gets anxious, they are likely to communicate that anxiety. And that's where, I think, an awareness of all the people that are interacting with the quarantined population of how to recognise, just in a very simple way, anxiety and having some simple strategies about how to de-escalate people's anxiety --- you know, there are very simple procedures that anyone can learn about how to do that, I won't go into details unless you want me to.

But the other sort of tendency is the opposite, which is people going into themselves, shutting down, withdrawing and becoming detached. And we know that in conditions of helplessness, some people will shut down and become detached. They will often come out of an extended stress situation and they can't tell you much about what's been happening. They haven't been processing the experience. They've been sort of just letting one foot go after the other and just going through the day somehow. But that's something that needs to be recognised.

And, again, I think there are very simple indicators that anybody can be trained to observe whether a person becoming detached, in order to recognise those people who may be at risk for thinking beyond detachment and withdrawal into depression, and

beyond depression into suicidality. Probably they are people with some pre-existing problems but we don't know about that. And I'm always aware that in that initial research that I drew on to develop these ideas, the statistics in Victoria that were done at that time said that there is about as many people suffering from mental disorders of various sorts who are not getting any treatment as there are people who are getting treatment. And we come across these in these population conditions --- a whole group of people who ought to be seeing someone, getting treatment, who aren't --- and they are very vulnerable to being severely affected.

The last of these factors, just as a brief indicator, are those people who are not going to experience the stressor or the problem as an internalised psychological experience but are going to immediately convert it into action, and these are people who are going to produce behavioural responses. That could range from drinking too much, if they have the opportunity, to becoming angry, to trying to manipulate people, to trying to get out of it somehow, ranging from maybe taking it out on people in the room with them, trying to, you know, escape. I'm just speculating. But you would expect that it would be a whole category of behavioural responses that need to be anticipated.

Q. Before we come to the question of the specific ways in which those stressors might be anticipated by those working in the system and managed, can I turn your attention a bit further ahead in your statement, Dr Gordon, to paragraph 68 and following, where you've set out what you might hypothesise as a timeline of how a person in quarantine for 14 days might progress through a series of stages. Could I ask you to take us through that before we then go back to the question of what supports could be put in place for those different stages.

A. So when I was asked to give consideration to this situation --- again, being inexperienced in pandemics --- I thought it's so important in disaster recovery or even trauma recovery to understand that there is a structure of processes that people go through. There are --- we can't call them strict phases, but a sequence of processes that people go through. So it strikes me that there is likely to be a series of stages for being in hotel quarantine for a period of 14 days.

In the natural disaster environment, it is enormously helpful for people to suddenly see that there's a process there of predictable stages that any reasonable person will be likely to go through and to understand where they are in this. Therefore it strikes me that --- and, you know, I think you could probably pick this up from people who've made observations with people in quarantine, you would probably pick it up within the first couple of weeks, starting to group observations for people. So that we could assume that in the early stage, the beginning of the first week, the whole thing is new and different and confusing. For some people, it will be exciting and different and, "Fantastic, I get a paid holiday in a nice hotel that I couldn't normally afford," right through to people who are saying, "I don't trust this. I don't know what they're on about," and everything in between.

So there will be a period of high stimulus. The stimulus for some people will be

excitement, but for many people I think it would be disturbing and anxiety-producing. Then I would expect slowly, around about the middle of the first week, they're starting to get into a bit of a routine, hopefully; nothing more is happening and things are stabilising. So that there's, towards the end of the first week, I would predict that this --- the end of the first week, there's a period of increasing sense of, "Okay, I've worked out how I'm going to deal with this."

Then around about the middle --- and we know that anniversaries are really difficult times and that when a person comes up to the same day of the week, a week later, they think, "Oh, my goodness, is it a week already?" or "God, I've got to go through another whole seven days of this, I don't know how I'm going to make it," depending on how they feel. So I think that would be a period where a lot of stress would come to the surface. The first half of the second week I think would be, for the people who are struggling, probably the most challenging and difficult period. And once you get halfway through the first week, they're probably starting to see the light at the end of the tunnel.

So that would tell me that if we want to identify people at risk, for instance, or those who we need to focus on, I think this would give several spots where, if we kept track of where people are in their quarantine, where we would want to have a more close monitoring of them, for example, or make increased resources available, just to make sure we can engage with any issues early.

Q. Thinking about the kinds of issues and resources that might be required, at paragraph 55 and following, Dr Gordon, you identify some ways to reduce arousal or to reduce the intensity of reactions, and the first one that you speak about is a supportive environment. Can I ask you to speak about what you mean by this concept of support?

A. Yes. The word "support" is bandied around in our culture all the time, but in my observations and work with people in a whole range of incidents, I became very interested in it, because it's so clear for people when they feel supported and when they don't. They use the word very clearly, "I wasn't supported," or "I'm so grateful for the support I received." So I began to try to work out what is the psychological mechanism that has to be present in order for a person to feel that an interaction is supportive.

What my observations took me to is the mechanism is what we call in psychology "identification". Identification is when I realise that the person that's talking to me has --- the colloquial term is "gets it" --- in other words, the person has got an experience of their own that they can refer to that is in some ways similar with my experience. It doesn't have to be traumatic, doesn't have to be the same, but they get it, what it's like to be, let's say, isolated. That "getting of it" is then communicated, that the person says something. You don't have to reveal your own experience, but if you use your own experience of a period of isolation, maybe you were in hospital, and you just say something like, "Gee, it must be hard for you not to feel you can just turn over and say hello to your partner," it could be as simple as that, and the person

says, "Well, this person gets it."

From then on, the communication is experienced as enormously supportive. And support really means, "I feel propped up psychologically." So you can convert that into a technique of support by actually helping people understand what they need to listen for and then how they need to provide feedback markers in the conversation to show the person that they are getting what are the key issues of concern. So it's a skill to really convey support.

We have people who feel supportive but they don't manage to convey it. We also have people who don't understand what they're trying to do and they often opt for, I don't know, problem-solving or telling them, "Just don't think about it," or misguided sort of strategies like that.

Q. As I understand it, Dr Gordon, you're speaking of circumstances where, for example, a person in quarantine might feel supported, even though they don't get what they ask for, if the person who declines their request shows that they understand why it was requested --

A. Absolutely.

Q. --- and understands why there will be disappointment?

A. Absolutely. Support is a qualitative feature of communication and is independent of what else is produced.

Q. And is that something that only psychologists can do?

A. No, no.

Q. You touch on this at paragraph 57. Is that a skill that one might expect the broad cohort of people working in a quarantine program to be able to learn and display?

A. I'm sorry, I have to confess that some of my colleagues are not necessarily supportive. And people will often complain they see mental health professionals who they don't feel are supportive, who just go straight to problem-solving.

But we would also say that some people, completely untrained, could be volunteers or anybody, naturally understand how to do this. But I'm quite sure that you can develop a sort of --- I won't even call it training, but you could say a kind of briefing, orienting process to help people really understand the features that are important for them to express in all communications. It's also about the way we produce written information, for example. So anyone can be helped to do it better.

Q. You also refer at paragraph 58, perhaps reflecting on what you've said earlier in your evidence about the importance of community, that another way to reduce potential stressors would be to assist in the creation of a sense of solidarity or

a community around the people who are all in their separate rooms.

A. Yes.

Q. Have you got some ideas on how that could be done and why it's important?

A. Yes, certainly. I mean, if you --- when I work with people who are diagnosed with a chronic illness, it's very distressing, and finding a support group or a forum online, it could be on the other side of the world, of people who suffer from this condition or have had this trauma, and the sense that they are saying what I'm going through, and this embodies a quality which some social psychologists call depersonalisation --- not in the psychiatric sense of "I don't feel like a person, I feel like a machine," but in the social sense of, "I don't feel like a solitary individual, I feel like a member of a group." And that immediately reduces this very painful sense of uniqueness.

Now, that also is a product of communication about the experience I'm having with others who again show that they are having similar features, or we might be dealing with it in a different way. We're having the same problem, you're doing this, I'm doing that, we get ideas from each other. This is the 80 per cent resilience factor coming in.

So therefore the development of community solidarity I think is a really important resilience feature. And research on resilience shows that resilient people make sure they actually join and connect with groups of people that can support them wherever they go and they make very deliberate plans to do that.

So it struck me that one of the first things that would be useful here is to create opportunities for those in the quarantine situation to communicate. But again, I think that needs to be managed and designed and possibly facilitated, because you've got to counteract the contagion effect of anxiety and anger and high emotion with the community-building, supportive process. Now, you won't do it completely, but our observations are that you can more or less assume that 80 per cent will pick up and use constructively any opportunity to meet with others. It's this smaller proportion of people who will have varying forms of disorder or difficulty. But again, if that's facilitated by people with a bit of training, not a great deal but a bit of training, they can actually often manage and contain those people.

Q. There's been some evidence to the Board that in fact some people formed such networks, whether on social media or otherwise, for themselves, perhaps outside of any Government control. Does that surprise you, that people would create those things?

A. No, I would expect that people would do that if they possibly could. That's a great resilience resource. But it would be much more effective to then integrate that into the Government communication process, because it's in that environment that the information about what the virus is and why the quarantine measures are

necessary and how to do PPE and how to do hygiene and all these things, that will get processed, and that's the environment in which this information can be helped to circulate.

Q. Can I turn then to the question of information, which you've touched on perhaps already several times. There's I think two particular issues. There's the provision of information in the sense of it being available and there's lines of communication, which might include discussion of information. Can I deal with communication first. At paragraph 60 you talk about opportunities for regular caring, informal, unsolicited communication. What's the significance of that?

A. This is to compensate for the loss of spontaneous communication. So we know that if we say to people in high-stress situations, "Here's a phone number, if you've got a problem, ring it," 20 per cent of us will ring it because they actually know how to use services; the 80 per centers by and large won't until things get absolutely desperate. So therefore what we have found time and again is the only way to effectively intervene with the populations that are carrying high levels of disturbance but haven't had past experience is to actually initiate the communication process with them, draw them into environments where they can discuss and exchange and understand their problems.

So we have in the United States a lot of research into what's called help seeking, and they identify from their studies that the carrying of a symptom of stress or distress is quite a separate factor from having an understanding of your behaviour that this is a symptom of stress or distress that can be alleviated by talking to someone with training, for instance. That's something that has to be developed. Now, for the people that use services, they've already got that message before they ring up and make an appointment.

So we need to, as part of the social psychology I mentioned at the beginning, where we need to have people that are engaging and communicating and prompting people by asking simple questions like, "How are you sleeping?", "How's your concentration"?, "Have you been finding things to do?" That would be a very simple range of indicators to tell us where the person is on that graph and how they're going, which then could be the stimulus for providing them with some additional information resources.

So that if we actually say, "You let me know if you want to talk," they will go quite a long way over the hill in the graph before they make the phone call and they don't need to do that.

Q. At paragraph 61 and 62, you talk about information, and as I understand it you talk about someone being given and being the passive recipient of information on the one hand, versus being able to be a participant in discussions about relevant things on the other hand. What's the significance of that distinction?

A. Yes. This again is a very repeated observation in all sorts of areas to do with

emergencies. It's to do with warnings and how people process warnings and how they process recovery information. And we have this simple notion that you provide a person with a body of information, either in written or verbal form, and they take it away and process it. Now, that presupposes the person is in the comfort zone of the graph, because that's when your cognitive capacity will be at its optimum. If they're in any degree of stress, they'll be going down the right-hand side, and that is related to compromising of your normal cognitive function. Your high-order verbal conceptual skills steadily deteriorate as you go down into that stress zone. Therefore, first of all, if people are in a stress state, maybe they've just got off a flight, we've probably all done it, and you're trying to read a form or something unfamiliar, it's very hard to process the information, and you will find what happens is people talk to the people next to them and start doing it. So you've just got to have unusual information in a stressful situation. Or if the information itself is stressful, you get the same difficulty of processing it.

Therefore what I'm observing people in this situation, what I've come to is in order to hear, we need to talk. So in other words, the process of integrating information is an active process. It's not just receptive; it's actually taking it in and then getting a response, saying, "Is this what you mean?" or "Why are you asking me to do this? What is the virus?" And then this kind of exchange, this conversation, and if it's in the conversation that challenging, stressful, unfamiliar information is effectively integrated into my body of understanding. Otherwise what you get is most people will be polite and nod and say, "Oh, yes, that's right. Thank you. Yes, thanks very much." But they haven't taken anything in. I'm sure everybody has been to a doctor who gave you in the opening sentences of the consultation a piece of information you didn't want about yourself or somebody else, and you didn't hear anything else, and they talked to you for half an hour and you came out of it and you didn't remember a single thing. This is because you're struggling to process.

So it's this recognition that it's only under optimal circumstances that our sort of individual psychological notion of cognition works; that in any kind of stressful process, it's a social psychological process of communication and exchange that effectively brings information in.

Q. You identify in your statement and your evidence, Dr Gordon, that therefore there will need to be effectively an ongoing process of information being available for discussion at multiple points throughout the quarantine process.

A. Yes. People will vary in their ability or their need for that. You might have people who have got medical knowledge, they get it straightaway. They might need support for emotional aspects. But you will have other people who don't have any background in this, they never thought about pandemics, they don't understand quarantine. They will have a need for that in an ongoing way.

Another observation we make of people in various kind of stressful situations is if you take into account this sort of narrowing of attention that I mentioned, they are focused initially on just a few pieces of key information that they identified as crucial

to their current welfare, and they don't --- everything else is noise, and disregarded. When they get a little bit further down the track, they've sort of got hold of that bit. Now the circumstances have changed, they're worried about something else. Their sort of narrow slit of information is looking for something else. If the information has been given in --- and we've seen this often in bushfires --- a whole range of pamphlets and hand-outs and notices which are lying on a stack, let's say, on the table in their hotel quarantine room, they've now moved from needing piece of information A to needing piece of information C, and it's in there, they're not going to say, "I wonder what about --- can we do this, can we do that," and then go through all the stuff. That presupposes a very well-organised frame of mind of actually going out and problem-solving. What we'll find is a lot of people won't be that clear that they must have been given the information. They'll say, "We don't know this. The authorities never told us this. Why have they not told us? Do they know what they're doing?"

I think a very demoralising feature for people who are in any kind of disaster or trauma situation is losing confidence in the clarity and consistency of the authorities, because they are very, very dependent on them, and if they can't feel confident in them, then you see this massive escalation in their level of anxiety. So therefore we come to the notion of regularly repeating all the basic information in varying forms and in varying modalities, speech, written information, stuff on the internet, television, whatever, and just having this circulating through. It's better to bore them than for them to go into this state where they just don't know what's going on.

Q. What about if there's a perceived or actual inconsistency or variation in information available from various sources, so that the information is seen to change? There plenty of information but it doesn't all hang together. What would you expect to be the effect of that?

A. I think that's very disturbing, and we've made that observation often in varying disasters. It often happens in criminal events, let's say shootings and various things, where it's a very unusual situation and organisations are trying to work things out. With the best intentions, any inconsistency, contradictions or serious failure of coordination has a very profound effect on the confidence and security and therefore the anxiety management of the people concerned. So I'd say that that would be a really important point to be monitoring and watching. Again, it's about the social psychology of the information management.

Q. May I ask you finally, Dr Gordon, about a discrete issue you've raised in paragraph 74 and following in your statement, and that is about the role in any hotel quarantine program of a process that would actually occur after quarantine is over.

A. Yes. I've spent a lot of my career working with people after events, big events and small events. In a very simple way, we can say that once you get down the right-hand side of the graph, you don't integrate all of your experience. The more highly aroused you are, the more likely you are to simply record a series of highly vivid fragments that are not connected, and the fragments that are most strongly

perceived are those that are most threatening.

So if I just simply make up an example out of the quarantine situation, it's hypothetical based on other situations, but if a person in one of those moments somewhere in the middle of the period hits the wall, so to speak, and says, "I don't know how I can manage this anymore, I feel absolutely terrible, I can't cope with this," and later on, you ask, "What was hotel quarantine like?" And they will say, "It was absolutely terrible. I never thought I would hit the wall about something like that. I've lost confidence in myself." What they actually need is for someone to say, "At what point did this happen?" "Around about the middle, the first weekend." And then they need someone to say, "So how did you get through? What did you do? You obviously didn't get carted off in a straitjacket and given injections and put in a psychiatric hospital, so you must have got through."

But what you actually find is when you ask those questions, the person will stop and they'll think, and what you can see is they actually have to go to a different part of their memory, something that's not in the uppermost readily available set of memories --- that's all the horrible experience --- and they'll say, "Well, actually," and then they'll come out with what they did to. "I rang my grandmother and told her to read me a story like she used to when I was a kid," anything, "and that made me feel better." "Good for you. You must have a good grandma," you know. So people generally engage in a lot of productive actions to resolve problems, and there's no guarantee that the effectiveness of what they did is bound in and integrated with the terrible moments where they didn't know how they were going to cope or whatever it might have been.

So this is where an opportunity to go back over and bring up those disturbing moments and insert them into a narrative of the whole experience that then also, with a bit of help, lifts into the foreground their resilience features, their coping, their problem-solving or simply their survival, that they felt they were going to break down and they felt terrible for the rest of the week, but they managed somehow. It could be as simple as that. So they can have confidence, sending them out of the room saying, "Well, congratulations. you did survive it. You must have learned something. What would you do next time if it ever happened?" And they go away with an enhanced sense of having learned something.

Now, my experience is without that process, it's piecemeal, it's hit and miss as to whether a person integrates it in a productive way or carries away a whole lot of self-diminishing fragments. Some people will do well, some people won't. I don't think we should leave it to chance.

Q. So that would mean, Doctor, I take it, to the extent that people do experience hotel quarantine as traumatic, and you've explained about the range of factors that might be relevant to whether they do experience it that way or not, you would see a role for some structured and formalised availability of a debriefing model or some kind of support for those after they leave?

A. Yes. If I was asked to recommend, I would say that when people come to leave, the idea would be they have a short review conversation, and that could include a very important function which is them giving feedback to the system. It's a great relief for people to feel that if they've had this distrust and this disorganisation of information or whatever, that they can give information and the person listening to them gets it and says, "That must have been terrible. Thanks very much. I'll make a note of that. We'll pass that on."

When they're going, they probably want to leave, and debriefing shouldn't happen at the end of a situation. We call that a demobilisation. You're actually helping them --- and I would include a few questions like, "What are you going to do when you go home?" And a little bit of information about --- I think I mention in my notes the idea of a decompression reaction. They've been in a stable state of stress for two weeks, and people don't just simply snap back to normal. They have an adjustment. And then I'd be suggesting that they be followed up maybe a few days or a week later with some kind of --- given the number of people, it might not be able to be a phone call, but some message to say, "If you experience any of this, that and the other," and let's not make it psychological, most people won't go for that, "but if you would like to discuss this or get a bit more information on why you might be reacting or how you might deal with that, we can arrange something."

Q. So that would be a combination of providing people with information about the kinds of experiences or emotions that they might experience in the days and weeks after they leave --

A. Yes.

Q. --- and then a follow-up providing them an opportunity if they have had those feelings to seek out some form of support?

A. Yes, and that would probably vary. Some distressed people might need an hour and a half, and maybe a lot of people might value, you know, 15, 20 minutes just to review. And again, you could train quite a wide range of health professionals to have that kind of conversation, and if there's some kind of triage as to people who need more technical help, you could sort them out.

Q. Dr Gordon, this is the final question. You've described a range of emotions or reactions that you might expect from those experiencing the stressors of hotel quarantine, from resilience through to the kind of behavioural issues that you've described. The evidence that the Board has received is that overwhelmingly, the experience of those working in the quarantine system was that those being quarantined were quite compliant and that there was only a small number of issues or of people who presented as having certainly behavioural issues or posing any real problems; largely very compliant. I wonder if you've got any reflections on what that says either about the way the system must have worked or about whether that would be expected, given the risks and threats that you've identified?

A. I think the issue of compliance is a reflection of our culture. It also would be a reflection of the confidence or trust that most people have in the authorities. But you would also have to say it must also be indicative of the way in which they were managed, and the kind of relationships they formed with the people they dealt with that developed that confidence.

The issue of compliance, I think, however, is not the same as the issue of stress. We know that many people will subject themselves to very high levels of stress for long periods for reasons --- you know, for particular motivations. And so I think that the impact on people is not necessarily indicated by the issue of compliance. But again, I would say it's a very unusual and different situation, and it would be most interesting to hear some detailed information about how people experienced it to fine-tune that. Probably if, you know, if I were asked to sort of make recommendations about services, I'd be saying --- what I found in natural disasters is if you compute about 20 per cent of the affected population, they're the ones that you probably need to plan services for. The others can deal with a range of very general population-based interventions or information. So it would be those 20 per cent that I'd be imagining might need more assistance or have more severe responses.

MS ELLYARD: Thank you very much, Dr Gordon. Madam Chair, those are the questions I had for Dr Gordon. I haven't had notice of any applications by any leave to appear party to question him, but I'm conscious that you yourself may have questions before I ask that he be excused.

CHAIR: It doesn't look like anybody is giving any indication at the moment that they have any further questions of Dr Gordon, and neither do it. Dr Gordon has provided a very helpful and comprehensive statement which has now been elaborated on in the course of his oral evidence. Dr Gordon, thank you very much for the assistance that you've given to the Board, and thank you for your attendance. Given the nature of what has been discussed this afternoon, I think it prudent for me to remind everybody of the number for Lifeline, which is 13 11 14.

Thank you, Dr Gordon, for your attendance, and you are now excused, which means you're able now to turn off your camera and your microphone. Thank you.

A. Thank you, Madam Chair.

THE WITNESS WITHDREW

MS ELLYARD: Madam Chair, before I outline the procedures for next week, I'm aware of a particular issue that Ms Harris on behalf of the Department of Health and Human Services wants to raise, correcting an error, as I understand it, in the tendering of a document yesterday. So might I call on counsel for DHHS to deal with that issue.

CHAIR: Thank you. Ms Harris.

MS HARRIS QC: Madam Chair, in the examination of Mr Helps yesterday, I took Mr Helps to a document and then neglected to tender it until the end of his evidence, and by the time I tendered it, I gave the incorrect document number for that exhibit. It was Exhibit 168. The document to which I took Mr Helps was DJP.101.002.8853. I incorrectly gave a different number. But that is the correct email. And the incorrect document, just to make sure that the information for Solicitors Assisting is there, I had incorrectly referred to DJP.102.008.69 --

CHAIR: 81.

MS HARRIS QC: Thank you, Madam Chair.

CHAIR: Thanks, Ms Harris. I will make sure that that's corrected on the record.

MS ELLYARD: Thank you, Madam Chair. Might I turn then to arrangements for the balance of the public hearings, and firstly deal with the question of final submissions. It had originally been announced and anticipated that Senior Counsel Assisting would make final submissions to you next Friday, with the leave to appear parties then having a week, until the following Friday, 2 October, to provide submissions in writing. Having regard to other logistical arrangements and the extent to which we're going to be hearing evidence next week, may I foreshadow a proposed change to that. It's now proposed that Mr Neal will make final submissions to you on Monday, 28 September, with the time for parties to make written responses extended similarly to the following Monday, 5 October. So that will be 28 September, and then the following Monday for responses.

Having indicated that, may I indicate that next week we propose to call evidence on Monday, Tuesday and Wednesday at least, subject to how many witnesses we get through. On Monday morning, we'll be calling Mr Chris Eccles, the Secretary for the Department of Premier and Cabinet. On Tuesday, we'll be calling Mr Phemister, the Secretary of the Department of Jobs, Precincts and Regions, and Ms Peake, the Secretary to the Department of Health and Human Services. And then on and from Wednesday, subject to finalisation of arrangements, it's proposed to call Minister Pakula, Minister Neville, Minister Mikakos, and the Premier, Mr Andrews. Most statements, certainly the statements of the three Secretaries, are already available on the hearing book and I'll correspond with my fellow counsel about timelines for applications for leave. To the extent that the statements of Ministers aren't already on the hearing book, they will be made available shortly.

CHAIR: Thank you. Thanks, Ms Ellyard. So I will adjourn now until 10.00 on Monday morning. Thank you.

MS ELLYARD: If the Board pleases.

HEARING ADJOURNED AT 3.45 PM UNTIL 10.00 AM ON MONDAY, 21 SEPTEMBER 2020

Index of Witness Events

Index of Exhibits and MFIs