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IN THE NEW SOUTH WALES STATE CORONER'S COURT

STATE CORONER O'SULLIVAN

MONDAY 28 APRIL 2025

2024/00139002 - BONDI JUNCTION INQUEST

NON-PUBLICATION ORDERS MADE

Dr P Dwyer SC with Ms E Sullivan and Mr C Murphy assisting the Coroner
Ms S Chrysanthou SC with Ms T Harris-Roxas for the families of Ashlee Good, Dawn Singleton and Jade Young
Mr L Fernandez with Mr P Townsend for the family of Faraz Tahir
Mr D Roff for the families of Yixuan Cheng and Pikria Darchia
Dr I Freckelton AO KC with Ms C Melis for Commissioner of QLD Police Service
Mr H Chiu SC with Ms M Summerhayes for NSW Ambulance and NSW Health
Ms S Callan SC with Ms A Richards for Commissioner of NSW Police
Mr D Jordan SC with Ms A Bonnor for Scentre Shopping Centre Management Pty Limited
Mr A Casselden SC for Glad Group Pty Limited appeared
Ms L Clarke for Falcon Manpower Solution Pty Ltd appeared
Mr C Gnech for Queensland Police Officers [redacted], [redacted], [redacted], [redacted] and [redacted] appearedL
Ms R Mathur SC for Dr [redacted], Dr C, Dr [redacted] and Dr Barkla appeared
Mr J Pen for SafeWork NSW appeared
Ms S Robb KC for [redacted] and [redacted]
Mr B Wilson for [redacted]
Mr M Lynch for Dr A

AUDIO VISUAL LINK COMMENCED AT 10.09AM

HER HONOUR: Good morning. Firstly I'd like to start by acknowledging the families who are with us today and those joining us remotely. We'll do all that we can to assist you over the coming weeks, but please let your legal representatives know if you have any questions or concerns, and you are of course free to come and go from this courtroom as often as you would like to. Before I make some opening remarks, I'm going to take appearances from the legal representatives.

DWYER: My name is Peggy Dwyer and I appear as senior counsel assisting with my learned friends Emma Sullivan to my left and Chris Murphy, together with a team of solicitors led by Ms Amber Doyle who sits behind me from the Crown Solicitor's Office. We assist your Honour as the counsel assisting team.

CHRYSANTHOU: I appear with Ms Harris-Roxas for the families of Ashlee Good, Dawn Singleton and Jade Young.

FERNANDEZ: My name is Fernandez. I appear with Mr Townsend. Your Honour has granted us leave to appear for the family of Faraz Tahir. We're instructed by Legal Aid NSW.

ROFF: For the record, my name is Roff. I'm instructed by Mr Paul Blake of KPT Defence Lawyers on behalf of the families of Pikria Darchia and Yixuan Cheng.

FRECKELTON: My name is Ian Freckelton. I appear as senior counsel with my learned friend Christine Melis for the Queensland Police Service instructed by Jonathon Paratz of that service.

CHIU: My name is Chiu and I appear with Ms Summerhayes for NSW Ambulance and NSW Health instructed by Makinson d'Apice Lawyers.

CALLAN: If it please the Court, my name is Callan. I appear with Ms Richards for the Commissioner of Police of NSW. I'm instructed by Ms Atherton from the Office of General Counsel of the NSW Police Force.

HER HONOUR: I think now we go over to those in court 2 please.

JORDAN: My name is Jordan. I appear with Ms Bonnor for Scentre Shopping Centre Management Pty Ltd, instructed by Holding Redlich Lawyers.

CASSELDEN: My name is Casselden. I appear on behalf of Glad Group Pty Ltd, instructed by McCabes Lawyers.

CLARKE: Clarke, initial L, I appear for Falcon Manpower Solution. I'm instructed by Numair Malik of I-Global Lawyers.

GNECH: My name is Gnech. I appear with your Honour's leave on behalf of five Queensland police officers.

MATHUR: For the record Mathur. I appear on behalf of Drs [redacted], [redacted], C and Barkla, instructed by Moray & Agnew Lawyers.

PEN: My name is Pen, initial J. I appear for the SafeWork NSW instructed by the Department of Customer Service.

ROBB: My name is Robb. I appear on behalf of [redacted] and [redacted] and I'm instructed by QNMU Law.

WILSON: My name is Wilson. I appear on behalf of [redacted] and I'm instructed by Ms Nicolle of Meridian Lawyers.

LYNCH: My name is Lynch. I appear for Dr A.

HER HONOUR: Thank you. I think that's everyone.

DWYER: Thank you. Before we start the livestream, might I just mention a couple of housekeeping matters. The first is in relation to the court's sitting hours. Although regrettably we've got a short delay today of about 15 minutes, in the ordinary course, the Court will commence at 10am and conclude at 4pm. There might be some earlier sitting times which will be advised as necessary and only in conjunction with discussions with the families, and that depends on the progress of the witness list. A morning tea break will be 11.30am until 11.50am, and lunch is 1 to 2pm unless we need a shorter period of time on some days to get through witnesses.

We ask all the practitioners at the bar table to be strict about ensuring their attendance at court in accordance with those times, including of course the counsel assisting team. It's just imperative that we complete these proceedings in the allocated time that's been highlighted, and even a drift of half an hour or so every day can make a difference to whether we ultimately have to go over for a week and the families have said right from the outset they really want this inquest done in the five weeks that has been allocated, and we are very mindful of that. As the counsel assisting team, we'll be conscious of those strict timings, and so if anybody needs to confer with us in terms of witnesses or lawyers, we make ourselves available at any stage during the evening or the very early hours of the morning, or on the weekend, but we'll do it outside of court times.

The second issue is this. It's customary in this Court, as your Honour knows, to refer to the person who has passed away by whatever name the families would prefer us to refer to. Sometimes that's included nicknames or family names, and sometimes it's included more formally. In these proceedings, I'll be either saying the full names of the person who has passed, or using the name that the families prefer. When it comes to talking about Jade Young, I'll be saying Jade; Faraz Tahir, I'll be saying Faraz; and I'll be referring to Ms Singleton, Ms Cheng, Ms Good and Ms Darchia wherever possible. I apologise in advance if I make a mistake, but we're really mindful of trying to be respectful at all phases of the inquest.

HER HONOUR: Thank you, Dr Dwyer. Today we commence the coronial inquest into the tragic events that occurred at Westfield Bondi Junction on Saturday 13 April 2024, that is the killing of six people, the death of Joel Cauchi, and injuries to many others, both physical and psychological.

I wish to make some very short remarks before turning to Dr Dwyer to deliver her opening. I have previously offered my condolences to the families and I do so again today. There are simply no words that can properly convey the magnitude of your loss. I acknowledge the grace and courage, strength and dedication, of each of the families of Ms Singleton, Jade, Ms Cheng, Ms Good, Faraz and Ms Darchia in engaging with this coronial process, and in tirelessly advocating for their loved ones.

I also recognise the emotional fortitude and resilience it takes to participate in this process only a year after the tragic events of 13 April 2024, and indeed soon after the one year anniversary.

Throughout the next five weeks, the team assisting me will continue to engage with the families and their legal representatives, and of course other interested parties and stakeholders, to conduct this coronial process in an efficient and trauma-informed manner. Our ultimate hope is to provide families and their loved ones, and also the broader community, with much needed answers about how the tragic events of 13 April 2024 occurred, and how such events might be prevented in the future.

I thank all parties involved in these proceedings and their legal representatives for their assistance to date. This inquest has moved to hearing as quickly as has been humanly possible allowing, as we had to, for the thorough investigation to be completed. The investigation has been searching and comprehensive. I understand some further material will be received during the course of the hearing from interested parties. No doubt parties will continue to work constructively with counsel assisting to manage the further material to be provided, as they have done to date.

There is one final matter I wish to raise. At the last directions hearing, reference was made by counsel for the families and by senior counsel assisting to the potential for harmful media reporting of these proceedings. Accepting that there is an important role for open justice in our society, I can only underscore, in the strongest terms, the need for empathy and sensitivity in the coverage of this inquest, given the immense trauma that each family has suffered to date. I'll now hand over to senior counsel assisting Dr Dwyer.

DWYER: Your Honour, I estimate that my opening will take around two hours, so we'll have a break for morning tea. As your Honour and families know all too well, this inquest will explore the tragic events of Saturday 13 April 2024 that unfolded at Westfield Bondi Junction. The events of that day, the anniversary of which have just passed, have forever changed the lives of the victims, the families, and loved ones. Those who were injured, those who were present, and the community at large. Some of the events are already well known.

On 13 April 2024, Joel Cauchi, then aged 40, killed six innocent victims. Five were women: Dawn Singleton, Jade Young, Yixuan Cheng, Ashlee Good, and Pikria Darchia. Mr Cauchi also killed a security guard, a young man named Faraz Tahir. It was his first ever shift at Westfield Bondi Junction as a security officer. Mr Cauchi wounded ten others before being fatally shot by New South Wales Police. Of those ten people, two were men, and both of those men were very seriously injured.

While the inquest will explore what happened on that day on 13 April 2024, it is not confined to those events on that day. A detailed issues list has been distributed to parties, and has been shaped with the assistance of those who lost their loved ones.

I'll go further into those details shortly. But in summary, the inquest will review Mr Cauchi's mental health treatment in Queensland, including the decisions that led up to a reduction and ultimately cessation of medication that had previously been prescribed to manage Mr Cauchi's mental health. It will review the apparent gaps in the Queensland mental health system that Mr Cauchi fell through, which meant that he was effectively without treatment, and without adequate supervision, for nearly five years before his death, even though he had previously been medicated and well supervised. Although, as I will set out, Mr Cauchi did have a few brief interactions with the medical profession, from early 2020, there was nothing in the way of active supervision, monitoring or follow-up.

This inquest will explore Mr Cauchi's interactions with Queensland and New South Wales Police, and consider if any opportunities for intervention were missed, and if so, how the system can be improved to assist front line police who are increasingly being asked to deal with members of the public who appear mentally disturbed and are not receiving adequate psychiatric care.

Your Honour, I expect the Court to hear from experts about a paucity of community-based care for mentally ill men like Mr Cauchi, and why that is a burden increasingly being felt by police and the broader community, and I expect that there will be some serious practical recommendations that arise in that regard.

It is not proposed or intended that this inquest will be a roving inquiry delving into the totality of issues facing the mental health system in this State of New South Wales or Queensland. It may be accepted that the mental health system in both New South Wales and Queensland is under strain, and it's neither possible or appropriate for this inquest to seek to identify how to reform the entirety of the mental health system. But, through the lens of Mr Cauchi's lived experience, and in recognition of the devastating consequences caused by his actions, the inquest will seek to identify practical and realistic recommendations about what can be done to improve the treatment of those suffering from chronic and severe mental health conditions, with a particular focus on schizophrenia.

It is hoped that this inquest and your Honour's findings will offer a meaningful and informed contribution to an area that is in need of urgent reform and resourcing.

A further topic for this inquest to investigate is how the operator of Westfield Bondi Junction, known as Scentre Group, and its security contractors, and New South Wales Police and New South Wales Ambulance, responded to the events of 13 April 2024, including whether they were adequately prepared to deal with the violence that unfolded on that day on such a significant scale, and whether they were adequately prepared to deal with the number of casualties and what, if anything, could have been done differently.

The Court is not interested to single out any single individual who was doing their best in a fallible system that was put to the test by Mr Cauchi's acts of violence. It is necessary to establish an authoritative account of the events of 13 April and relevant prior matters, and of course individuals will be called to assist with that, and they have already been called on to give a detailed written account.

Individuals are encouraged to give a frank and full account of their experience knowing that the goal of this inquest is to work out what happened, and why, in order to identify any gaps in systems and processes, and to learn valuable lessons from any mistakes that were made, allowing this Court to make recommendations that might save lives in the future.

We are very fortunate in Australia that this type of terrible tragedy that unfolded on 13 April 2024 happens rarely. But that is little comfort to those who have lost a loved one. Resources have been invested in this inquest to understand what happened; to recommend what is possible to prevent it happening again; and to ensure that, if it ever does happen, the response to it by emergency services will be as rapid and as effective as possible.

This morning, I will provide an overview of the matters that will be canvassed during this inquest over the five weeks. I will provide a summary outline of the evidence, which comprises witness statements, documentary records, and electronic materials, as it currently stands. That evidence will further emerge over the next five weeks as your Honour hears oral evidence from witnesses, many who were directly involved in the events of 13 April.

Your Honour alluded to the fact that further evidence comes in during an inquest and we are mindful of the way that parties have been moving as quickly as possible to put that evidence on.

There is one final matter I will address at the outset before we get into the facts. It's really just to echo what your Honour has already said this morning by way of opening. We understand that there's a genuine public interest in the matters to be addressed in this inquest. We know that the media are present today and will be reporting on the evidence. That is a function of open justice and an active democracy. It is the reason for the live stream of selected parts of this inquest, which may include expert evidence, and ultimately the findings. The public are interested, but also experts in the particular areas that the inquest touches on are interested to understand the issues and to learn from them for their own purposes for the sake of the community.

The media does indeed have an important role. But we ask again that the media be conscious of the impact their reporting has already had on the families of the victims and may have again, and on all of those affected by the events of 13 April 2024, many of whom we will not see in this Court, but who are at home and reading the media, conscious of their own experiences on that day.

The grief of the families who are impacted is raw and deep, as it would be for

any family, and the extent of their loss is truly unfathomable for the rest of us. We can only imagine it. The inquest is a huge strain on their emotional reserves. Most people in the community will grieve the loss of a loved one at some point in time, but they generally get to do so in their own private way; in their own private time. We all think of what happened in this case every day, and we empathise deeply with families who have lost a loved one. We also remember where we were that afternoon when the events unfolded.

That afternoon, families, as so many other people around New South Wales, heard breaking news about a public emergency at Bondi Junction, and they immediately made calls to check on the people they loved as so many thousands of people must have done on that day. But for the families involved in this inquest, they were to discover that a public tragedy had touched on them personally and profoundly, and irrevocably.

The public nature of this grief is a burden for the families that we are trying to be mindful of at every stage of the inquest. Your Honour has urged the media to be sensitive to the families' requests. The families' lawyers are here to guide the media, if necessary, if they have any questions in that regard about how to be respectful. Non-publication orders have been put on by your Honour to assist the media with the boundaries of what is in the public interest. That has been done in consultation with the families.

Your Honour and those assisting has emphasised that these proceedings will be trauma-informed to the extent that we possibly can be. As a corollary of that, and as I said at the last directions hearing, sensitive footage will not be played in open court. We concern not to unnecessarily traverse any graphic detail in the oral evidence, or in this opening.

However, to be clear, much of the traumatic footage of what happened on 13 April, which includes Mr Cauchi running through the centre with a knife, approaching victims, is in the public domain, but is not in the brief of evidence. We do not think that playing that footage in open court serves any forensic purpose. We hope that individuals from the media outlets who are reporting upon the inquest can exercise their own judgement about what is played and what is being replayed to the public, mindful of the preferences of families and the pain and suffering they have expressed.

Access to witness statements will be made available to the media following the conclusion of the relevant witness' evidence. The index to the brief will also be made available. To the extent that access to further material in the brief is sought, and acknowledging the sensitive nature of much of that material, it will be conditional on the media making an application to your Honour, and that application should clearly identify the specific material to which access is sought, and the reasons for the access.

Acknowledging the volume of material in the brief, those applications will be considered by your Honour as quickly as possible, and we are mindful of open justice, but a priority of this Court, and therefore this counsel assisting team, is to be careful, and to support the families through this process. So it will be

necessary to carefully check documents prior to their release, and to assist the media to understand the non-publication orders in place, so there may be a need for patience.

I come now to the purpose of an inquest. To assist the community to understand what an inquest is all about and why it happens, and why the government have carefully resourced this inquest, I'll explain again that this inquest is mandatory according to the New South Wales Coroners Act. Sections 23 and 27 of the Coroners Act provide that an inquest must be held where it appears that an individual has died as a result of a homicide, or where a person has died as a result of a police operation. I mean by that, of course, that Inspector Scott was required to fatally shoot Mr Cauchi, and that is a police operation.

For both of those reasons, an inquest in this case must be heard. A coronial inquest is fundamentally different to an ordinary court hearing. No-one in the Court is accused of a crime. There are not civil proceedings concerned with compensation, and as I've previously stressed, guilt or innocence or liability is not what a Coroner's Court is all about. This is a fact-finding jurisdiction. Your Honour is tasked with investigating the identity of those who have passed away, which of course is well-known in this case, as well as the date, the place, and what's referred to in the Act as the manner and cause of persons' deaths. Manner of death really means the circumstances leading up to someone passing away and the surrounding issues.

In undertaking the investigation, the Court has a broad remit, and a broad discretion to consider a wide range of matters within its jurisdiction. Importantly, as I've already touched on, your Honour has a power to make recommendations in connection to a death, including matters concerning public health and safety, and that of course is also the reason why the government has seen fit to resource this inquest so significantly, because it is of such great importance to the community that any public safety lessons are learned.

Before turning to an overview of the matters to be addressed during the inquest, I'll just give a brief outline of how the inquest will run over the next five weeks. Consistent with your Honour's direction about the inquest being trauma-informed, the counsel assisting team has emphasised again and again the need for us to finish during that period. We do so having consulted the families.

As to the procedures to be followed, counsel assisting will be principally responsible for examining the witnesses who are to be called. Your Honour will hear oral evidence from over 40 witnesses during the hearing so that it is essential that the proper and efficient conduct of the inquest be at the forefront of parties. That means we need to avoid duplication, and all the experienced counsel at this bar table understand that. So most of the questions are asked by counsel assisting, and we ask people to avoid duplication. We doubt that stopwatch orders will be necessary, but they're available to your Honour.

HER HONOUR: Can I just pause for a moment to ask anyone who is listening in remotely to put your microphone on mute, thank you.

DWYER: A small number of witnesses have made applications to be excused from giving oral evidence and they are witnesses who would have ordinarily been called, but they've asked to be excused due to their health and wellbeing, either physical or mental health. They were individuals who give evidence directly relevant to the events of 13 April 2024.

We understand interested parties and particularly families need to carefully understand the events of that day. In a small number of cases, your Honour has determined to excuse witnesses based on compelling medical evidence that they have provided. That only relates to a very small number of witnesses. The medical evidence they provided demonstrates that the risk posed by requiring those witnesses to re-live the events of 13 April far outweighs any potential benefit that might be obtained from hearing evidence from that person.

But importantly, those witnesses who have asked to be excused have each given detailed written accounts of their movements, and they have offered to provide supplementary statements answering further questions that have been put to them by the counsel assisting team in consultation with the families. They have cooperated with that process. The counsel assisting team is confident that by the end of this inquest, all the necessary information will be before this Court to enable your Honour to make the necessary findings and, crucially, the recommendations.

The scope of the inquest is informed by the issues list. That document has been prepared again on a collaborative basis with the interested parties, and particularly with the families. We again acknowledge the contribution of families who we're asking to participate at a time very soon after they are coming to terms with the loss of their loved ones. The issues list, which is available, identifies 17 discrete issues and multiple sub-issues that will be explored during the inquest.

I touched on that issues list and read from it during the last directions hearing, so I don't propose to do so again in detail. However, I can say from the outset by way of an overview that the following matters will be central to the inquest and the evidence to be heard. Firstly, of course, the events of 13 April 2024, including the level of preparedness for an active armed offender. That's a particular term which is used by security and has a particular meaning. It will be referred to by its acronym in some documents as AAO, active armed offender, and it has international currency.

Your Honour will look at the response by each of the Scentre Group and its security contractors, New South Wales Police and New South Wales Ambulance on that day, and in particular, the inquest will explore the initial response by security staff at Westfield, including when staff first became aware of what Mr Cauchi was doing, and what actions were taken in response to what he was doing, and the nature and timing of any alerts that were set up as

a result, and I'll come to that in more detail shortly in my opening.

Secondly, the Court will look at the New South Wales Police response, including the actions of Inspector Amy Scott in apprehending, or attempting to apprehend Mr Cauchi and fatally shooting him. It will also look at how New South Wales Police interacted with New South Wales Ambulance and with Westfield or Scentre Group staff, and the implementation of the relevant command structures as well as the potential identification of an additional offender. Your Honour will recall that on the day there was some level of confusion as to whether or not Mr Cauchi was acting alone, and that had implications for the response of first responders, and we'll look at that, and the response.

The timing and nature of the response by New South Wales Ambulance to this mass casualty incident is an important topic. It includes first-aid treatment and triage decisions of New South Wales Ambulance paramedics. It will also consider what, if any, consequences resulted from the declaration of Westfield Bondi Junction as a hot zone following the possible identification of a second offender. None of that is intended as a criticism of individuals doing their best in that chaotic environment, but it is important to learn from this catastrophic event.

As I've already touched on, Mr Cauchi's mental health treatment in Queensland is a very important topic. That includes his treatment for schizophrenia, and the decision to reduce and ultimate cease his psychotropic medication, the consequences of that reduction, whether there were early warning signs of a relapse. That includes early warning signs in late 2019 and early 2020, very shortly after he was taken off that medication. And if there were any opportunities for an intervention that may have prevented what ultimately occurred on 13 April 2024.

We know from the evidence in the brief that Mr Cauchi had several interactions with Queensland police officers, including most notably in January 2023 where Queensland Police were called to Mr Cauchi's family home following an incident where his father had confiscated a number of knives that were a similar style to that used by Mr Cauchi on 13 April 2024. Mr Cauchi's father was worried about him having those knives, and the Court will explore whether that was an opportunity missed for intervention by police, which may have resulted in Mr Cauchi being re-engaged with the mental health system at that time.

The inquest will also consider, at the specific request of families of victims, the nature of the media's response in the aftermath of the events of Westfield Bondi Junction on that day, 13 April, and beyond, and it's expected that family members will give witness statements detailing their experiences with media in de-identified form following the events and the impact of them, to see whether or not anything can be learned and done differently next time.

Given the inquisitorial nature of these proceedings, other issues may emerge during the hearing, and we stress that the issues list is not a form of pleading

like in a civil case that binds your Honour. It's not an indictment like in a criminal case where there is difficulty changing it. Rather, it's a guidepost to keep the inquest on track and put parties on notice of the main issues that we expect to be heard.

By way of a hearing plan - and this is the last thing I'll say before I outline the facts - it's anticipated that the five week hearing will proceed as follows. In weeks 1 and 2, that is this week and next, your Honour will hear evidence from those directly involved on 13 April. The first witness will be Detective Chief Inspector Andrew Marks of the New South Wales Police Homicide Unit who, along with his diligent team, has been responsible for the investigation into the events that occurred at Westfield Bondi Junction, and your Honour will hear that Detective Chief Inspector Marks was involved from day 1, 13 April, and has continued his involvement.

Your Honour will also hear this week from Inspector Amy Scott, the New South Wales Police first responder who confronted Mr Joel Cauchi, and who shot him as he was armed and running towards her at speed. Inspector Amy Scott is an important witness no doubt. Evidence will be called from her tomorrow. But there is no question with respect to the propriety of her actions, and in fact her professionalism and courage on 13 April 2024 is clearly beyond doubt. Having spoken with Inspector Scott, I expect that she will also want to give evidence about the courage of others on that day.

Your Honour will also hear from other first responders from New South Wales Police and New South Wales Ambulance who will speak to their experiences on 13 April, as well as from Scentre Group security staff, including security subcontractors who were confronted with something that was beyond their imagination.

Consistent with your Honour's instructions to conduct this inquest, being trauma-informed, the counsel assisting team in conjunction with discussions with families has determined not to call civilian witnesses to give evidence of what they observed on 13 April, with a limited exception that I will come to. The Court has the benefit of nearly 250 statements from civilians present at Westfield Bondi Junction and that comprehensively covers their respective accounts. It's therefore, in our respectful submission, not necessary for any of those witnesses to be called to give oral evidence to re-live the events of that day, and indeed it’s the specific wish of families that they not have to do so.

There are two exceptions to that position and that is we will be calling Mr Silas Despraux and Mr Damien Guerot who are likely already known to many. Silas and Damien confronted Mr Cauchi during the attacks and they helped direct Inspector Amy Scott to locate Mr Cauchi. They were witnesses to the eventual shooting of Mr Cauchi, and we understand that both of those witnesses are comfortable to give evidence in this inquest and they'll do so tomorrow.

Finally, with respect to the first two weeks, we will also hear from those members of Queensland Police who interacted with Mr Cauchi in the period

where he was unmedicated and operating outside of the mental health system in 2022 and 23, and that's done with a view of the importance of understanding what more, if anything, could have been done in relation to those interactions. Your Honour also, for the most part, has the benefit of bodyworn video that was turned on by those police officers, so you're able to see how Mr Cauchi was presenting at that time.

We'll hear from police officers about his presentation as opposed to very many members of the public with a mental illness who they are required to deal with on a day to day basis and how to distinguish between those who are in need of more urgent attention, and what resources are available to them in those circumstances.

In week 3, the Court will focus on individuals who were involved in Mr Cauchi's mental health treatment in Queensland. That includes psychiatrists, particularly the psychiatrist who saw Mr Cauchi for over a decade. It includes psychiatric nurses and it includes general practitioners. It's anticipated that this evidence will address the circumstances that led to Mr Cauchi disconnecting from the mental health system by early 2020. Among other matters, as I've already said on numerous occasions, the Court seeks to understand whether there were opportunities to reintegrate Mr Cauchi that were missed or could've been pursued more assertively.

Week 4 will primarily comprise evidence from various experts that have been retained by your Honour and the parties, or retained on behalf of your Honour and the parties. Your Honour will have the benefit of hearing from pre-eminent experts on topics that are of critical importance to the inquest, including from international experts where they are relevant. We acknowledge the dedication of those experts to assist this inquest and prepare the reports so promptly and to take time out of their other work, putting it to one side so that this can be their priority.

I will briefly canvass now those various experts in the disciplines that we will cover. As a security expert, your Honour will hear from Mr Scott Wilson. He's an international expert in counterterrorism, policing, security and crisis management, with over 31 years of policing experience in the United Kingdom. Mr Wilson has previously assisted the commissions of inquiry into the Manchester Stadium bombings and the Christchurch Mosque attack.

Mr Wilson will give his expert opinion as to the preparation and response of each of Scentre, its security contractors, New South Wales Police and New South Wales Ambulance. It's not suggested that this is a terrorist attack, what happened on 13 April, but there are similar type of responses required when you have a mass casualty event and Mr Wilson, we believe, is expertly placed to have assessed the response of those groups just mentioned. He will come to Australia for the purposes of giving oral evidence.

Secondly, your Honour will hear from general practitioner experts Dr Hester Wilson from New South Wales, who has given evidence in this Court on numerous occasions, and Dr Edwin Kruys from Queensland. They will give

their expert opinion in respect to the treatment Mr Cauchi received from general practitioners in Queensland during the period in which he was medicated for his schizophrenia and in the period after medication ceased.

The third category relates to the medical response to the events of 13 April 2024. Your Honour will hear evidence from Dr Stefan Mazur, an expert emergency physician. Dr Mazur will give evidence about the treatment received by those who were fatally wounded by Mr Cauchi. He will also opine on the adequacy of the response by New South Wales Ambulance, acknowledging of course, as in, we do and he does, the difficult circumstances that first responders were faced with.

The Court will hear from Dr Philip Cowburn in response to a new approach to triage known as the Ten Second Triage tool, which has been adopted in the United Kingdom and in some parts of Europe in response to what they have had to deal with by way of mass casualties. It's anticipated that this evidence may offer very important lessons in New South Wales and throughout Australia that can be used in the future management and treatment of victims following mass casualty events.

The last category relates to the psychiatric expert evidence. This inquest will have the benefit of hearing from four expert witnesses whose reports have been obtained by this Court. That is Professor Olav Nielssen, Professor Edward Heffernan, Professor Anthony Harris and Professor Merete Nordentoft. Professor Nordentoft is the one psychiatric expert who is the international expert; she comes from Denmark. Further, an expert report has been obtained on behalf of one of the parties, and that is the report to Dr Matthew Large.

Each of those five psychiatrists are truly national and international experts. They will give evidence in a conclave. Each of the experts will draw on lessons from their own jurisdictions and they'll provide their views on Mr Cauchi's mental health treatment over the course of his life and his mental health as at 13 April 2024. Further, they will seek to identify any missed opportunities that could've resulted in Mr Cauchi's reintroduction to the mental health system. They will express their views on major gaps in our mental health systems in New South Wales and Queensland that allow for people like Mr Cauchi who are experiencing psychosis to fall through the gaps, and they will point to important opportunities for reform and help to shape your Honour's recommendations in that regard.

The final week of the inquest, week 5, will conclude with executive statements. The Court will hear from the CEOs of Scentre Group, security contractors Glad and Falcon, from Scentre Group itself, from the executives of New South Wales Police, the executive of the Queensland Police Force, and the New South Wales Ambulance, all of whom have reflected on the evidence and can provide an outline of what has already been done by their agencies to respond to any perceived gaps and what they think is still to come.

The hearing of this inquest will conclude with statements from families. There's no obligation or expectation in any inquest that families will participate

in that process, however, the counsel assisting team and this Court would welcome family members who wish to speak about their loved ones, who wish to talk about what they've lost and the impact that this has had on them and what they hope can be achieved from the inquest. At all times through the inquest we think of them.

The counsel assisting team is available at any time to speak with families about that and about any concerns they have. Family statements can be read by anyone who the family prefer to do that, including legal representatives or friends or family members themselves, and it can be delivered in whatever format a family is comfortable with. It may be that certain family statements are given in closed court if that's the preference of the families, but we'll come to that process throughout the course of the inquest.

The current intention is that we sit through Monday to Friday of each week, although there are two Fridays that are kept in reserve as overflow days to make sure that we can finish in the five week timetable.

I come now to a brief overview of the evidence that it's anticipated we will hear in the five week period. It will necessarily be high level. The brief of evidence is extensive and it currently spans 50 volumes with approximately 1,700 individual tabs. All of that material once the brief of evidence is tendered will be before your Honour as evidence to inform the issues. In that context, the central purpose of this opening is to contextualise the enormous brief that will be provided and the evidence that will be heard orally.

I'm going to provide an overview of the following matters then in this order. First, the movements of Mr Cauchi on 13 April 2024. Secondly, the response of Scentre Group, New South Wales Police and New South Wales Ambulance. Thirdly, Mr Cauchi's mental health, his mental health treatment, why that ceased and the events that led to him falling outside the mental health system.

I come now to the tragic events of 13 April 2024. During the directions hearing last year, I provided a brief synopsis of those events. Investigations have continued since that time and the counsel assisting team, with the benefit of the material and statements contained within the brief, including the extensive CCTV records, have a clear and detailed understanding of the actions of Mr Cauchi on that day, as well as the responses of the various agencies involved.

It is necessary for me to once more go through those events but at a high level and trying to be as sensitive as I possibly can, and without granular detail. But even at a high level, we understand it's extremely difficult for the families, and can I take the opportunity to note again that families should feel free to move in and out of the courtroom as they please. We'll also seek to provide warnings in advance of any evidence that may be considered distressing, and no doubt legal representatives at the bar table will do the same. I'll show a number of slides during this opening. None of them are of sensitive material.

It's impossible, however, to sanitise completely what occurred. One of the

reasons for providing a broad outline at all of what occurred on 13 April is because we are not calling any civilian witnesses, and we're not calling most of the first responders, so this is the only time that I anticipate the overview will be given. In the case of each of the victims who passed away, your Honour determined that only an external examination was required by the pathologist who performed the examination. The medical cause of death is set out in those reports in one line as either a stab wound or wounds to various parts of the body, and I don't need to say any more than that.

While the events of 13 April are marked with tragedy, there are also instances of hope and courage and selflessness by untrained civilian bystanders who, in circumstances of uncertainty, and with no guarantee as to their own safety, provided first aid and comfort to victims. I won't identify any of those particular individuals but I am conscious that today some of them are listening on the livestream. It's expected that Detective Chief Inspector Marks might canvass broadly how those individuals are recognised either when he gives evidence today or at the end of this inquest.

The expert psychiatric evidence is clear and unanimous that Mr Joel Cauchi was floridly psychotic on 13 April 2024. The accounts of several civilian witnesses who interacted with him in the days prior and those who interacted with him on 13 April accord with that assessment, and it's consistent with the progress of his mental illness which was first diagnosed when he was a teenager, and which was untreated and largely unmonitored in the four, nearly five years leading up to this tragedy.

Expert toxicology evidence suggests that Mr Cauchi had been using cannabis or marijuana in the days preceding his death. The use of marijuana also preceded Mr Cauchi's initial diagnosis of schizophrenia in 2001 which I'll come to later in this opening. I expect the Court will hear expert psychiatric evidence that use of cannabis would likely have exacerbated the psychotic symptoms that Mr Cauchi was experiencing around 13 April but, conversely, expert evidence is also likely to shed light on the fact that use of cannabis may be a symptom of schizophrenia or psychosis.

As to whether there was any planning or motive to the attacks on 13 April, police investigators have reviewed numerous records from the phones belonging to Mr Cauchi, including his web browsing and messages. Those records are distressing. They demonstrate that Mr Cauchi was a person who was extremely unwell. Searches on his phone indicate that from at least around 2022, Mr Cauchi was preoccupied with weapons, with violence and with mass killing.

There is certain evidence suggesting that Mr Cauchi's actions on 13 April 2024 may have been the subject of rudimentary planning for these reasons. First, he had, in the years prior to 2024, purchased several KA-BAR USMC knives, known as KA-BAR knives, one of which was ultimately used at Westfield Bondi Junction on that day. On 24 February 2024, Mr Cauchi purchased the KA-BAR USMC knife that he was to use on 13 April 2024 from a Tentworld store in Punchbowl.

Second, leading up to the attacks, Mr Cauchi made a note on his phone, which is dated 25 January 2024, that read, "Call knife sharpener and confirm it doesn't need sharpening for mall use", and on 12 February 2024, he made a note to "Check out malls and also where to run". Other notes made by Mr Cauchi that are dated 31 January 2024, 3 February 2024 and 14 February 2024, all suggest that he was planning a strike, or an attack.

I interrupt myself to note that that is very different to how Mr Cauchi presented or behaved or appeared to think when he was medicated.

Third, the browsing history on Mr Cauchi's mobile phone, beginning in around late 2022, suggested a preoccupation with death and murder. There are bookmarked pages on serial killers, searches containing mass stabbing incidents in Australia, and searches in relation to serial killers. That is all in the days leading up to the attack. Mr Cauchi also searched for information concerning the Columbine shooters on 13 April.

However, apart from this insight into Mr Cauchi's inner turmoil, there is no direct evidence indicating any motive associated with his plans. I will repeat that. So, apart from that insight into Mr Cauchi's inner turmoil and his dark thoughts leading up to this incident, there is no direct evidence indicating any motive in relation to what happened.

What those records unequivocally show is a man who was seriously unwell; who was far from home; and far from the watchful eye of his parents who had previously been able to keep him linked in with health services over such a long period. From the time that he was a teenager to when he was about 36 years of age, his parents had been able to keep him linked in with services while he was living with them. But by 2024, Mr Cauchi was 40 years old, homeless in Sydney, completely detached from the mental health system.

He did have sporadic exchanges of text messages with his parents, including one on 9 April 2024 about registering his car, but there was nothing to alert his parents to just how sick he had become. They knew he was sick when he returned to live with them in early 2023, and they informed police of that when police came to their house. But Mr Cauchi did not, at that stage, have any history of violence, and his parents were not aware of just how dark his thoughts had become towards the end of what was obviously a downward spiral, and the Court will hear about that.

It is not proposed that any of the dark material he was researching will be released to the public. It's enough in terms of the public interest that I have provided a broad overview, in my respectful submission.

On the morning of 13 April, Mr Cauchi was sleeping outside at Maroubra. By that time he was homeless, although he had suggested to his parents in text messages that he was in a hostel. In fact, he was not. He was far removed from any support networks. His limited contact with any other humans was largely transactional for the purposes of him getting food or drugs, or getting

his belongings.

At 6.26am that morning, Mr Cauchi packed up his belongings and left Maroubra Beach. He appears to have spent the night in the toilets, or near them. He travelled by bus to the Kennards storage facility in Waterloo and arrived at 7.30am. He went to a locker he had rented. The evidence in the brief indicates that he was a frequent user of Kennards facilities across various locations, and there is CCTV in that location so we can see what his movements are.

Between around 8.20am and 8.30, that CCTV footage, which has been obtained with the co-operation of Kennards, depicts Mr Cauchi, amongst other things, taking a knife out from a box and inspecting it. It also shows him placing the knife in and out of different bags.

At 9.03am, Mr Cauchi left Kennards Waterloo and travelled to Bondi Junction by train. It doesn't appear that he took a knife with him on that trip. He briefly interacted with a shop attendant at a restaurant near Bondi Junction before returning to Kennards Waterloo by train. He entered Kennards Waterloo at 11.09am and proceeded to take a backpack containing a knife from his locker.

From the evidence in the brief, we know that that knife was designed for utility use during World War II. It was created to replace the fighting knives of World War I. It is a knife with wide distribution, and one that is mass produced. There is only one authorised importer and distributor into Australia, but it is available for sale in Australia from various outlets, primarily outback supply and camping stores. The knife weighs 317 grams and has an overall length of 30 centimetres. The blade itself is 20 centimetres long. I expect your Honour will hear further evidence about that knife and its legitimate uses, and how it is sold, and whether there can be any restrictions on its sale, or should be.

At 11.31am, Mr Cauchi left Kennards Waterloo with a backpack containing the knife, and he travelled again to Bondi Junction by train. Shortly after he arrived, he fell to the ground outside a store on Oxford Street Mall and righted himself. It is not clear why he fell. He then walked around Westfield Bondi until around 1.15pm.

He next travelled to Bondi Beach by bus arriving at 1.25pm. We believe he then slept for a short time on the beach. At 2.10pm he returned to Westfield Bondi Junction by bus and got off at 2.25pm. At 2.48pm, he bought food and drink, and then walked around Westfield Bondi Junction, at times exiting the building. The CCTV evidence depicts him walking around the shopping centre in what appears to be an aimless manner.

At 3.22pm and 29 seconds, Mr Cauchi re-entered Westfield Bondi for the last time. At around 3.30pm, while Mr Cauchi was on level 4 of Westfield Bondi, he headed towards the Sourdough Bakery. It will be obvious that I am about to refer to the first victim and some very sensitive material. As I have said, I will do so in the minimum detail possible. I am mindful that your Honour has a statutory function to make findings in relation to manner and cause of death,

but I certainly don't need to go into any specific detail.

The first and youngest victim who was killed by Mr Cauchi was Ms Dawn Singleton. She was only 25 years old and a much loved daughter, sister and fiancée. Mr Cauchi walked towards the Sourdough Bakery and stood in line behind Ms Singleton. He removed the knife - that's the KA-BAR style USMC combat knife I have just described - from the backpack and Mr Cauchi then stabbed Ms Singleton. She suffered multiple stab wounds.

Two civilians were waiting for their coffee order at the time of the attack. They immediately ran to assist Ms Singleton, helping her to lie down, and using a cloth to apply pressure on her wounds. Another male was in Country Road nearby to the Sourdough Cafe when he heard the screams of others and went straight to Ms Singleton's assistance. Another woman quickly came to Ms Singleton's aid and provided initial first aid, and she called triple-0 to provide critical information to police.

The two males I have already referred to, who were in the line, continued to provide assistance to Ms Singleton until the arrival of New South Wales Police. They were briefly interrupted by Mr Cauchi re-approaching the Sourdough Bakery, and they both exposed themselves to unknown danger in order to provide care to Ms Singleton. They stayed with her, even after hearing the gunshots.

Another member of the public, who had been shopping with his family nearby and saw some of what occurred, rushed out to assist Ms Singleton and the men who were helping her. He armed himself with a chair that had metal legs, which was the only thing available to him, and he guarded that group in the event that Mr Cauchi returned. None of those people knew each other. In the statement that one of the men who had assisted Ms Singleton wrote, he said:

> "The man that came out of Country Road seemed to come out of nowhere. His wife was in the Country Road store, and I later worked that out when I saw them together. That man held the neck of the chair and the legs outward. He came from the shop and said, 'I'll fight him off for you guys if he comes back', and I thought he was really brave because he saw what we were trying to do to help the woman."

New South Wales Police were the first emergency responders to attend to Ms Singleton at 3.39pm. They tried to assist her in relation to her wounds, and they opened her airway and continued CPR. They continued to assist her until New South Wales Ambulance arrived at approximately 3.50pm. New South Wales Ambulance then assessed Ms Singleton's injuries. They understood that she had clearly suffered multiple stab wounds, and they were able to assess at that time that, tragically, she had passed away.

The second victim was Ms Jade Young. Jade was an accomplished architect, only 47 years of age. Mr Cauchi attacked Jade at 3:33:01pm near the

RM Williams store, a short distance from the Sourdough Bakery. She suffered a single stab wound to the left of her back. As is well known by this time, Jade was with her daughter at the time that she was attacked. After the attack, her daughter used her mum's phone to contact her dad, who was also at Westfield Bondi Junction. After being notified, her dad, Noel McLaughlin, made his way to level 4. During that time he encountered Mr Cauchi. He warned others that Mr Cauchi had a knife before running to find his wife. He found Jade outside the RM Williams store and Noel commenced CPR with the assistance of two bystanders.

New South Wales Police attended on Jade at 3.39pm and further officers attended shortly thereafter to assist in managing her wounds and continuing CPR. New South Wales Ambulance attended on Jade at approximately 3.47pm and, despite their best efforts, she did not regain consciousness and Jade was declared to have passed away at the scene.

The third victim was Yixuan Cheng. She was 27 years old, in Australia completing a Masters of Economics at the University of Sydney. On 13 April she had just finished an exam and had decided to go shopping at Westfield. Mr Cauchi stabbed Yixuan at 3.33 and 17 seconds outside the Peter Alexander store on level 4. Yixuan was attended to by New South Wales Police officers and civilians within the shopping centre.

An off duty lifeguard was shopping in Myer when he was told by an employee that someone was stabbing people outside. Shortly after that, the roller doors were shut to lock shoppers inside for their own safety, but when he looked outside of the doors, he could see that a woman had been injured and he asked for the doors to be opened so that he could slide outside and assist.

One of the persons he assisted was Ms Cheng, who was being attended at that stage by New South Wales Police officers and then ambulance. New South Wales Ambulance attended to Ms Cheng at around 3.48pm. They determined that she had not been conscious or breathing since their arrival, so following assessment, she was declared to have passed away. The medical cause of her death was a single stab wound to the central chest structures.

Despite the fact that she had been declared to have passed away, there were subsequent attempts at resuscitation by later arriving New South Wales Ambulance crews. Obviously they were to no effect, and I will return to the further efforts of CPR made later in the opening, and it is a topic that will be explored. That is the relevance of the Ten Second Triage tool and what might be learnt from these circumstances so that everybody who can be helped can be helped within the optimal period of time.

The fourth victim was 38 year old Ashlee Good. Ms Good originally qualified as an osteopath before having a career change and moving into a corporate role as an executive in 2022. She was shopping at Westfield Bondi Junction with her baby daughter who her and her partner, Daniel Flanagan, had welcomed into the world in 2023. Ms Good was stabbed at 3.34pm near AJE Athletica on level 4 of Westfield Bondi. At the time she was stabbed, as

the public well understand, she was pushing her daughter in a pram.

After Mr Cauchi attacked Ms Good, it caused her to stumble away from the pram and he then proceeded to stab her infant daughter, who survived the attack, incredibly. Despite her wounds, and in an act of what was tremendous and instinctive courage, Ms Good confronted Mr Cauchi. She was able to defend her child and to save her child's life.

Following that attack, bystanders called Ms Good, who was carrying her daughter, into the nearby Tommy Hilfiger store, and once inside the store, they attempted to apply pressure and assist her in terms of the bleeding from her wounds. Ms Good contacted her mother-in-law who was at the shopping centre, and she made her way to assist her daughter-in-law and was there to comfort her and her granddaughter in the midst of that fear and uncertainty.

New South Wales Police and Ambulance both attended on Ms Good at around 3.45pm. She had suffered multiple stab wounds. New South Wales Ambulance deemed that she was in a critical state and deteriorating. They evacuated her from Westfield Bondi Junction and transported her to St Vincent's Hospital at around 3.54pm. Upon arrival at St Vincent's at 4.04pm the surgical team undertook emergency surgery but despite those efforts, tragically, Ms Good was declared deceased at 4.29pm. Mercifully, and thanks to the efforts of those emergency staff and ambulance, the baby survived.

Faraz Tahir was the fifth victim on that day. He was 30 years of age. Faraz moved to Australia in December 2022 and had been working in the security industry. As I've already said, Scentre contracted various subcontractors for the provision of security guards at Westfield Bondi Junction and Faraz was employed as an ad hoc security guard by Falcon Manpower Solutions, which is a subcontractor of Scentre's primary security subcontractor at Bondi Junction, which is called Glad Group. That is why, of course, we have at the bar table Scentre, Glad Group, and Falcon.

It was Faraz's first shift at Westfield Bondi Junction. Faraz was stabbed once in the abdomen by Mr Cauchi at 3:34:24pm. At that time Faraz and his colleague, Muhammad Taha, were responding to a notification of a code black from another security guard, so the pair had been directed towards the Sourdough Bakery by civilian bystanders. A code black situation involves a personal threat, including when an armed person is threatening to injure themselves or others. After his attack on Faraz, Mr Cauchi stabbed Muhammad.

Faraz was attended by New South Wales Police Force officers at 3.41pm. They used bandages to apply pressure to Faraz's wounds. His breathing was shallow and they found a soft pulse and continued to comfort him until paramedics arrived. Paramedics attended on Faraz at around 3.58pm. By that time, he was in a critical condition. They initially treated Faraz in the air bridge on level 4 of Westfield Bondi Junction.

At around 4.07pm, they transported him by stretcher to an ambulance outside

Westfield Bondi Junction. There, there were two doctors who could attend on Faraz and they performed emergency surgery on him. Despite their best efforts, they were not able to stabilise Faraz and he was pronounced to have passed away at the scene at 4.24pm. The cause of his death was the single stab wound to the abdomen. Faraz was thrust into an unprecedented and serious situation on his very first shift, but he nonetheless continued towards an unknown danger. That demonstrated great courage and selflessness on his part and the part of his colleague.

A person who was shopping nearby in the Sourdough café has provided a statement and says that she felt relief when she saw Faraz and Muhammad heading towards the café. In her words, "They appeared so calm which helped me feel calm". She will remember Faraz as a hero walking towards Mr Cauchi and in danger. Others understandably ran and took shelter as they were directed to do so, but we know that there was nothing that the security guards could do to assist shoppers on that day when they were unarmed and they were facing that weapon that Mr Cauchi was holding.

The sixth and last victim was Pikria Darchia. She was 55 years old. She had arrived in Australia from her native country of Georgia in around 2012, and she came here with one of her two sons. Both of her sons have been involved in assisting to prepare for the inquest. Ms Darchia was stabbed multiple times by Mr Cauchi at 3:34:50 seconds. That was around the vicinity of the Chanel boutique store where she'd run to. By that time, Mr Cauchi had crossed the level 4 air bridge above Oxford Street and had headed into the northern building at Bondi Junction.

After she was attacked, Ms Darchia made her way into the Chanel boutique store where she collapsed. It was apparent to the civilian bystanders that Ms Darchia's wounds were extremely serious. Witnesses inside the Chanel boutique store report that she suffered rapid blood loss and almost immediately lost consciousness. New South Wales police were directed to the Chanel boutique store and arrived at 3.51pm. They couldn’t obtain a pulse at that stage, but they commenced CPR in any event. Ambulance arrived at around 4pm and they assessed, but tragically she was unconscious, she wasn't breathing, she didn't have a pulse, and Ms Darchia was declared to have passed away soon after.

In addition to the attacks on each of those six persons who passed away, there were ten civilians who were attacked and injured by Mr Cauchi on 13 April 2024. That I have not referred to them in detail in this opening is in no way to diminish their suffering, or that of their friends and relatives, whether on 13 April or in the period after. Some of them were very seriously hurt and a number of them very nearly passed away. We acknowledge their trauma and its ongoing impact.

With the exception of two of those individuals, who are content for their names to be published if required, the remaining eight victims prefer not to be named, and prefer to be referred as pseudonyms during the proceedings where it is necessary to refer to them, and it may not be necessary.

So it will be evident that in just over three minutes Mr Cauchi had stabbed 16 people, six of whom did not survive the attacks, and others who nearly did not survive the attacks, and I think that is the last time I will have to run through those details.

The investigation team have prepared plans of all three levels at Westfield Bondi Junction which outlines the route that was taken by Mr Cauchi and the location of those who were injured. The plans also depict the route that was taken by Inspector Amy Scott after she arrived at Westfield Bondi Junction, including the foot pursuit that she undertook leading to Mr Cauchi which I'll refer to shortly.

Your Honour will then be able to note the distance travelled by Mr Cauchi throughout the shopping centre, and the locations where each of the victims were injured, and it's spread across levels 3 and 4 of the centre. I'm going to briefly display on screen, but not on the livestream screen, those maps, so that parties know that those maps are available in the event that that becomes relevant when we are examining or cross-examining witnesses.

So there are obviously close-ups available of these maps. They depict the movements of Mr Cauchi, the positions of victims, and the movements of Inspector Amy Scott. They might be relevant to timings, for example, of when New South Wales Ambulance or police could get to victims to assist them. I'm about to move onto the section where Inspector Scott responded to Mr Cauchi. I might do that and then ask your Honour to break for the morning tea.

HER HONOUR: Certainly.

DWYER: Based on the evidence in the brief, it appears that the first call to police was made at around 3.34pm. The caller indicated at that stage that there was a knife attack in Westfield Bondi Junction and that people had been stabbed. Inspector Amy Scott was the first police officer to respond at around 3.35pm. Inspector Scott was the tactical duty officer at the Eastern Suburbs Police Area Command on 13 April 2024. At the time of being assigned to the call she happened to be in the vicinity of Bondi Junction undertaking other duties, having made her way around various police stations that morning.

Inspector Scott entered Westfield at 3.37pm and 14 seconds. So going back a step, she was the first unit to respond at 3.35pm. She happened to be in that area attending to other duties, and she entered Westfield as soon as she humanly could, at 3.37pm and 14 seconds. She drove her car there, jumped out and then followed her training in terms of what was required in dealing with an active armed offender. That is, to stop the killing and to stop the dying. That's how police are trained. Without waiting for backup, she immediately entered Westfield Bondi Junction where she was directed by civilian bystanders to go up the escalator to level 5 because they had seen Mr Cauchi just enter the escalator.

Inspector Scott then started a foot pursuit of Mr Cauchi, with the assistance of

the bystanders who were directing her. Inspector Scott told the bystanders to stay behind her but to show her where he had gone. There are a number of visual aids to assist to understand what happened, including police having done a fly-through video and reconstruction. I won't show them now but I may return to them in the evidence of the officer-in-charge of this inquest, Chief Inspector Andrew Marks, and the evidence of Inspector Amy Scott.

Inspector Scott's foot pursuit continued to the sky bridge on level 5. At that time, Mr Cauchi paused and turned around. At 3.38pm and 12 seconds, Inspector Scott ordered Mr Cauchi to drop the knife. He didn't do so and she drew her firearm. She then had the situational awareness and presence of mind to direct a woman who was sheltering behind a pot plant with her young children to get away from the range of fire and to run. She also moved bystanders back behind her to protect them, and she repeatedly directed Mr Cauchi to drop the knife. She was mindful of him and everybody else around her to make sure that they weren't killed by a stray bullet if she had to engage him.

Seconds after she'd given those directions, Mr Cauchi then began to run towards Inspector Scott at speed and downhill. At 3.38pm and 33 seconds Inspector Scott fired three shots from her police-issued firearm. Two of those three bullets struck Mr Cauchi in the shoulder and the neck, causing him to collapse on the floor, only 6 metres or so in front of Inspector Scott. It is uncontroversial that the quick and courageous actions of Inspector Scott on 13 April 2024 saved the lives of many others in Westfield Bondi Junction. The ongoing threat that was posed by Mr Cauchi was immediately stopped.

After discharging her weapon, Inspector Scott reholstered her firearm and approached Mr Cauchi, putting him into the recovery position, removing the knife that was underneath him, and then working out what was required by way of CPR. New South Wales Police Force officers attended on Mr Cauchi very soon after and commenced CPR at 3.42pm. He was pronounced deceased when paramedics attended at around 4pm.

I expect your Honour will receive evidence that the use by Inspector Scott of her firearm was consistent with New South Wales Police training and policy. In the circumstances confronting Inspector Scott, there can be no doubt that lethal force was the only available option, and further evidence about that will be led through Chief Inspector Andrew Marks this afternoon. Is it convenient to pause there for a break your Honour?

HER HONOUR: We'll take the morning adjournment and resume at 11.50.

SHORT ADJOURNMENT

DWYER: While 13 April 2024 was a terrible day of fear and sadness, there were, as I have already alluded to, many instances of exceptional courage and compassion from those who were simply caught up in the events. They, like so many at Westfield Bondi Junction, in terms of the staff, had little awareness of what was unfolding as Mr Cauchi continued with the attacks. They didn't

know if he was the only offender; they didn't know if he had a gun; they didn't know if this was a terrorist attack; and they didn't know what would happen next. But despite that, for many people, their focus was on helping those who had been injured.

When I started preparing the opening I had started a list of persons who could be put into that category, whose acts of selflessness were overwhelming. But there are simply too many to list, and then I fear missing those who might not have prepared a statement. Can I simply say, there were so many people who were called on to do something exceptional that day who rose to the task.

There were also many instances of retail assistants acting with a clear head, and at least projecting calm when they must have felt anything but, while they locked down stores to protect customers. Many grabbed people from outside the store to bring them inside and to shield them from the attacker. Many of the civilians also comment in their statements on the bravery of staff in shops who took action quickly and who comforted the terrified customers, or who assisted with first aid as required.

In many instances, the staff who were employed at those stores are very young and they are casual employees who could never have imagined that they would have been caught up in an attack like that. Their response on the day was even more impressive in those circumstances. Staff and customers alike comment on the efforts of many others, and particularly very young people who assisted. Included amongst those people are the very young police officers who ran in after Amy Scott and who assisted to try and make sure there was no second attacker, and to attend to the wounds.

I turn now to the security response to the events at Westfield Bondi Junction on 13 April. The operator of Westfield Bondi Junction, called Scentre or Scentre Group, does not directly employ or otherwise provide security staff at its centres. Rather, the Scentre Group enters into subcontracting arrangements with third party security service providers. At Westfield Bondi Junction, Scentre engages Glad Group to provide specialist security services. Glad further contracts, or subcontracts, with other companies who provide security staff on what is described as an ad hoc basis. That includes Falcon Manpower Solutions, the company I have mentioned earlier, who provided certain of the staff on site on 13 April, including, as I have already noted, Faraz Tahir who was employed for the first time that day.

Scentre Group had policies and procedures on how to respond to an active armed offender - I have used that term previously and I will use it again: AAO or active armed offender - and they had policies and procedures to ensure the safety of occupants, property and Scentre Group during an emergency, or to try to ensure the safety. Scentre provided relevant training for its staff, and that included multiagency exercises with New South Wales Police and New South Wales Fire and Rescue, the last one of which was held in October 2023.

A key aspect of the security of Westfield Bondi Junction is achieved through CCTV monitoring. That takes place from a CCTV control room. The control

room is located underground on parking level 4 at Westfield Bondi Junction. I will show a slide here because I anticipated that what went on in the CCTV room, I anticipate, will be a subject of evidence. What we see there is a snapshot, or photograph, of the CCTV room earlier in the day, some time around 2pm, on 13 April. You will see, unsurprisingly, it is a room full of television screens. It is also a room which has a CCTV camera focused on it so that the movements and reactions of staff within the room are recorded. The room has changed slightly since 13 April 2024, and your Honour and those at the bar table have had the opportunity to see what that looks like on an earlier view.

On 13 April, two members of the Glad security team were working in the CCTV control room, one male and one female. Since your Honour has granted a non-publication order over their names, I will simply refer to them as Control Room 1 for the female operator, and Control Room 2 for the male. On 13 April 2024, there was no requirement in any policy of the Scentre Group that there be more than one person in the CCTV room at any one time.

Evidence in the brief, including statements and that CCTV footage I was referring to, shows that Control Room 2, the male security officer, left the CCTV control room at around 3pm with his supervisor to undertake training up on level 13 of the centre management control room. That left only CR1, the female security officer, who had commenced work at 6am and was rostered to stay in the control room on a 12 hour shift until 6pm. At 3.32 and 15 seconds, CR1 left to visit the bathroom, which is situated a few metres outside the control room. From that time on until 3.34pm - that is a period of some one minute and 45 seconds - there was no active CCTV monitoring in place at Westfield Bondi Junction.

It just so happened that exactly 40 seconds after CR1 left for the bathroom, at 3.32 and 55 seconds, Mr Cauchi attacked Ms Singleton, the very first victim, and over the next 30 seconds Mr Cauchi attacked a further six individuals. A number of Scentre staff located in the centre management control room on level 13 were alerted to the attacks at around 3.33:32pm. These timings will obviously be of some considerable significance during the inquest.

So a number of security staff up on level 13 where the training was going on to alerted to the attacks at 3:33:32pm. Based on the evidence in the brief it appears that this notification most likely came from a security guard who was located on level 5 and saw Mr Cauchi attack someone near Cotton On, Lululemon and Myer, and who signalled a code black via radio.

The staff in the centre management control room left that level in response to the alert, and other security staff throughout the centre also responded. CR1, the female control room operator I referred to who had been at the bathroom, is seen re-entering the CCTV control room at around 3:33:55pm. She was out of the room for one minute and 40 seconds. During that time, Mr Cauchi had attacked eight individuals, three of whom would die from their wounds. Active monitoring of CCTV footage did not resume again until 3.34pm at around the time that Ms Ashlee Good and her daughter were attacked.

That the CCTV room was vacant at the time of the attacks appears to have impeded Scentre's initial response. It meant that during the initial phase of the attack, where the prompt collation of information is crucial to providing situational awareness, security staff were effectively behind the eight ball. That is, they were then playing catch-up to understand what was unfolding. CR2, the male control operator, re-entered the CCTV control room at 3:36:40. By this stage, 16 individuals had been stabbed by Mr Cauchi. Despite it being nearly four minutes after the attacks commenced, there does not appear to have been any communication from the CCTV control room, nor any alerts to members of the public in the centre.

This initial response by Scentre was also impacted by the following factors. First, based on the available evidence, I expect your Honour to hear that the initial contact and exchange of information between the CCTV control room and emergency services occurred approximately ten minutes after the attack, about four minutes after Mr Cauchi had been shot by Inspector Scott. The security expert that has been retained by the Court, Mr Scott Wilson, has analysed this call that came from the security room and expresses the view that the quality of information supplied during that triple-0 call to police was not what would be expected from professional security personnel.

I pause to note that of course other people within the centre had made triple-0 calls. That's how Inspector Scott came to be on the scene so quickly. But the first exchange of information from the CCTV control room and emergency services occurred approximately ten minutes after the first attack, and after Mr Cauchi had been shot dead.

The centre management emergency override system, or CMEO, is something that your Honour will hear a significant amount of evidence about in the inquest. The CMEO system displays warning on all electronic billboards present in Westfield Bondi Junction. The CMEO system is pictured here, that is the one from level 4 at the time, and I'll describe what you can see for those who can't see it from where they are sitting.

On screen is a picture of the CMEO activation system located in the CCTV control room on level 4. Your Honour would note six buttons on that photograph which include one yellow button that is marked "armed offender". Another button that is blue and marked "Evac all" and there are other evacuation buttons for specific areas within the centre. An alarm or alert or button, whatever we call it, was not activated until 3.39pm, again, after Mr Cauchi had been shot. It also appears that rather than using the CMEO system to warn customers of the presence of an AAO, or armed offender, security staff instead activated the evacuation alert.

I'll say that again to be clear. Your Honour will see a series of six buttons going down in a row that can be pressed to activate particular warning alerts that go out throughout the centre. I expect your Honour will hear that what should have been pressed in response to information about Mr Cauchi's attack was the armed offender alert, but instead what was pressed was an

evacuation alert, and that was only pressed after Mr Cauchi was shot dead.

While this error was later recognised, attempts at correcting it were unsuccessful because an evacuation override was already in place, and your Honour will hear the evidence, of course, as to why that happened and what barriers there were to correcting it. Ultimately, of course, Mr Cauchi was deceased by the time of the alert, and fortunately there were no other offenders. But appropriately warning customers and staff is clearly one of the key functions that an operator of a commercial or public space can implement in response to an active armed offender, and it appears clear that that did not occur promptly on 13 April, and did not occur in the way that it should have done.

I'll just for assistance to see now slide 5. That's an image of the signage that goes up in the event of various alerts being made. In the event of an evacuation alert, you'll see there a billboard that says, "Attention emergency evacuation. Please evacuate the centre" and gives further details. On the left-hand side in the top left is what should happen if there is an active armed offender, and it says, "Attention armed offender, escape, hide, tell". Then as your Honour will hear, the operator can then give specific instructions to customers in the event of an active armed offender.

The first public announcement that was made from the control room was not made until around 3.52pm. It occurred from the fire control room located externally to the CCTV control room. What's displayed on the screen there is a photograph of a large electrical system, and on the left-hand door, we see a poster with specific instructions that are available for the control room operator to read from in the event that there is an active armed offender, or an evacuation is required.

Your Honour will hear evidence about what the mechanisms are in this room, what announcements were made from there - that is the fire control room as opposed to the CCTV room - and I expect your Honour will hear that one person from the control room on level 4 was directed to go there, to the fire control room, by another, and to make an announcement and that person did so, but they made an announcement in relation to an evacuation rather than an armed offender. That was almost 20 minutes after the start of the incident and 14 minutes after Mr Cauchi had been shot by police.

Witnesses within Westfield Bondi Junction recall that CR1, the CCTV control operator who was tasked with making public announcements, sounded distressed and distraught, so much so that they weren't sure whether that person had actually been taken hostage in some circumstances. As a result, there were concerns from civilian bystanders that that person might have been making the announcement under duress, and they weren't sure whether they could trust the announcement that was being made.

The instructions provided in the public announcements were also inconsistent with later advice provided by emergency services and retail staff. So while the PA announced that all bystanders should evacuate the centre, New South

Wales Police were advising that it was still an active situation and people should remain in place. Similarly, certain shop attendants advised bystanders that they should not evacuate around that time.

That will all be the subject of evidence. A copy of the scripts for the broadcasters that are available, or were available at that time, is being displayed currently on screen. They were on display on both the CCTV control room and the fire control room. Your Honour will see there is literally a script for control room operators to read, and in this case I expect you will hear that the control room operator who went there read verbatim from the script in a distressed voice, advising about evacuation in a way that may have led to confusion.

Can I say again two important things, so that this evidence is not misconstrued. Firstly, Mr Cauchi had been shot about 15 minutes prior, so it's not suggested that that level of confusion at that stage, at the 15 minute mark, made a difference to who could have survived. Secondly, clearly these are individuals who had never been through something like this before, so it is natural that stress in some circumstances is overwhelming, or might be. But it is important in our submission to learn from the mistakes that have been made here.

The third issue is that CR1, the female within the control room, called triple-0 at around 3.36pm, but it's very unclear what the timing is of the contact she made with a triple-0 operator, and that issue of confusion will have to be explored and explained during the inquest.

Many customers and first responders reported that the emergency alarms, once activated, were extremely loud and they impaired effective communications. The impact of the volume of the alarm upon the response of New South Wales Police and New South Wales Ambulance will be explored in the evidence in the coming weeks.

Communication from the CCTV control room to both security staff and first responders might appear overall, from what I've said, to have been ineffective, but that's in part exacerbated by issues faced by New South Wales Police and Ambulance first responders, and the paucity of the information that they exchanged may have contributed to the declaration of Westfield Bondi Junction as a hot zone by New South Wales Ambulance, and I'll return to that issue shortly.

As I have tried to make clear, the potential consequences that may have flowed from those communication issues were ultimately avoided by the quick and effective action taken by Inspector Amy Scott. However, if that had not occurred, if she had not been on the scene so quickly, there's a real possibility that Mr Cauchi's attacks would have continued unabated for a further period, with some civilians and security staff unaware of what was unfolding, including the critical need for them to evacuate or locate themselves and others to safety.

The response by Scentre and its security subcontractors, what could have been done differently, and what changes to policies, procedures and training have been implemented as a result of the events of 13 April are all issues to be explored further during this inquest, and they are issues of importance to families. I expect your Honour will hear that there have been proactive steps already taken to remedy some of the issue outlined, and we understand that interested parties are open to hearing other suggestions for improvements that emerge from a review of the evidence, particularly from the expert evidence that will be called.

I come now to the response of the New South Wales Police Force, some of which I have already touched on. Shortly after this tragedy unfolded, parliament sat for the first time, and in those few weeks after, Premier Minns acknowledged the way that strangers came together to assist each other that day, and he acknowledged the extraordinary work of first responders, police and ambulance, and the crew of staff at hospitals nearby. Premier Minns spoke of the importance of acknowledging that we ask a lot of our police in these circumstances. In volatile situations they are sent in as law enforcers, as peace keepers, and sometimes, as he acknowledged, as social workers, but always on the front line.

The premier acknowledged that they do a complex job in very difficult circumstances and that split second decisions need to be made almost every day. I've already explained that Inspector Scott quickly identified and shot Mr Cauchi three minutes after accepting the assignment, and just over a minute after she entered Westfield Bondi Junction. Mr Scott Wilson, the security expert, expresses his opinion that on any view, this is an exemplary response.

I've already said, and can uncontroversially foreshadow, that counsel assisting will be submitting to your Honour that Mr Wilson's opinion would be accepted, but it wasn't just Inspector Scott who risked her life on that day. New South Wales Police attended Westfield Bondi Junction with speed. They had a number of officers on the scene. They attended soon after first notification and the majority of those officers provided first aid or assisted with the ad hoc evacuation of civilians which was underway.

Many of the first police crews on scene were junior officers, each of whom acted with enormous courage and professionalism in chaotic and violent circumstances, described by some as nightmarish. The contribution of those officers, and particularly the crews attending in the first hours are worthy of acknowledgement and commendation. A number of civilians comment on how impressed they were at the time. I anticipate that the officer-in-charge, Detective Chief Inspector Marks, may wish to give evidence on how they can be acknowledged. They restored a degree of order and safety to the frightening scenes at Westfield Bondi Junction and they performed first aid in extraordinary circumstances.

There are areas for potential improvement that emerge from the evidence for them and for each of the first responders. One such issue is confusion

amongst first responders as to whether there was the second offender present at Westfield Bondi Junction, and that's really the most significant issue in terms of the first responders' issue of communication. The possibility of a second offender ultimately led to the declaration by New South Wales Ambulance that Westfield Bondi Junction was a hot zone, and that resulted in paramedics being ordered to leave the centre and stand down pending further direction. That happened at around 4.30pm.

Fortunately, by that time, all the patients had in fact been evacuated, so it's not suggested that there was any loss of life as a result. The relevance of this is as a learning exercise in the event - and we hope there never will be another one, but in the event that a mass tragedy like this happens again. If there had been any severely injured individuals in need of urgent medical attention, any form of lockdown or restriction on access by first responders would obviously have the potential to compromise care and could've had a catastrophic consequence. Fortunately it did not.

It appears that the confusion came about in part due to poor communications between Scentre Group and New South Wales Police. It'll be clear from what I've already said that by 4pm, Inspector Amy Scott was certain that there was only one suspect and she had shot him. Based on the evidence of the brief, it appears that a review of that information occurred inside the CCTV control room based on the CCTV footage.

By around 4pm, I expect the evidence to show Scentre staff and security had ascertained that there was only one suspect. However, there was no effective mechanism in place for the sharing of accurate and timely information between the agencies on the ground in that terribly confused state. Better communication between New South Wales Police and the Scentre Group staff may have avoided that confusion, and that's what parties have been looking at over the last year as we piece together these events to see what can be done to work together to avoid it.

Related to this, there were also issues concerning the coordination between Scentre, New South Wales Police and New South Wales Ambulance and the sharing of information that's important to learn from. In particular, I expect your Honour to hear that there was confusion as to the location of an overall incident command post to be used by both New South Wales Police and New South Wales Ambulance, with New South Wales Ambulance staging at Oxford Street between two Westfield buildings, and the police staging a command post in a loading dock in Gray Street off Bronte Road. There was also confusion on the part of New South Wales Ambulance as to the address of the police command post once established and it was later necessary to move the command post due to reception issues. It was ultimately situated within Westfield.

Likewise, there was confusion about the potential identification of a second offender and poor communication between emergency services on the ground in relation to that issue. None of that is said to blame individuals. We can only imagine, sitting here with the benefit of a hindsight lens, how confusing and

difficult that scene must've been to process, but that is exactly why we take this opportunity to try and assist those groups to learn from it.

Police radio broadcasts at 3.52pm and 3.58pm suggested that police had been provided with intelligence that indicated there may be a second offender. As at 4.07pm, some police still held concerns about the possibility of a second offender which led to a New South Wales Police officer being dispatched to the CCTV control room to review the footage and confirm the total number of offenders.

At around 4.15pm, New South Wales Police Public Order and Riot Squad members acted on intelligence which suggested that there might be a possible offender on the rooftop car park at Westfield Bondi Junction, and it appears from the brief of evidence that confirmation of one offender was provided to police at around 4.30pm in spite of that confusion. Despite that, New South Wales Ambulance still held onto their concerns about the presence of a second offender at 4.30pm and the period thereafter and that resulted in a hot zone. Even just an outline of that information will perhaps convey the level of confusion with the multiple numbers of agencies and staff who were trying to get across the information and make sure of course that a critical mistake was not made at that time.

I expect the evidence to show that it took nearly two hours for the first multiagency tactical command meeting to take place with senior police, ambulance and centre staff. That took place at around 5.30pm. In his evidence the expert security advisor Mr Wilson expresses the view that that is too late and that had multiagency meetings occurred earlier, the subsequent confusion that punctuated the initial response about a possible second offender may have been avoided.

Importantly, however, it doesn’t appear, at least based on our review of the brief of evidence, that any aspect of that confusion affected the survivability of any individual on 13 April. We hope that any recommendations that emerge from this inquest will be relevant to saving lives in the future.

New South Wales Ambulance, if I may turn to them now, received the first call for assistance at 3.34pm. Just over two minutes later, the first ambulance crews were assigned. The first crews arrived at Bondi Junction at 3.42pm, eight minutes after they had been notified, 11 minutes after the attacks by Mr Cauchi. There were 17 crews present at Westfield Bondi Junction and over the first hour of the incident, a total of 47 ambulance resources were assigned to the centre. So there's no disputing, in my respectful submission, that the response was prompt and the first responders at the scene acted with courage in what was still an uncertain and unfolding and volatile situation. Based on the evidence available, once they arrived, there was more than sufficient ambulance resources available.

Commendably, despite the volume of resources that had to be deployed at Westfield Bondi Junction, it appears that that didn't result in any adverse impact to New South Wales Ambulance broader metropolitan business as

usual operations because of course there will be other people around the State needing emergency care during that time. As with both Scentre and New South Wales Police, whether aspects of the response could be improved, and largely from an operational management and communications perspective, will be the focus of the inquest.

That doesn't detract from the actions of New South Wales Ambulance staff present on 13 April 2024 and we're conscious that some of those ambulance officers will be watching the livestream or attending court, because they think of the individuals who they were working with on that day doing everything that they could to try and save their lives. The events of 13 April are in all probability hopefully a once in a career incident and the professionalism and dedication of the attending New South Wales Ambulance crews as well as the call takers and dispatchers in the ambulance communication call centre is exceptional, worthy of commendation and certainly gratitude on behalf of the community. Notwithstanding that, it's likely that evidence will indicate there were issues at a higher level of the New South Wales Ambulance response and important lessons to be learnt.

The two most senior initial New South Wales Ambulance attendees were Ambulance Officer 1, who has been given a pseudonym, and Mr Brett Simpson. They faced a highly complex scene with patients spread over three levels of this very busy shopping centre with the added difficulty of security barriers and screens on the majority of shopfronts. Compounding this was the very large number of frightened and shocked civilians and an extremely loud evacuation alarm system which was hampering communications.

The inquest will explore the New South Wales Ambulance command and control structure in that critical first hour of the incident and thereafter. I expect it will indicate some confusion as to who was undertaking the various roles specified in the New South Wales Ambulance major incident response plan and ultimately who had overall leadership at the scene. As a result, there may be evidence that there was, in effect, some form of leadership vacuum at the scene during the critical first hour, notwithstanding the best efforts of all personnel on the scene.

The expert evidence I anticipate will suggest that there was a lack of clear overall incident command which contributed to the interagency communication issues and that there are important issues to learn from in that regard. In particular, based on unidentified New South Wales Police intelligence which I've already alluded to, at around 4.01pm, Inspector Simpson reported that there was a second armed offender. On the basis of this and other communications, there was the declaration of the hot zone that I've referred to earlier, and as a result of that, no ambulance personnel were permitted to reenter the centre after 4.30pm. By that time, that is by the time it was declared a hot zone, there were sufficient resources in the centre to attend to those who had been wounded.

Given the issues with communication amongst the paramedic crews, the

deafening alarm at that time and the layout of the scene contributed to the difficulty of doing a complete scene sweep, and those difficulties appear to have contributed to inefficiencies in the triaging of victims and those injured at Westfield Bondi Junction. There doesn't appear to have been a clear application of the triage sieve system, with arriving crews doing a combination of triage and then attempting to provide treatment to the victims in the centre. That's generally contrary to triage practice and procedure.

It also appears from the evidence that not all New South Wales Ambulance responders carried triage tags to indicate that a patient had already been assessed and that meant that some patients who had already passed away were then re-triaged by crews and that was not the best use of valuable resources, and I've referred to that happening in the case of Ms Cheng.

On the issue of triage process and procedure, Dr Philip Cowburn, a UK consultant in emergency medicine, with a speciality in prehospital care, will give evidence in week 4 about what's been introduced in the UK and Europe by way of a Ten Second Triage tool. That's a new streamline triage process which allows first responders from any emergency service to effectively triage patients during a mass casualty incident, and that's anticipated to be a fertile area for future recommendations.

It is perhaps a function of the fact that Australia has had so few mass casualty attacks that we are learning more about the Ten Second Triage tool and how to implement it in this country now. In Europe and in particular the UK, of course, sadly they have had to deal with this much more than we have, and there are important lessons to be learnt from what they've experienced.

One clear question that emerges from that summary is whether these command and communication issues adversely impacted on treatment received by any victims on the day. I've referred to Dr Stefan Mazur, an expert who's been retained. He's an emergency physician at the Royal Adelaide Hospital. Dr Mazur expresses his expert opinion that the injuries suffered by each of the civilians who passed away were not survivable. However, his opinion is caveated in respect to Faraz whose injuries are expressed as being probably unsurvivable.

What I mean by that is in spite of the communication issues that we will learn from, for the most part, it is unlikely, extremely unlikely, to have made a difference on the day, however Dr Mazur observes that Faraz was treated by New South Wales Ambulance approximately 13 minutes after their arrival on the scene and 24 minutes after he was stabbed.

Prior to Faraz being assessed by New South Wales Ambulance, Ms Good's daughter had been seen by three separate teams; Jade by two; Ms Cheng by two; and Ms Good had been extricated, along with her daughter. Dr Mazur says that if Faraz had been triaged earlier and identified as critical, and an arriving paramedic crew had been directed straight to him, this may have allowed for earlier intervention and extrication. Although Dr Mazur ultimately concludes that Faraz's injury was probably unsurvivable, the potential for

earlier treatment is a matter that will be explored during the inquest.

I reiterate here - and I have perhaps done it too many times, but I will do it again here - that I reiterate that the purpose of this inquest is not to blame individuals or organisations who were obviously doing the best that they could, but the team assisting has to look at these issues with a view to what can be learnt. We appreciate that all of those ambulance crews were dealing with an unprecedented situation, and it is anticipated that we will submit that they did the best they could in those circumstances. But we will identify what, if anything, could have been done differently for the purposes of identifying lessons that will assist with any future responses. For that reason, it is hoped that Dr Cowburn can attend in person in these proceedings and talk us through the Ten Second Triage rule and how it can be introduced.

I turn now to the last major topic, which is Mr Cauchi's mental health and the management of his condition prior to the attacks. For over 18 years, Mr Cauchi had been successfully treated for his schizophrenia. It is perhaps part of the terrible tragedy of what then unfolded in 2024. His condition was appropriately managed. He was supported by his family and clinical care team, and he was voluntarily taking medication from when he was about 17 to 36 years of age, and he was regularly attending his appointments, as directed.

However, by April 2024, he had been effectively unmedicated for nearly five years. He had no consistent or formal engagement with the mental health system, or the health system more generally, and he was effectively lost to follow-up, the consequences of which were the catastrophic events of 13 April. How that happened, and what could have been done differently, are key issues in this inquest.

Importantly, the inquest does not seek to stigmatise persons living with mental illness, in particular with schizophrenia. We know that most people with schizophrenia - and there are tens of thousands of them in our community - most people with schizophrenia will never commit an act of violence, let alone a serious act of violence. But it is an unavoidable fact that a small number of homicides are committed by people with psychotic illnesses.

The parents of Joel Cauchi had loved and cared for him all his life. I expect the evidence to show that they were absolutely shocked when they realised on 13 April that he had committed these terrible acts of violence, and had taken the lives of innocent people. As soon as they saw images on the television of the person who appeared to be the perpetrator, they contacted police by telephone to identify to police that they believed that that was their son. They then co-operated fully with Queensland and New South Wales Police in providing them with all the details about their son.

There can be no doubt about their efforts to provide him with support and care, and to deal with an incredibly challenging and demanding illness throughout his life. We empathise with their suffering and we are grateful for their engagement in the inquest to date.

Mr Cauchi was born on 13 June 1983. He grew up with his family in Toowoomba, Queensland. He had what can only be described as a relatively normal childhood, with parents who loved and cared for him. Around the age of 14, however, his family began to notice changes in his behaviour and personality. He is reported to have experienced delusions, hallucinations, thought disturbances, and disorganised behaviour. He became aggressive. His family sought treatment in the mental health system.

Between 26 January and 23 February 2001, Mr Cauchi was admitted for the first time to a mental health hospital. He was admitted to Toowoomba Hospital following a particularly acute psychotic episode. At the time of admission, Mr Cauchi described to doctors that he had hallucinations. He reported seeing and feeling demons entering his body; feeling as though his movements were controlled; and that people were inserting thoughts into his mind; he believed that he was being followed.

The initial diagnosis was paranoid psychosis and schizophreniform disorder. Around six months following that first admission, he was diagnosed with schizophrenia. It will be obvious that some of those ideations had clearly returned from around 2022. Schizophrenia generally requires lifelong care and treatment, including, I expect your Honour to hear, lifelong use of anti-psychotic medication.

From 2001 to 2012, Mr Cauchi received that care in the Queensland public health system from the Toowoomba Mental Health Service. I will repeat that again. From 2001 through to 2012, Mr Cauchi received that care in the Queensland public health system from the Toowoomba Mental Health Service. He was first trialled on an atypical anti-psychotic medication called olanzapine from around January or February 2001. Clinical records indicate that despite consistent treatment and an increasing dose of olanzapine, his psychotic symptoms gradually returned. He was further trialled on risperidone in around mid-2002 to around October 2002. I expect your Honour to hear from the psychiatric experts that there does have to be a period of trialling various medications when persons with psychoses are first put onto a regime.

In October 2002 Mr Cauchi was once more admitted to Toowoomba Hospital to manage a change in his medication, this time from risperidone to clozapine. Mr Cauchi was prescribed clozapine from October 2002 to around June 2018, so nearly 14 years. Based on the view of the experts retained to assist your Honour, Mr Cauchi's treatment with clozapine is an indication that he suffered from what is sometimes called treatment resistant schizophrenia. Olanzapine is often an effective and high risk anti-psychotic with significant and potentially severe side effects. As a result, that medication is only used in people with schizophrenia where other anti-psychotics are ineffective.

As stated in the expert report of psychiatrist Professor Heffernan, which will be tendered shortly, olanzapine is generally considered, along with other aspects of treatment, care and monitoring, to be lifelong medication. If treatment is ceased, there is a real risk of relapse and readmission.

Mr Cauchi's clozapine dose was steadily increased until it reached 575 milligrams a day in June 2003, by which stage his auditory hallucinations ceased. In around July 2007, Mr Cauchi's treatment was augmented to include Abilify. Around this time he was also diagnosed with obsessive compulsive disorder.

Mr Cauchi maintained his use of psychotropic medication whilst treated in the public health system. In December 2011 his clozapine dose, which had been increased at a maximum of 600 milligrams a day, was reduced to 550 milligrams, and that was because there were concerns of oversedation. He was discharged while he was on that amount in March 2012. That is, discharged from the public system to a private psychiatrist who was based at a private clinic in Toowoomba.

Prior to discharge, Mr Cauchi was noted as being a particularly good candidate for transfer of care to a private setting, given that he had, at that stage, high levels of insight into his illness. His compliance with treatment, the absence of significant risk factors in the course of his treatment, and his considerable family support made him a candidate for private care.

At that time in March 2012 his circumstances were relatively stable. I have already mentioned his supportive parents. He had accommodation. He was attending university. He was not misusing substances critically. He adhered to his treatment, and he hadn't demonstrated any high risk behaviours, such as violence to himself or others, since he had commenced treatment. All those issues were critical in the decision to discharge him to private care.

The private psychiatrist who then took over care at that stage was Mr Cauchi's treating psychiatrist from March 2012 until February 2020 when, as I will come to shortly, he moved to Brisbane. Mr Cauchi saw her, that is, that private psychiatrist, approximately once per month in a Toowoomba private clinic. He also saw nurses who acted as his clozapine co-ordinator.

Those appearing on behalf of the psychiatrist and the two nurses have asked at this stage for a non-publication order over their names. Your Honour is not prepared to grant a permanent non-publication order at this time. An interim non-publication order has been granted and will be re-visited after the panel of psychiatrist experts have given evidence. That is so that the evidence can be put in context and the views of experts properly canvassed so that they are not misunderstood. For the purposes of this opening, I will refer to her for now as Psychiatrist A.

Over the period that Mr Cauchi was treated at the private centre, his clozapine dose was gradually reduced until it ceased all together in June 2018. Based on available medical records, the reason for his clozapine dose being reduced appears largely to be related to his concerns of oversedation. He reported that the medication made him feel tired. He also expressed a desire to decrease his reliance on medication. Based on the available evidence, it appears that Mr Cauchi was otherwise compliant with his clozapine during the entirety of the period that he was prescribed it. Ultimately, it was determined to reduce his

dosage. That was supported by a second opinion from a psychiatrist in 2015 who had treated him in the public system.

He was monitored closely for a period of time as the tapering-down process for the clozapine continued, until it was ultimately ceased in June 2018, as I have already noticed. In around June 2019 he further ceased treatment with the other drug I mentioned, Abilify, and thereafter he never took psychotropic medication again. To repeat: he stopped all psychotropic medication in June 2019.

Clearly, an important issue in this inquest is the decision to reduce and ultimately cease his medication, first with clozapine, and then with Abilify. I have already noted that expert evidence suggests that individuals who have been diagnosed with treatment-resistant schizophrenia face an increased risk of relapse and readmission, and adverse impacts on recovery when clozapine treatment is ceased.

In Mr Cauchi's case, his cessation of treatment unfortunately coincided thereafter with him exiting the mental health system altogether. He was effectively lost to follow-up from early 2020. It is to that issue that I now turn.

Evidence in the brief suggests that from October 2019 to February 2020 - obviously shortly after he ceased all psychotropic medication - Mr Cauchi's mother raised concerns on several occasions with the private Toowoomba clinic about her son being unwell and the risk of possible relapse. I expect the evidence to show that that included Mrs Cauchi, Joel's mother, expressing the concern that he was again hearing voices and that she had found some notes he made which suggested that he believed he was under satanic control.

In the period November to December 2019, Dr A provided Mr Cauchi with prescriptions for Abilify and then something by the name of Rexulti, which is another atypical anti-psychotic. The medication records suggest that Mr Cauchi's mother hoped that he would restart his medication, but that Mr Cauchi had said he wasn't keen to do so because he didn't want the dysphoric effects that he'd experienced in the past when the medication he was taking impacted on him.

Mr Cauchi was advised by Dr A to self-determine whether he should start taking the medication again that she had provided on script. The evidence suggests that Mr Cauchi did not do so. An important issue for this inquest is whether the warning signs disclosed to Mr Cauchi's psychiatrist, Psychiatrist A, in late 2019 and early 2020 should have been acted upon in a more assertive manner, including whether more rigorous psychiatric assessment was required, which may, in turn, have prompted a reconsideration of Mr Cauchi's management plan, or alternatively a referral for a public mental health service assessment.

I've said that Mr Cauchi was effectively lost to follow-up after early 2020. There was sporadic one-off contact with two different psychiatrists in Brisbane in the following year but it didn't result in any ongoing supervision. On

17 February 2020, Dr A was in Caloundra and Mr Cauchi attended an appointment with her by Skype. In mid-March 2020, Mr Cauchi had moved to Brisbane. He tried unsuccessfully to join a Skype session with Dr A, but he was unable to do so because his Skype wasn't working.

At around the same time, staff at a private Toowoomba clinic became aware that Mr Cauchi had moved to Brisbane and was therefore, as they saw it, no longer eligible for Medicare Skype appointments or nursing support. Mr Cauchi did not want to attend face to face appointments, because of his difficulty travelling from Brisbane to Toowoomba. Your Honour and those listening will recall that that was also around the time tragically of the onset of the COVID pandemic which made it difficult to travel. So as a result of all those issues, the private Toowoomba clinic cancelled the appointment with Mr Cauchi.

The private clinic staff contacted Mr Cauchi regarding a referral to his GP in Brisbane. Mr Cauchi said he didn't yet have a GP in Brisbane and he would let them know when he did. In the absence of Brisbane based GP, Dr A discharged Mr Cauchi into the care of his long-term Toowoomba based general practitioner, and that discharge signified a rather sudden end to Mr Cauchi's treatment by Dr A after what had been consistent treatment and attendance over an eight year period.

Clearly the inquest will consider whether there was a missed opportunity by Dr A or anybody else to ensure that Mr Cauchi had continuity of psychiatric care, no matter where he was located, and your Honour will of course hear from Dr A in that regard, and what were the limitations for her of what she conceived of what she could do. The inquest will consider whether, in circumstances where Mr Cauchi had already left Toowoomba, it was appropriate to discharge him into the care of a Toowoomba-based GP instead of a Brisbane-based GP. The inquest will consider whether or not that clinic properly took into regard the concerns that had been expressed by Mr Cauchi's mother over a period of months.

There's no reference in the available medical records that would indicate that Mr Cauchi attended any subsequent appointment with the Toowoomba-based GP following his discharge by Dr A. That's perhaps not surprising given that he'd moved to Brisbane. There's no mention of a recall of Mr Cauchi by the Toowoomba GP other than recall letter dated 11 May 2020 from the practice. That was in relation to blood testing. But that's an unsigned letter addressed to somewhere in Toowoomba not Brisbane. Records were later transferred from the private psychiatrist in the clinic in Toowoomba to other practitioners, but much later in time and in response to requests from those practitioners for the records.

I expect your Honour to see that there's no evidence of a particular plan regarding continuation of Mr Cauchi's mental health care or transfer or care records to another GP or psychiatrist, so the steps that could have been taken by the Toowoomba GP practice will also be an issue to be explored in the inquest. In short, what ultimately occurred is that when Mr Cauchi moved from

Toowoomba to Brisbane he wasn't taking any antipsychotic medication, and there was no specific plan that we can locate for follow-up of his mental health care. He had left behind his strong support networks in Toowoomba and in Brisbane he was in effect on his own.

After Mr Cauchi ceased receiving treatment at the Toowoomba centre in early 2020, the available evidence indicates that he received limited mental health care, whether from a GP, psychiatrist, or anybody else. The expert evidence suggests that Mr Cauchi's mental health condition was not effectively treated or managed from that time on. After discharge from Dr A, Mr Cauchi saw two psychiatrists in Queensland but primarily because he was requesting that they provide a short report, in support of an application for a gun licence which is an issue that I'll return to shortly.

On 26 November 2020 Mr Cauchi saw the first Brisbane-based psychiatrist, Dr B, which is a pseudonym at this point in time, although I note that that's only an interim order for a non-publication. Dr B was at a medical centre in Brisbane and Mr Cauchi left the appointment that he had made with Dr B before that psychiatrist could even complete the assessment. Almost two months later on 18 January 2021 Mr Cauchi saw a second psychiatrist, who I'll call Dr C, but noting again that it's only an interim non-publication order at that stage. He was at [redacted] in Brisbane.

Mr Cauchi was referred to that clinic by his treating GP who requested an assessment and follow-up by a psychiatrist for management of schizophrenia. The psychiatrist was then told, that is Dr C, that Mr Cauchi had been diagnosed at the age of 17. It was noted that Mr Cauchi moved from Toowoomba to Brisbane and so was unable to continue to see his long-term psychiatrist, Dr A, and on the basis of the information provided by the GP, it was suggested that Mr Cauchi was at that stage in remission and did not have active symptoms of schizophrenia and was not on any psychiatric mediation at the time. Obviously that contrasts with what Mr Cauchi's mother had said at the end of 2019.

At that consultation on 18 January 2021 Mr Cauchi advised the doctor that he was seeking a psychiatric review for the purpose of a medical fitness so that he could visit a gun range and practice target shooting under supervision. It appears that Mr Cauchi was able to explain his psychiatric to the psychiatrist and was largely open about it. He reported, for example, that he'd been hospitalised in 2000 at the Adolescent Psychiatric Unit at Toowoomba Hospital following a psychotic episode where he experienced tactile hallucinations, secondary to significant use of cannabis for over a year.

It was clear that he explained that following his admission to Toowoomba Hospital he was then commenced on antipsychotic medication, initially on clozapine and then aripiprazole or Abilify. Mr Cauchi stated to Dr C that he remained asymptomatic in his view and in remission during the period that followed. Mr Cauchi reported that he had been off the Abilify for the past 18 months and had not suffered a relapse in psychotic symptoms, and he told Dr C that he wasn't on any medication at all. Mr Cauchi denied any recent or

current drug use and said that his last drug use was prior to the hospital admission in 2000. He denied any acute medical problems or allergies other than bee stings and reported no known family history of schizophrenia. I pause to note that that last statement was not correct.

Dr C undertook an assessment of Mr Cauchi. I expect your Honour to hear evidence that he didn't think that Mr Cauchi displayed any thought disorder or psychotic symptoms in that one interaction that Dr C had with him in his clinic. His mood was noted to be euthymic or stable, so the doctor recorded that he was a stable mental state with a positive stable mood. Mr Cauchi reported no hallucinations, no psychotic symptoms, no problems with memory or functioning and normal appetite and sleep. He denied thoughts of suicidal ideation or self-harm or thoughts of harm to others.

Dr C did notice that Mr Cauchi had some twitching of the mouth, but Mr Cauchi told Dr C that was due to nervousness. This of course is a significant period of time prior to the Bondi Junction attack. This was 18 January 2021. With respect to the application for a gun licence, Mr Cauchi apparently told Dr C that he didn't plan to purchase a gun but only intended to practice target shooting at a gun range which would be supervised. He also mentioned that the previous time he visited a gun range was when he was 25 years of age in 2001.

Dr C obtained Mr Cauchi's consent to obtain collateral history from the Toowoomba psychiatrist, Dr A, who I've already mentioned, and that was in relation to his psychiatric history, medication history and other treatment and associated risk, and Mr Cauchi signed a consent form which enabled Dr C to contact Dr A. I expect your Honour to hear evidence that the Brisbane-based psychiatrist that I'm just mentioning, Dr C, who saw Mr Cauchi for Mr Cauchi's request of getting a gun licence, saw him only on that one occasion, and he determined that Mr Cauchi's risk to himself and others was low. In those circumstances he did not consider it necessary to provide him with a follow-up appointment or any ongoing treatment, because Mr Cauchi was not on any psychotropic or psychiatric medication that would have required follow up. I expect that to be evidence that is of significance to your Honour.

Following the consultation, Dr C did indeed obtain the collateral information sought from Dr A in Toowoomba. It confirmed that clozapine was ceased in around June 2018 and Abilify ceased after a review in June 2019. It confirmed that according to Dr A, Mr Cauchi had not suffered a relapse in psychotic symptoms following ceasing Abilify for approximately 18 months prior to the review. After receipt of that collateral information from Dr A, Dr C wrote to Mr Cauchi's Brisbane-based GP and recommended that Mr Cauchi have "six monthly reviews to monitor for mental state, even though he is currently asymptomatic".

It's unclear who it was intended should perform those six monthly reviews. That is, was it a psychiatrist or was it a GP, or both, and it's unclear who it was intended or recommended that the relevant psychiatrist or GP should be, and your Honour will no doubt hear further evidence about that. In any event, that

recommendation didn't result in any follow-up action. Dr C did not receive any further correspondence from Mr Cauchi or his Brisbane-based GP, and was not involved in any follow-up care or treatment.

Mr Cauchi had been referred to these psychiatrists by a Brisbane-based general practitioner who first saw Mr Cauchi in May 2020 via a Telehealth consultation, and Mr Cauchi continued to attend on that GP periodically, with a final consult being 30 April 2021, and after that, Mr Cauchi didn't see a doctor for two and a half years. On 20 January 2021, following up from what I've just said about the interest in obtaining a gun licence, the Brisbane-based psychiatrist provided a report in support of Mr Cauchi's application for a gun licence, which was then submitted by Mr Cauchi on around 25 January 2021.

In response to a letter dated 8 February 2021 from the Queensland Police Service Weapons Licensing Branch, that psychiatrist, Dr C, provided a further report dated 19 February in which he confirmed that Mr Cauchi was at that stage, in his view, a fit and proper person to be issued with a weapons licence, and Mr Cauchi was ultimately issued a statement of eligibility. A statement of eligibility supports a condition required to accept a person for membership to an approved pistol club under the Weapons Act. A statement of eligibility is not a weapons licence and nor does it allow for the purchase of a weapon.

A statement of eligibility is not a pre-requisite for holding a weapons licence. But with that in mind, the interest shown by Mr Cauchi in obtaining access to firearms, even at a pistol range, whilst untreated for schizophrenia raises questions regarding the scrutiny of any applicant for any form of firearms permit where the applicant has a history of involuntary psychiatric hospital care, particularly for the sort of treatment resistant schizophrenia that Mr Cauchi was suffering, and I anticipate that your Honour will hear evidence about that from our psychiatric panel.

The available evidence suggests that Mr Cauchi did not follow through with a gun licence and that is very, very fortunate, because the evidence on Mr Cauchi's iPhone and his internet searching suggests a very significant deterioration of his mental health steadily from the time that he was unmedicated, and a significant deterioration around this time.

Interactions with a psychiatrist in 2021 may have provided an opportunity to reengage Mr Cauchi in treatment and care in a proactive manner, and the extent to which these possible opportunities were missed by both doctors A and C will be explored in this inquest. As with other witnesses, those doctors are encouraged to be forthcoming with this Court, to give evidence in a way that is full and frank and genuinely directed to assisting with the systemic issues that arise in this case with a view to saving lives in the future.

By late 2023, Mr Cauchi was back in Toowoomba. On 13 November that year he saw a GP from Northpoint Medical in Toowoomba. I've just been given a note about the time. Would your Honour permit me to continue? I have only I think ten minutes and then we can finish and break for lunch.

HER HONOUR: Yes.

DWYER: By late 2023 Mr Cauchi was back in Toowoomba. On 13 November that year he saw a GP from Northpoint Medical in Toowoomba for the first and only time, and that was solely for the purpose of consulting about a driver's licence. His driver's licence was expiring and he was required to see the general practitioner, so it will be evident that Mr Cauchi was not going to his GP for mental health care at that time.

The appointment with the GP at that stage was not cursory. The doctor obtained additional information from Mr Cauchi who disclosed his diagnosis of schizophrenia. The GP spoke with Mr Cauchi's mother and undertook a mental state examination. He determined that, according to him on that brief interaction, there were no acute issues that appeared to him to require immediate attention and he ultimately completed a medical certificate noting that Mr Cauchi should retain the M condition on his licence.

That is to say that following that consultation, the GP wrote a letter to Dr A, who we all know was the long-term treating psychiatrist in the clinic in Toowoomba, seeking further information regarding Mr Cauchi's mental health history, and that was subsequently received. In that letter, the GP stated that Mr Cauchi was not frankly psychotic at that point. It noted that he'd been off his medication for a number of years and that GP thought he had not had a major relapse and he said that he could not find a reason why he required an ongoing M on his licence to be honest, in his words, given that he wasn't medicated.

I'd just ask your Honour to note the date here. That was 13 November 2023 and the relevance of that date is that I'll come shortly to an interaction that New South Wales Police had around that very time with Mr Cauchi at his home address which clearly shows that Mr Cauchi was experiencing significant mental health issues at that time, and had been in the leadup.

As the last occasion on which Mr Cauchi was seen by a medical practitioner about his mental health, and just prior to the interaction with Queensland Police, and five months prior to the terrible events at Bondi Junction, the circumstances of that presentation to a general practitioner will again be explored in the hearing. Yet again it might've been an opportunity for the GP or indeed Dr A to recommend a comprehensive review of Joel Cauchi at that time, given the possibility of his mental health having deteriorated, given he had not been medicated for so many years and had had such a significant condition chronically to start with, and particularly given the concerns that had been expressed by Joel Cauchi's mother in 2019 and early 2020.

The expert psychiatric evidence to date emphasises the importance of allowing persons with mental health conditions the autonomy to manage their own lives, medical conditions and medications, but at the same time, I expect the Court to recognise that we also need a system that can respond appropriately when a person becomes unwell and potentially constitutes a risk to themselves or

others. The interaction or intersection between autonomy, human rights, selfdetermination and compulsory treatment is a vexed topic but it is so important that we get the balance right.

The problem Mr Cauchi faced from 2020 onwards was that no health practitioner held responsibility for his ongoing care, or didn't obviously hold responsibility, and so no person was in a position to re-evaluate the appropriateness of previous treatment decisions including the fact that his antipsychotic medication had been ceased. This emphasises the importance of providing optimal clinical handover of a patient, particularly a patient like Mr Cauchi, to reduce the risk that someone like him suffering from a chronic mental health condition will be then lost to follow up after the transition of care, and thereafter doesn't get the care that they need, or that the community needs them to get.

Likewise, opportunities for reintegration into the mental health system, including on the part of adhoc or irregular health practitioners who step in, should always be actively considered, particularly where a parent or close relative is expressing concern. The lack of access to a detailed clinical history was an issue for the practitioners seeing Mr Cauchi after 2019. Various clinicians did seek additional history but they weren't able to readily access it or at least the entirety of it, and this inquest will consider what alternatives there may be to assist. One option proposed by the experts is a single record permitting all involved in care with public, private or nongovernment organisations across all states and territories to access medical records in these circumstances.

I come now then to the interactions with Queensland and New South Wales Police. There were several interactions as between Queensland and New South Wales Police and Mr Cauchi after he ceased treatment in 2019 and before the events of 13 April. The interactions with Queensland Police included fare evasion in August 2020, July 2021 and October 2022, being stopped due to erratic driving in October 2020, November 2020 and September 2021, and street intercepts by police in Toowoomba in August and September 2023. He was also wanded, that is Mr Cauchi was wanded with a handheld metal scanner on the Gold Coast in December 2023, but he was not carrying any knives at that time.

Mr Cauchi had one interaction with New South Wales Police on 21 July 2023 when he was found sleeping rough in the Sydney CBD and a bystander had contacted police because of concerns for Mr Cauchi's welfare. Police checks at that stage revealed that he had a warning in relation to knives, mental health and self-harm in Queensland, and that resulted in Mr Cauchi being subject to a general search, but no dangerous knives or other items of interest were identified at that time and there were no further interactions with New South Wales Police.

The inquest will explore whether certain of those interactions were missed opportunities to see if anything could've been done differently. In particular, the inquest will look at how police first responders deal with those who might

be suffering mental health conditions, and what resources they have at their disposal to consider whether or not there should be more to assist them deal with persons in the community with mental health issues.

On 27 May 2021, Queensland Police were called to Mr Cauchi's unit in Brisbane following reports of a male screaming and someone being hit. Police attended and spoke to Mr Cauchi who told them he was frustrated with his fridge because it was broken. There was no offence detected at that time - so I'll pause to note this is dealing way back in May 2021. There was no offence detected but a caution was added to the Queensland Police system stating that "he was a diagnosed schizophrenic who doesn't take medication."

On 27 July 2022 a Crimestoppers report was received regarding Mr Cauchi's contact with a high school in Toowoomba and his attendance at the school sports centre in an attempt to spectate a swimming carnival. That's almost two years prior to Bondi Junction. The school took swift action and he was not permitted to attend.

The most significant interaction with Queensland Police came on 8 January 2023 when officers of the police attended the home of Mr Cauchi's parents in Toowoomba where Mr Cauchi was then residing. Your Honour, I misspoke earlier when I said that police had attended in November 2023. This is 8 January 2023 and it's clear that in this interaction, Mr Cauchi appears to be mentally disturbed or mentally unwell and your Honour will note that it's then in November 2023, much later in that year, that a GP, on a snapshot of Mr Cauchi, assesses him to be presenting as not unwell, which I anticipate submitting shows the importance of having a longitudinal understanding of Mr Cauchi's mental health and to ensure that anybody doing that snapshot review has access to those records.

On 8 January 2023, officers from Queensland Police attended the home of Mr Cauchi's parents in Toowoomba where Mr Cauchi was then living. Mr Cauchi had accused his father of stealing his military collector knives. Andrew Cauchi, Mr Cauchi's father, had taken the knives, effectively confiscating them because he was concerned about his son having access to them. The interactions between Queensland Police and Mr Cauchi are captured on body-worn video and I anticipate that they will be played during the inquest.

During the interviews with police at that time captured on body-worn, both of Mr Cauchi's parents state that in their opinion, he's mentally unwell, that he needs treatment and that he's been observed, for example, to be making odd noises, banging his feet and slapping his face, and that he was seemingly distressed by auditory hallucinations in the early hours of the morning. On one occasion, Michele Cauchi, Joel's mother, says to police, "He really needs to see a doctor but he does not know he's sick," and that's in stark contrast to the insight that Mr Cauchi appeared to show when he was being medicated.

Mr Cauchi Senior expressed significant concerns to Queensland Police about the need to remove his knives, including his fear - I withdraw that, I'll start

again. Mr Cauchi Junior, that is Joel, expressed concerns to Queensland Police about his dad removing his knives. He said that the fact that his dad had removed his knives might lead to him becoming broke, living on the street and potentially put him at risk of being killed, which suggests that Joel Cauchi might have had fears for himself at that stage and possibly from the auditory hallucinations. Joel was unable to articulate why the knives were so valuable or why those consequences might result.

While the evidence in the brief appears to suggest that the Queensland Police officers formed the view that Mr Cauchi was unwell as a result of that interaction, they determined that it wasn't necessary for them to take immediate steps to have him assessed or arrested, particularly while he was not presenting as a threat to himself or his parents.

Later on 8 January 2023, one of the attending Queensland Police sent an email to Darling Downs District Domestic and Family Violence and Vulnerable Persons Unit requesting that a follow up occur for Mr Cauchi's mental health. That didn't happen. It appears that the email was missed by a relevant officer who was then acting as the mental health intervention coordinator. The inquest will explore whether the attendance by Queensland Police and the subsequent lack of follow up was a missed opportunity for intervention, which may have resulted in a review by a mental health service and Mr Cauchi being reintroduced into the mental health system.

The evidence also indicates that information concerning Mr Cauchi's interactions with police was not available to the clinicians who saw Mr Cauchi from 2020 onwards, or at least not all of it was, and having access to that information may have given the clinicians some visibility. So there's an important issue in terms of the overflow of information between clinicians and between police and clinicians that might've been of assistance. It will be important to hear from those Queensland Police officers I anticipate about how Mr Cauchi was presenting on that day compared to so many other callouts that they get for mental health.

Mr Cauchi's experience demonstrates how quickly someone can fall out of the mental health system and, once outside it, the barriers to reintegrating them. The expert psychiatrists retained have identified that in addition to the benefits of early intervention, and ensuring people with mental health conditions are encouraged to remain compliant, there must be oversight of their treatment and there must be stable accommodation that facilitates oversight.

I expect that your Honour will hear that they identify that one major gap in our mental health services in New South Wales and other States is the absence of supported accommodation for people with severe forms of mental illness who require basic support and supervision to remain well. I expect the Court will hear that from around the mid-1980s in New South Wales, there was a serious shift to move mentally ill people out of institutions and into the community. While that might be an admirable goal, given the previous horrors of chronic institutionalisation, it appears that demand for community housing for people who are suffering mental illness, particularly schizophrenia, has vastly

outstripped supply.

Professor Olav Nielssen will give evidence about an initiative known as Habilis Housing. Habilis is a registered charity recently established to bridge the gap in New South Wales mental health by providing indefinite supported accommodation and care for people with disabling forms of mental illness. It provides oversight for medication as well as accommodation.

Professor Anthony Harris will give evidence about the Haven Foundation which aims to provide that sort of stable and affordable social housing for people with significant mental health challenges, and encourages independence for those suffering mental health conditions so that they can manage daily activities and improve their quality of life.

I have already mentioned that the Court is fortunate to have the expertise of Professor Nordentoft, a leading international expert in relation to schizophrenia, based in Denmark. Professor Nordentoft played a key role in developing and implementing early intervention services in Denmark. She will express her views on the best programs and how mental health conditions, in particular schizophrenia, are managed in Denmark.

This includes acute psychiatric outreach, which is available in Denmark, targeting individuals who have severe mental illness, or those in crises, who can't resolve their problems through a GP on call, or by visiting a psychiatric emergency room. That service is uniquely staffed by a psychiatrist and an ambulance driver, allowing for emergency visits, even in challenging and potentially dangerous situations. Your Honour, I expect that you will hear from Dr Olav Nielssen that that sort of emergency outreach work is critical and should be introduced throughout this State.

I expect it will come as no surprise that all of the experts are likely to speak of the need for urgent reform to services to alleviate some of the burden on police and to keep the community safe. I have alluded to the fact that it will be important to hear from Queensland Police about the legislation that they were working under when they went out to assess Joel, how that presentation of Joel compares with other presentations, and the limitations on the resources available to them.

I expect the evidence to hear in New South Wales and elsewhere that the Court should consider a co-responder model so that police can be accompanied in circumstances by trained mental health workers who can take over follow up, and should also hear about greater community outreach and the accommodation options I have spoken of that link mentally ill persons into treatment.

Your Honour, this opening has set out the factual matrix for the inquest and has foreshadowed the evidence to come over the next five weeks. I am nearly finished. At this point, on behalf of the counsel assisting team and before concluding, can I take this opportunity, on behalf, no doubt, of all the lawyers at the bar table, not just my counsel assisting team, to express our deep

condolences to the families of those who have lost lives; some who are listening online and some who are in court. We have got to know some family members in the lead up. We feel for you deeply. But we do not pretend to know the extent and depth of your loss. We will really try over the next five weeks to conduct this inquest that has you front and centre, and at the top of our minds throughout the entirety of the five weeks.

We remain available throughout this period. So we will just be in court this whole time and accessible if anybody would like to speak with us or, critically, to talk to us about things we should be doing differently or better or more sensitively. We will stay here for the whole of the five weeks to make sure that that happens. It might be time now to take the lunch break, your Honour

HER HONOUR: Just before we do, and just following on from Dr Dwyer - and thank you very much for your opening - I also want to acknowledge that, by necessity, there is formality because we're in a court. This is an inquest. But I want to acknowledge, we're all human and we all have hearts, and our hearts go out to you today. I just wanted to say that because it's formal here, but there is that human aspect of this that we're all feeling for you. We'll adjourn now and we'll come back at 2.20.

LUNCHEON ADJOURNMENT

DWYER: Your Honour, just before we start. I understand that Mr Dean Jordan of senior counsel, who appears for the Scentre Group, would like to say something.

HER HONOUR: Yes, Mr Jordan? Just make sure that we've got sound in court 2. Sorry, Mr Jordan, just one moment. Can we try again?

JORDAN: Your Honour, I was just thanking you and Dr Dwyer for the opportunity to say something very briefly, at this stage, on behalf of Scentre, the owner and operator of Westfield Bondi Junction. Can everybody hear okay?

HER HONOUR: Yes.

JORDAN: Thank you. The events of 13 April 2024 were shocking and unprecedented. Within a period of less than three minutes, innocent lives were lost, and the lives of many others were changed forever. On behalf of Scentre, we again express our condolences to each of the families and loved ones of the six victims who tragically did not survive; Dawn Singleton, Jade Young, Yixuan Cheng, Ashlee Good, Faraz Tahir, and Pikria Darchia. We acknowledge their loss and the ongoing grief and suffering experienced by their families and friends.

Scentre also recognises the physical and psychological trauma experienced by many others who were present that day, and pays tribute to the selfless bravery of first responders, including members of the public, police, ambulance, retail workers, centre staff and security guards.

In the immediate aftermath of the horrific events of 13 April 2024, Scentre focused on assisting the police investigation and providing support to the families who lost loved ones, and also those persons who were injured and survived. Since then, Scentre has been engaged in an ongoing review of security measures to learn from the events of 13 April 2024 and identify any opportunities to improve emergency response systems and procedures at its shopping centres.

A recent feature of this ongoing review has been to give careful consideration to the report provided to your Honour by Mr Scott Wilson. As explained by Dr Dwyer in her opening address, Mr Wilson is a security expert and has reviewed the emergency response that took place on 13 April 2024. Scentre has been assisted by Mr Wilson's report and agrees with many of the principal findings made by Mr Wilson.

These areas and agreements and some matters of difference have been identified and explained in a statement recently provided to your Honour from Mr John Yates, director of security for Scentre Group. In keeping with this process of review and reflection, Scentre has been assisting the coronial investigation and will continue to assist throughout this inquest hearing.

Scentre is also committed to facilitating and implementing any practical recommendations arising from these coronial proceedings, and will continue to work with all involved parties in the interests of safety and security. Thank you.

HER HONOUR: Thank you, Mr Jordan. Review and reflection is always most welcome in this jurisdiction. Dr Dwyer?

CASSELDEN: With your Honour's leave, may I also, on behalf of my client, say some short words of condolences?

HER HONOUR: Yes, Mr Casselden.

CASSELDEN: I would like to acknowledge that the events of 13 April 2024 were devastating to the families who lost their loved ones. On behalf of Glad Group, I extend my deepest condolences and sympathies to the families, friends and colleagues of these victims. I am sorry you lost these special people to such a senseless attack.

I would like to directly acknowledge security officers Faraz Tahir and Muhammad Taha, the Glad employees on duty at Westfield Bondi Junction on 13 April. Faraz died from his injuries, and Muhammad was severely hurt and continues to live with the horrible memories of that particular day. Their courage will never be forgotten.

Numerous other people were injured that day both physically and psychologically. On behalf of Glad I want to recognise all of them for what they went through, and for the trauma and pain they no doubt continue to live with. Glad Group is a family owned business. In its many years of providing security

services they have never experienced an incident as grave, or overwhelming, as this particular attack. It has profoundly affected many of its people. Over the past year, Glad Group has endeavoured to support them and their families, as well as our contractors, to process and cope with the aftermath of this tragic event.

Like Scentre, your Honour, Glad will also consider and facilitate any meaningful, practical recommendations that can be implemented to avoid such a senseless attack in the future. May it please the Court.

HER HONOUR: Thanks very much, Mr Casselden. Dr Dwyer?

DWYER: Your Honour, I'm at the point where I may tender the 50 volumes of evidence. I note that they are all lined up behind Brad, our court officer, there. You would appreciate that most of us are working electronically, but I formally tender those 50 volumes. And then if I may turn to my junior counsel, Mr Murphy, who is going to address the non-publication order issue.

EXHIBIT #1 50 VOLUMES OF BRIEF OF EVIDENCE TENDERED, ADMITTED WITHOUT OBJECTION

MURPHY: Your Honour, there have been several applications for non-publication orders. Can I say that a number of those applications following engagement with the counsel assisting team have been appropriately refined, and are accompanied with a clear explanation as to the need for those non-publication orders. The majority of those applications are supported by the counsel assisting team.

Unfortunately, and due to the time in which certain of those applications was received, it's not been possible to resolve all of those applications before the commencement of the hearing today, and they are still in the process of being reviewed by the counsel assisting team.

Those applications for non-publication orders fall into two distinct categories. The first is the names of individuals, including any information or image that would identify those persons. The second being documents or information within documents that are comprised within the brief of evidence.

If I could just hand up to your Honour a bundle of short minutes. I apologise in advance for the format in which they've been provided. A soft copy will be provided to your Honour to assist in making of those orders.

The first set of short minutes marked A are from the assisting team. In summary, they revoke the interim non-disclosure order that was previously made in relation to the brief of evidence. They further provide for non-disclosure and non-publication orders over certain graphic and sensitive material in the brief of evidence, or material that is otherwise sensitive police information. There are non-publication orders over the names of those who were injured on 13 April 2024, and certain other individuals, and those orders in A also provide for an interim non-publication order over the names of certain

other individuals whom have made applications for non-publication orders.

The balance of the short minutes, which your Honour doesn't need to go through in any great detail, B through F, have been prepared by those parties who are seeking non-publication orders over documents, and it's proposed that they will be interim orders over those documents pending the resolution of the applications that have been made this week.

In that respect, and repeating somewhat what I've just said, it's proposed that non-publication orders will be made over the names of the individuals who have made applications, as well as the documents, the subject of any of those applications in accordance with the orders that have been handed up, and those applications will be determined this week in accordance with the following timetable.

Any further submissions of no more than five pages concerning the non-publication orders in respect of names of individuals to be provided by 5pm Tuesday 29 April 2025, and any further submissions of no more than five pages regarding orders for non-publication in respect of documents or information are to be provided by 5pm on Thursday 1 May 2025. Then we propose that your Honour would make or determine those applications on the papers, at which time the interim orders that have been made will expire and any further orders in relation to non-publication will continue on from that point, and I'd request that your Honour make a direction in those terms as to the timetable.

HER HONOUR: Yes, thank you Mr Murphy. I make the direction consistent with what you have submitted. That is that any application regarding the names, submissions no longer than five pages, to be provided to those assisting me by 5pm tomorrow, Tuesday. In relation to the documents, that that be provided to those assisting me by 5pm Thursday, and then I will make a determination on the papers.

CHRYSANTHOU: Can I just say one thing about the non-publication orders?

HER HONOUR: Yes Ms Chrysanthou.

CHRYSANTHOU: From our perspective on behalf of our clients we've been very careful acknowledging the public interest in open justice and the reporting of the inquest to limit our applications for non-publication orders to limited aspects of the evidence that is considered to be upsetting and sensitive insofar as my clients are concerned, and we just wish to reassure your Honour and those watching and the media that we haven't in any way sought any broadbrush substantial orders in relation to large documents, and we've been very careful to try and limit our application as much as we can.

The only names over which we've sought non-publication orders are the names of children, from our perspective, either victims or persons involved or affected by what occurred, and we've made some written submissions for your Honour, which we've provided to the counsel assisting team today. But if

there's any further information that your Honour requires we would be happy to assist. But we're content to otherwise have that determined on the papers.

HER HONOUR: All right, thanks very much.

CHRYSANTHOU: We just wish to reassure your Honour that we've been very careful to not go overboard as best we can and we're refining what we're seeking as much as possible as we progress through the documents.

HER HONOUR: Understood, thanks very much Ms Chrysanthou.

MURPHY: Could I also just confirm that the interim non-disclosure order has been revoked by your Honour.

HER HONOUR: Yes, I'll do that now.

MURPHY: And the other orders as well be made in accordance with the short minutes?

HER HONOUR: I make the interim non-publication orders now. That's all that's required Mr Murphy now?

MURPHY: All that's required your Honour.

DWYER: I call Detective Chief Inspector Andrew Marks. His statement is found in vol 1 at tab 30, and I think our court officer is placing it in front of him.

LTS:DAT

<ANDREW PAUL MARKS, SWORN(2.35PM)

<EXAMINATION BY MS DWYER

Q. Could you please tell the Court your full name and your rank?
A. Andrew Paul Marks, Detective Chief Inspector of Police.

Q. You are located within the Homicide Squad in New South Wales, is that right?
A. That's correct.

Q. You're the investigations coordinator for team 4 of the Homicide Squad?
A. That's correct.

Q. You're the officer-in-charge of this inquest, is that right?
A. That's correct.

Q. You've prepared a statement to assist her Honour which is some 93 pages I think, excluding the exhibits to it?
A. That's correct.

Q. Is the evidence in that statement true and accurate to the best of your knowledge?
A. Yes, it is.

Q. Can I ask you firstly, you're the officer-in-charge of the inquest, but have you worked with a significant team to bring this together?
A. Absolutely. Initially there were probably up to 100 detectives in the first couple of days, and then from that a smaller strike force of up to a dozen police investigators were working on that job.

Q. Who were the key members of that time?
A. You've got Detective Sergeant Paul Mangan. We've got Detective Senior Constable Brendon Coppola and Detective Senior Constable James Bale. I have a number of other key members of that team which I would acknowledge at a later time.

Q. Before I start with the substantive questions for you, I understand that you wanted to say something to the families?
A. Yes. I just wanted to say to the families that my sincere condolences for your loss and for those that are injured. I just hope that our investigation goes in some way to providing some answers for you for what happened on that tragic day.

Q. You were on call on 13 April 2024, is that right?
A. That's correct.

Q. How were you notified that you were required to attend?
A. I received a phone call on my mobile phone from the State coordinator who works inside the Sydney Police Centre.

Q. That was at about 4.15pm, is that right?
A. That's right.

Q. You were told at that time that there was an incident at Bondi Junction Westfield and there were multiple people who had been killed and this was a critical incident?
A. Yes, that's correct.

Q. That term critical incident means something to police and in terms of the requirements of the investigation. Can you tell us about that?
A. Yes, a critical incident is declared by an Assistant Commissioner of Police, usually a region commander of the area where the incident happens. A critical incident is defined by a number of issues. One, it could be a homicide of a police officer. It's the death or serious injury of a member of the public when police use their firearm, or whether it's been by a physical confrontation or use of other appointments. They are classified as level 1 critical incidents. And there's other critical incidents that are categorised as level 2, which potentially could be from the death of using a police vehicle or in a pursuit and/or in a police operation.

Q. You were appointed the senior critical incident investigator, sometimes called a SCII for short. That's the role of a SCII?
A. A SCII is to conduct the investigation into the critical incident, and the objectives of that is to identify the lawfulness of the actions of the police, whether the police have followed all policies and procedures, or if there's any other issues that are identified in relation to the behaviour of the police.

Q. For that reason is it important that the SCII comes from an independent command?
A. That's correct.

Q. Separate to you, there's also another inspector, Acting Detective Inspector Laurence Millburn. He was from Professional Standards Command and he was appointed the review officer. Can you explain the difference?
A. Yes. He's from the Professional Standards Command and he is the liaison between the New South Wales Police and the Law Enforcement Conduct Commission, referred to as LECC, and they oversight the investigation as to the ethical nature of the investigation and the appropriateness of it.

Q. I'll come to what you did on 13 April 2024 in response to information you received and I'll return to the actions of Inspector Amy Scott that you were required to have oversight of. By the time that you were notified of what had taken place, Chief Inspector Whalley was in command and control of the scene at Bondi Junction, is that right?
A. That's correct.

Q. Where was the command station at that time?
A. It was at the loading dock near Bronte Road.

Q. Understandably of course you had a number of conversations with him en route to Bondi Junction, is that right?
A. Initially I had the first phone conversation whilst I was at my home address, and then I had another conversation with him on the way to the location.

Q. You explain in your statement that shortly after receiving the first phone call you contacted Chief Inspector Christopher Whalley who was in command and control, and you were advised of what he was aware of at that stage?
A. Yes, that's correct.

Q. Approximately what time was that?
A. My first conversation was shortly after 4.15.

Q. You were told at that stage that as far as police knew at that time there were four victims who had been stabbed, two people had been confirmed to have passed away, the offender or at least one offender had been shot and killed at 3.37pm inside the shopping centre. So it's clear from what you're being told that information is still getting to police as at about 4.15?
A. Yes, that's correct.

Q. You note then that you had a further conversation with Chief Inspector Whalley in regard to a potential second offender. Was that also while you were en route to the scene?
A. Yes, that's right.

Q. What was that conversation?
A. I discussed ensuring that the CCTV video was secured and also reviewed to ensure whether there was any outstanding offenders.

Q. I'll ask you shortly about your arrival to Westfield Bondi Junction - I should say you received the call about 4.15, what time did you get to Bondi or to the Westfield Shopping Centre?
A. Shortly after 5.30pm.

Q. En route did you learn anything about this issue about a second offender?
A. Yes.

Q. Can you tell us what you knew and when?
A. I had a conversation with Chief Inspector Reimer who was tasked to review the CCTV and that was also en route to Bondi Junction, and he confirmed with me that he had reviewed the footage himself and he was confident that there was not a second offender and that Joel Cauchi was on his own.

Q. That's Mr Reimer, R-E-I-M-E-R, is that right?
A. That's correct.

Q. I appreciate that you're driving at this stage so you can't write notes at the same time, but approximately what time were you informed of that?
A. I would say roughly around 5 o'clock.

Q. It appeared to you that that information had come directly as a result of the review of CCTV footage, is that right?
A. Yes, that's correct.

Q. When you arrived at Bondi Junction at around 5.30 you were briefed by Chief Inspector Whalley and Inspector Adam Solah, is that right?
A. That's right.

Q. What were you told at that time?
A. At that stage, the information had changed from what I was first told, and then I was told that a number of other persons were confirmed deceased and that there were a number of witness officers that were, that were identified as witness officers in a critical incident, and that they were sitting in the command post.

Q. You name them in your statements, there's no non-publication order over their names I don't think, but it's not necessary to name them, but those officers had provided first-aid in very distressing circumstances to one of the individuals, is that right?
A. Yes, they provided first-aid to Mr Cauchi.

Q. You made arrangements for those two police officers to be taken back independently to Waverley Police Station to await further instructions, is that right?
A. That's right.

Q. Then you were also told that Inspector Amy Scott is the person who has discharged her firearm--
A. Yes.

Q. --at Mr Cauchi causing him to pass away?
A. Yes, I am.

Q. It's clear then from what I've just asked you, it was evident by that stage when you arrived at 5.30 that police knew who the offender was, Mr Cauchi, or did that come later?
A. I believe at that stage we were, we were aware of his name. We hadn't confirmed it but we, we were told that it may be Joel Cauchi.

Q. You will have heard in my opening, and we've discussed previously, that Joel's parents contacted police when they saw footage and confirmed that they believed that to be their son?
A. That's correct.

Q. After that, as you set out so carefully in your statement, you participated in a short briefing. You tasked Detective Senior Constable Megan Duckworth to secure the CCTV footage at that time from Westfield Shopping Centre and to ensure that was not released to any person, and that footage was then password-protected with only one Westfield employee having knowledge of that password, correct?

A. That is correct yes.

Q. As a result of that task and the briefing, you were then informed of seven persons being confirmed deceased including Mr Cauchi, five of the victims who had passed away were still within the shopping centre, Mr Cauchi was at the scene, ten victims were transported to various hospitals within the Sydney Metropolitan area and two victims that were transported to hospital were in a critical condition?
A. Yes that's correct.

Q. You tasked Senior Constable Lisa Meyers to remain at Westfields and you left for Waverley, is that right?
A. Yes that's right.

Q. For what purpose?
A. I tasked Detective Meyers to stay at the command post to be the liaison officer between the forensic officers and myself, and the investigation team and then I went back to Waverley Police Station to ensure that we could identify the deceased persons, to collect all known information about Cauchi and preparing profiles, collating a large number of witness statements from the witnesses from the Bondi Junction Westfield.

In relation to coordinating the CCTV canvass, tracking the movements of Cauchi from not just inside the Westfield Bondi Junction but also his movements prior to entering the shopping centre, downloading all the CCTV footage from Bondi Westfield and ensuring we kept that secure and that was not released to anybody and also identifying any of the surviving victims and their details and their current condition in the hospitals.

Q. I'm sure everybody listening understands we're not glossing over what took place then. You've mentioned hundreds of police officers who were involved in the investigation. There are an enormous amount of resources that then were channelled directly to Westfield Bondi Junction to do the investigation after the first priority, which was treatment, had been obtained, is that right?
A. Yes by the time our arrival as investigators, most of the treatment or the first aid had commenced on all of the victims and they had been transported to the hospitals as required.

Q. You mentioned your role in securing the CCTV footage. You directed that CCTV within Westfields be secured and not released to any persons. It's of some concern we know to families that footage was shown on the news. Did police release any footage?
A. No, and that was the main - my main concern that no footage was released. Obviously being aware of what happened and through my experience, I didn't want any of that footage to be released and I didn't want it to come from the police.

Q. Within the CCTV room we understand there's footage and we've seen a photograph of the CCTV room and you understand there are many hours of footage that police have reviewed. There's also CCTV cameras located

outside and inside shops that appear to be within the control of individual shops. Did police do anything about those shops?
A. Yes, we recovered all the CCTV footage from within the shops that were independently operated. The issue with that was that we could download that footage and store it on an external hard drive, but we couldn't remove that footage. It would mean that we would have to take the hard drives from every location which was not sustainable, so we did - everyone that was tasked to canvass with the CCTV footage was requested that they not release it to the media.

Q. You arrived on the scene at 5.30pm. Shops of course had been locked down in response to Mr Cauchi. Was it hard to exercise control over all that CCTV footage? That is, to stop the shops, individual shops themselves, releasing to the public?
A. Yes, and on top of that there's also mobile phone footage which we weren't able to gather straight away, and that footage within the first few hours was out there without our control.

Q. Yes, and you understand don't you, from liaising with families, the distress of families that that was released in the way that it was?
A. Yes.

Q. But from your perspective, everything was done by New South Wales Police to try and secure that and control that footage?
A. I was very mindful of that.

Q. The car park was locked down, various persons had to - who had gone to the shopping centre had to remain until police could canvass the car park, is that right?
A. Yeah the entire shopping centre was locked down for a number of days. Within 24 hours, witnesses and people that were attending the Bondi Junction Westfield shops inquired about releasing - getting access to their vehicles which were still stored at the - or still parked inside the Westfield compound. We arranged for a canvass to be conducted that every person who had a vehicle at Westfields had to go through a checkpoint and they were questioned and canvassed in relation to where they were and what they had seen and - before they got access to their car and then individually they were taken to their car and they got access to their car which was removed, but that happened some 24 hours after the incident.

Q. As you explain in your statement, at 7pm you contacted the New South Wales State Coroner, her Honour, and you briefed her. You were also required, I take it, to brief a number of executives from within the police. Is that correct?
A. That's correct.

Q. At 7.35pm you spoke with Inspector Amy Scott and you served her with what's known as a P1109 critical incident notice to directly involved officers. What is that?
A. That's a form that is signed by the directly involved officer. So in a critical

incident, somebody who's involved will be either nominated as a directly involved officer or a witness officer to the incident. That's usually done by a senior officer at the scene at the time and then it's ratified by the SCII, the senior critical incident investigator. They are then read the details on the form which explains the role of the SCII, that the matter that we're investigating is actually a critical incident, who it was declared - who declared it to be a critical incident, as in which Assistant Commissioner, the roles that the Senior Critical Investigator will play.

There's also that - there's an explanation that, that they will be required and their obligations as a directly involved officer, it explains that. It also advises that if I at any stage as a SCII identify any criminal behaviour that the investigation will roll into a criminal investigation, and it also advises them that they'll be directed to answer any questions in an interview, but they are not obliged to answer the directed questions.

Q. There's also a process where an involved officer has to undertake mandatory drug and alcohol testing, is that right?
A. That's correct.

Q. Of course in this case Inspector Amy Scott undertook that, there was negative for any drug or alcohol, and she also participated in an interview, is that right?
A. That's correct.

Q. I'll come back to that. I don't mean to gloss over any of your role but to note that you set out in detail what you had to do that night and in the days and weeks and months that have followed. That included very early on getting a warrant for Kennards Storage to recover any of the belongings of Mr Cauchi, is that right?
A. That's correct.

Q. You attended Bondi Junction again that night before midnight and that was to make sure that police had secured the crime scene, is that right?
A. That was to go over where the investigation was in relation to the crime scene examination, and it was also in relation to identifying the deceased victims that still remained at the site.

Q. At 12 midnight you had a conversation with Acting Assistant Commissioner Roger Lowe; that was to get his assistance, or the Queensland Police assistance to deliver the message to Joel Cauchi's parents that it was in fact their son involved and in fact their son who had been shot by police, is that right?
A. Yes that's correct.

Q. You note in your statement at 3.54am on Sunday, 14 April you had a conversation with Acting Assistant Commissioner Roger Lowe who told you that he had sent a team out to speak with Michele and Andrew Cauchi and they had body-worn video on and there was some information gathered as a result. Would you mind telling us about that at paragraph 20 of your

statement?
A. Yes. The information I received back from the Acting Assistant Commissioner Roger Lowe was that it was the belief of the police that went out to speak with the Cauchis that Michele Cauchi appeared to have no mental health issue, although they believed that Andrew Cauchi suffered from some mental health issues. The information from Michele Cauchi was that Joel Cauchi had been diagnosed with schizophrenia, although he was not currently medicated, that Joel comes and goes from the home address although he had not been living with Michele and Andrew for some months.

That Joel had no friends or family and the last message they received from him indicated that he was staying at a backpacker's hostel in Coogee. Joel owned a vehicle which was Queensland registration 825 DS9, a 2009 silver Toyota Aurion, that Joel had no terrorist ideology or fixation, he held no grievances nor was he a violent person, although he did have a current fixation with knives, and he held no hunting related skills, and he was not currently being treated or medicated for his mental illness.

Q. Is it fair to say that they were forthcoming with Queensland Police and tried to assist them?
A. Yes they were.

Q. Have you subsequently spoken to Mr and Mrs Cauchi, Joel's parents?
A. Yes I have.

Q. In your view, have they attempted to assist New South Wales Police with this investigation?
A. They have and they have from the very start, yes.

Q. You make a note there that what they tell police at that time is that he did not have any terrorist association or ideology or fixation. Since that first conversation and your first review, you've conducted an extensive search of Joel's phone or you've sought - tasked others to do so, also the Kennard Storage facility, numerous statements have been obtained from family and friends or former friends of Mr Cauchi's. Is there any evidence of any terrorism or extremist ideology that you can see?
A. No, not at all.

Q. Can I come now to the movements of Mr Cauchi on 13 April. In your statement, you set out his movements in Bondi Junction. I've covered some of them in the opening and in fact police have done a painstaking review of CCTV footage around the city that captures Mr Cauchi at various moments, starting off in Maroubra, going to Kennards and Bondi Beach and back to Bondi Junction, correct?
A. Yes that's right.

Q. There is also a compilation of CCTV that has been done by police in the brief of evidence that's available to her Honour and parties, is that right?
A. Yes that's correct.

Q. That leads up to the moment where Mr Cauchi was shot?
A. Yes.

Q. You and your team have reviewed hundreds, perhaps that's an underestimate, of footage of CCTV and body-worn and in fact everything that exists including the footage from shops. Does it appear to you from what - from your review that Mr Cauchi was targeting any particular individual in Bondi Junction?
A. No I don't believe he was at all.

Q. In paragraph 26 of your statement, you describe the attacks on civilians on that day as indiscriminate. Just to remind you, not that you need a reminder, there were 16 people who were killed that day other than Joel and 13 of them were women and three of them were men. Did it appear to you that Mr Cauchi appeared to be targeting women?
A. No, not at all. He, he - from the start of his attack, he moved very quickly and he appeared to attack people that were, were not ready, didn't know what was happening. He had an opportunity to stab numerous people and numerous females and I just believe that whoever was in his way where he was running is who he attacked.

Q. From reviewing hours and hours of CCTV footage, is it the fact that there were more women, or there appeared to be more women, on that day, on a Saturday, in Bondi Junction than men?
A. Yes. That's right.

Q. You would defer to any psychiatrist expert giving evidence later as to whether or not there was any indication on his phone or web searches about particular ideas about women, I take it?
A. Yeah. From what I researched, and what the team researched, I, I did not see anything that suggested that he was going to attack women. There was obviously information that he was going to attack, but there's no evidence that I could find that it was a attack specifically on women.

Q. I'll come to that web browsing and phone searching shortly. Some of the evidence to draw out from your statement includes the acts of civilians on that day. Can I take you to paragraph 29 of your statement?
A. Yes.

Q. There's some information there about when Joel was attacked. I won't go through that again. It's not necessary. You make a note of what Noel McLaughlin did that day in confronting Mr Cauchi. Is that right?
A. Yes.

Q. Is there anything else that you want to say about that?
A. I just believe that the actions of Noel McLaughlin were very brave in trying circumstances that he approached and tried to warn others of what Joel Cauchi was doing that day, and I think he should be acknowledged for his bravery.

Q. You also make a comment at paragraph 82 in relation to Ms Good and her actions?
A. Yes. That's correct.

Q. Without going into any of the detail, is there anything that you wanted to say about that?
A. I think that Ms Good should be posthumously awarded a valour award for her bravery in what she did in trying to save her daughter.

Q. It's pretty clear, isn't it, that her actions did in fact result in saving the life of her baby?
A. Absolutely.

Q. You also make a comment about the actions of Faraz on that day, and Muhammad Taha, the other security officer. At paragraph 114 you talk about Faraz?
A. Yes.

Q. Can you elaborate on that?
A. The two employees approached the situation that - of an active armed offender without any appointments that law enforcement officers have, and I believe that their actions were very, very brave.

Q. You're going to return to give evidence towards the end of the inquest, I understand. Is that right?
A. Yes. That's correct.

Q. Are you able to put together a list of civilians who you think might, in whatever way is appropriate, be recognised for their efforts?
A. Myself and my team are putting a list together, not only for the civilians but also for the police. I believe the ambulance have already done so. And those that should be recognised for their, their actions on that day.

Q. I might return to the police in a moment before I finish. But can I come to the actions of one particular police officer, Inspector Amy Scott. On Tuesday 16 April 2024 at Manly Inspector Amy Scott participated in an electronically recorded interview. She sets out in detail what her movements were on that day and her actions and why she took the actions that she did. We will of course hear from Inspector Scott tomorrow. But from your perspective as the SCII, you were required to review the actions of Inspector Amy Scott. Correct?
A. Yes. Yes.

Q. You've done so in some detail. In order to understand her actions, is it the case that an interactive 3D video was prepared which puts a 3D interaction alongside the actions of Inspector Scott, so that we can determine distances, for example, and what she was experiencing on that day?
A. Yes. That's correct. We prepared that.

Q. I'm not going to play you the one that sits side by side, because we might put that to Inspector Scott tomorrow. In relation to the interactive video, if that

might be played now so that I can then ask you some questions about the distances between her and Mr Cauchi?
A. Thank you.

DWYER: Your Honour, families are aware, and in fact Inspector Scott is too, that this is about to be played. Apart from the very end where we see, after about a minute, a snapshot of Inspector Scott holding her weapon and we see Mr Cauchi, for the most part it is an animation of what occurred, so we can see the distances and the movement of Mr Cauchi and Inspector Scott through Bondi Junction.

HER HONOUR: Thank you.

VIDEO PLAYED TO COURT

DWYER: And that's a snapshot of what we see at the end.

Q. Does that video accurately convey the timing that was involved?
A. From the time that Inspector Scott walked - sorry, ran into the shops?

Q. Yes?
A. Yes.

Q. We saw at the beginning of that reconstruction, Inspector Scott enter into the Bondi Junction Westfield close to the Zara site and then move up the escalator as she was directed by civilians?
A. That's right. I--

Q. And again, that will be dealt with in some detail tomorrow?
A. (No verbal reply)

Q. There was a notification, or a notation, on that interactive video of the distance between Inspector Scott and Mr Cauchi at the point at which her firearm was drawn. Can you tell us about that?
A. 6.5 metres was the point where - watching the CCTV review, that's the distance we say was the time that Inspector Scott fired her firearm - discharged her firearm, and two of her rounds hitting Mr Cauchi, and the third round going past into a pot plant further up.

Q. Are you able to tell us the distance that was covered by Mr Cauchi and by Inspector Scott?
A. Yes. We believe that Joel Cauchi ran 737 metres from the start to the finish, and Inspector Scott ran 122 metres.

Q. When you say that Mr Cauchi ran 737 metres from start to finish, do you mean from the start of the attack to the end of it?
A. Yes. That's correct.

Q. And Inspector Scott ran 122 metres?
A. Yes.

Q. Is it evident when you see that location in real life that at the point that Mr Cauchi was running towards Inspector Scott he was armed with the KA-BAR knife that we've heard about and appeared to be about to deploy it?
A. Yes.

Q. He was running downhill towards her?
A. Yes.

Q. Having conducted your review, it might be obvious, but can you comment on what your evidence is in relation to the propriety of her actions on that day?
A. The investigation found that Inspector Scott discharged her firearm lawfully and - and within all policies and procedure. She acted bravely and professionally.

Q. In relation to her professionalism, I've said this in the opening, but is there anything you wanted to say about what she did in terms of getting people to stay behind her, but also the civilians in front?
A. I was - upon interviewing Inspector Scott I was in awe of her ability to recall the, the situation that she was faced with and the fact that the reasons why she had not drawn her firearm in relation to being a crowded shopping centre and, and worried about an accidental discharge, or having to discharge her firearm and making sure that there was nobody in the way for potential cross fire.

And the fact that she was aware of her surroundings, that she made sure that - Inspector Scott made sure that she had everybody behind her, so that they could not be in the way of the offender Joel Cauchi, and herself. And the fact that she ensured that the customers and the shop assistants within that area, across the air bridge, stayed inside. And more importantly, that - the presence of mind to know that there were people in front of her, but behind Joel that would have been in her line of fire, and she communicated with them to, to get out of the way.

Q. You mentioned that Inspector Scott discharged three rounds. Two of them struck Mr Cauchi, one of them didn't. Where did the round go that didn't strike Mr Cauchi?
A. The third round went past Mr Cauchi and across the air bridge into an area where a large pot plant was, and the area behind that was the position of a number of shoppers who had - there was at least two prams there, so females pushing prams, and another young child and, and two females pushing the prams. And they're the people that Inspector Scott communicated with to, to move away from that area.

Q. In a conference with you prior to this time I think you described her as professional and that what she did was textbook. Scott Wilson, the expert, describes her actions as exemplary. Do you agree with that?
A. Absolutely. Absolutely.

Q. There are other police of course who responded very soon after Inspector Scott, some of them were very young officers, and we understand,

from watching some of their actions, the work that they did to save lives. Is there anything that you wish to say at this point about them?
A. Yeah. Looking through - the investigation team and myself have, have looked through hundreds, if not thousands, of hours of CCTV and body-worn footage and what these police were confronted with was very distressing. Their, their actions were brave, going into an area that they weren't aware of exactly what was happening in the initial stages. Their response was professional and in line with their training. And on top of that, they did everything they could to save the lives of the injured and - and they should be commended for their actions.

Q. Can I turn to a different topic which involves the KA-BAR knife. There's a photograph of the knife at various points in the brief of evidence. One, for example, I'm not going to put it on screen, is at tab 922A. You set out in your statement the history of that knife. What is it?
A. The KA-BAR USMC, which stands for United States Marine Corp, knife, as said earlier, was a replacement knife for the, for the US Marine Corp for World War II. It was used to open rations; used to cut clothing; and also used as a last option in hand to hand combat. And that was the, the origin of that knife.

Q. The blade itself is around 20 centimetres. Is that right?
A. That's correct.

Q. You've undertaken some investigations about where it's sold. It's sold in what might be described sometimes as camping stores and hunting stores. Is that right?
A. Yes. That's right.

Q. Are there knives similar to that also sold in those stores?
A. Yes.

Q. What are the legitimate uses for that knife?
A. It's legitimately used, or sold, for the purpose of hunting and for - for those that are inclined to go camping and hunting and - and assisting with hunting animals and killing animals.

Q. We are still waiting on some information about the legitimate uses from the suppliers and retailer. Are you prepared to give some further evidence on that in terms of the possibility, or practicalities, involved in restrictions on knife sales?
A. Yes.

Q. In relation to Mr Cauchi's mental health, which I've gone through in some detail this morning, we can of course ask the mental health experts when they believe Mr Cauchi first became sick. But from our review of the brief of evidence it appears to the counsel assisting team that while he was living in Toowoomba and was under private psychiatric care and taking his medication, until the end of 2019, he remained stable. Is that your understanding, having reviewed the brief of evidence?

A. It is my view, yes.

Q. After he commenced medication then, was there any evidence that he was violent? That is, from the time he commenced medication until the time that he left to live in Brisbane?
A. No.

Q. Any evidence during that time of any perverse attitudes to women?
A. No.

Q. When he was living in Brisbane from early 2020 through to early 2023 when he returned to Toowoomba and lived with his mother, is it the case that he did not commit any offences known to Queensland Police?
A. Yes, that's correct.

Q. For the purposes of trying to determine what was in Mr Cauchi's head when these terrible incidents occurred, you have reviewed the content on various phones, is that right?
A. Yes, that's right.

Q. That has enabled you to view web searches?
A. Yes.

Q. Were there computers as well that were seized?
A. Yes.

Q. You deal with this at paragraph 290 of your statement. In relation to the first phone that was seized, we don't need any of the serial numbers, that included the following searches, and I'll just nominate some of them. On 24 October 2023 is it the case that police understood from his private browsing that Mr Cauchi searched "What can neuroscience tell us about the mind of a serial killer"?
A. Yes.

Q. That was bookmarked?
A. Yes.

Q. Also "Self-inflicted deaths in Australian prisons"?
A. Yes.

Q. "12 common traits of serial killers" and "21 famous serial killers". In November 2023 he appeared to have searched "Last mass stabbing Australia", "Five best assault rifles in the world" and "What things do people regret while dying?" by way of an example. We know that in November 2023 Mr Cauchi was assessed by a psychiatrist during a single care episode, and at that time during that single care episode - I withdraw that. It was a general practitioner who saw Mr Cauchi at that time in November 2023, and during that single care episode he did not identify any evidence of acute psychosis. But at that exact same time, what police have been able to identify is that he was searching this very dark material?

A. Yes, that's correct.

Q. And this is about nine months after Queensland police had an interaction with him where Joel's mother said to the police that she believed that he was unwell at that time but he didn't know he was sick?
A. Yes.

Q. In March 2024 there were five searches that were related to the USMC KA-BAR knife?
A. Yes.

Q. There had been various searches about that knife since October 2023?
A. Yes.

Q. Then in April, on 9 April 2024 for example, Joel searched "14 bands that serial killers loved" as well as cancelling a New South Wales registration and fine for not handing in numberplates. The relevance of that is the bizarre nature of his thoughts. That he was dealing with the registration. He texted his parents about his registration in a text message that seemed banal, but he obviously had these very dark thoughts at the same time, is that correct?
A. That's right. He'd sold his vehicle, the Queensland registration vehicle, in February of 2024.

Q. There are further searches that are identified in Wikipedia, in Google search, on Reddit, and on Spotify, and on Netflix, Twitter, that all relate to, if I might just broadly define them killing, or in some cases serial killing, is that right?
A. Yes. May I add as well that there's a specific search as well as "cop killer" as well that was on there.

Q. In fact, that emerges on a number of occasions doesn't it, he Google searched music with a cop killer video and then again searched cop killer?
A. Yes.

Q. There's a Reddit search on 13 April which is of course this terrible day relating to three posts of Columbine killers and that was at around 8.47am, including parent statements and what's your opinion of Dylan and Eric, correct?
A. Yes.

Q. I won't go into any more detail about that, but clearly that material suggests very dark and disturbing thoughts. Was it known to any agencies that you're aware of?
A. Not that I was aware of, no.

Q. In terms of Joel's parents, did they ever become aware that he was engaging in any of those searches?
A. Not that we could see, no.

Q. That's consistent with what they say as well isn't it, that they had no idea

that he had deteriorated in that way?
A. Yes.

Q. But there is evidence that they were foreshadowing or that his mum was foreshadowing a deterioration as early as late 2019 when he'd come off his medication, correct?
A. Yes, she'd seen some warning signs and she reported those.

Q. After Joel moved to Sydney he reported back to his parents that he was living in a hostel in Coogee. Is there any evidence of that?
A. Not at all.

Q. So he appears to have been homeless during the period he was in Sydney?
A. Yes.

Q. He had a Kennard storage unit. What was that used for?
A. He used the Kennard storage unit as an area to place all his belongings. As he was living on the street he would hire a Kennards storage, small cages, to put all his belongings, being his clothing, food, books, and all his belongings.

Q. When police attended on the premises of Andrew and Michele Cauchi on 29 April, Mr Cauchi senior handed him four of the KA-BAR knives and another type of knife called an Azero knife, and they were ones that he'd taken from Joel, is that right?
A. That's right.

Q. The evidence from Queensland police disclosed that police had had a number of interactions with Mr Cauchi. I've run through them at least broadly in the opening. They were interactions about Mr Cauchi's driving, they were interactions in relation to a random search that was conducted on the Gold Coast, on one occasion they were called because of banging, but the most significant appears to be an interaction in January 2023, is that right?
A. Yes, that's right.

Q. You have reviewed the body-worn video that police turned on during that interaction?
A. Yes, I have.

Q. Have you also reviewed the police executive statement from Queensland that's been provided?
A. Yes, I have.

Q. We can ask you to return to the witness box after you've heard the police executive of course, but you understand that in Queensland there appears to be a different legislative scheme that exists in New South Wales in terms of the police interacting with mentally ill people, such that in broad measure under the Queensland legislation they are directed to take somebody for assessment if they are deemed to be a harm to themselves but it doesn't specifically say a harm to others?

A. Yeah, that's right. That's the difference between the Queensland legislation and the New South Wales legislation.

Q. We understand the Queensland executive to be calling for a change in that legislation. Is that something that you think would be sensible?
A. Yeah, absolutely.

Q. We understand that police on that occasion who were in attendance did not think that they could or should remove Joel to ensure that he had an assessment, but they did think that he needed follow-up for his mental health because of what they were being told, and there was no follow-up because he appears to have fallen through the gaps. I want to come specifically to that information. There appears to be in Queensland a follow-up service that exists so that if police who are in attendance think that other services should go out as second responders, they can deal with that or send an email to that effect. Is there any such service in New South Wales?
A. There is a new mental health unit that has just been established within the New South Wales Police, but that's only in its infancy and I am aware that they are looking to have better practices in relation to mental health and how we respond to that. Mainly because it takes up a lot of the first responders' time.

Q. That's what I'm coming to, so perhaps we'll return to the specifics of what is being developed and what might be learned from this incident. Does it appear to you that this is a timely opportunity for the setup of that new unit to review what went on in this circumstance?
A. Yes.

Q. It's a long time since you've been a general duties officer, is that right?
A. It's a long time.

Q. How long?
A. 33 years maybe.

Q. Did you spend some time as a general duties officer interacting with people who appeared to be mentally ill on the street?
A. Yeah, throughout my career I've come across that. A lot within the role of a homicide detective, but also, also just as a detective and a general duties police officer, yes.

Q. Do you understand from what general duties police are saying now, that an enormous amount of their time is spent dealing with people who are mentally ill?
A. Yes, and I might say that 33 years ago there were institutions that were around at that stage. That no longer exists. There's a lot more doss houses where people are placed in, within the community that have mental illness. But from some of the figures and some of the intelligence reports and the documents from the New South Wales Police, a lot of the first responders' time is dealt with mentally ill people.

Q. There's the time that is involved when police interact with that person in the

first place. If they then take that person to hospital for assessment, what further time is required from the New South Wales Police perspective?
A. So if first responders or police come across somebody who is mentally ill under section 22 of the Mental Health Act they can take them in, and again as you stated if they believe that they're a danger to themselves or members of the public they can take them to be assessed at a hospital, and they are assessed by a medical practitioner, and then if they believe that they are in need of further medical assistance, they are scheduled and taken to an institution for, or a mental health facility, to be, to be treated.

There is a lot of time whereby the first responders are left at the hospitals waiting for the medical practitioners to review and to assess those that are, that are mentally ill, to do that assessment, and it takes a lot of the time of the first responders.

Q. That's time that police can't be dealing with domestic violence offences or any of the other offending in the community that they're required to attend to?
A. Yes, that's right.

Q. Are you aware of a level of frustration from police in relation to that?
A. I believe it's highly frustrating to the first responders.

Q. Is it often the case that police also might take someone for assessment and then very soon after they are released from hospital and they might be in the same situation where police are having to attend to a job where members of the community are concerned?
A. I believe that is the case, yes.

Q. In relation to critical incidents where police have discharged their firearm or had to use some other mechanism like a Taser, how many of those involve somebody who is deemed to be mentally unwell? That is, where police are using lethal action against someone who is mentally ill?
A. It's hard to put a figure on that, but in my time at the Homicide Squad the majority of cases where police confront somebody and use their appointments and unfortunately someone passes away, I believe that it, it is almost, almost the case that the majority - well, it's not every case but I would say nine out of ten cases involve mentally ill people where police are called upon, and again they're put in dangerous situations.

They're there to protect the community because there's dangerous situations. And I am mindful of what I am saying is that because there are inquests that are due to be heard, but from my experience, our first responders and those that are involved in critical incidents are almost always involve a level of a mentally ill person.

Q. Then the fallout from that for police, if they have to discharge their weapon in those circumstances and kill someone who's mentally ill, is that a vicarious trauma that you're aware of is impacting significantly on police?
A. It is, yes.

LTS:DAT

Q. With all of that in mind, is it your view that there needs to be serious consideration given to co-responder models, where police can attend either with mentally health trained individuals at the time or very soon after get follow up from mentally health trained individuals?
A. I know there is positions where there - that's afoot and that's happening. Although I'm not sure where that is at. But in a perfect world that would be, that would be ideal. The issue is sending in - and the balance of sending in a clinician to speak to somebody that's armed--

Q. Sure, but a co-responder model would involve police and the clinician, correct?
A. Yes. Yeah that's right.

Q. In terms of follow up, once the immediate danger had been removed, the mental health clinician can take over, is that the plan?
A. And that would be ideal.

Q. If those resources are spent upfront, significant resources might be saved down the track in terms of dealing with the trauma of somebody having been killed or the constant release of somebody who has a mental illness into the community?
A. Yes that's my belief yes.

DWYER: Your Honour I anticipate that we will hear more evidence about that from New South Wales Police and the specialist involved in mental health intervention and what is currently being proposed, and also of course from the psychiatrists who've worked in this system over decades and have seen changes, some for the better and some not, within New South Wales over this period of time.

HER HONOUR: Yes, thank you.

DWYER

Q. The last topic I had for you is in relation to the role of the FLOs, or family liaison officers. What is that position?
A. A family liaison officer is a new concept that's been going on for probably two years now where officers are dedicated to the families of victims of homicides and they are the liaison between the families and the investigators in relation to what they - to expect. Anything - any help they need. They play a very important role on the investigator's side where they can get the information that's required from the families in a timely manner.

I think they are an important resource for the New South Wales Police and they do an exceptional job. Again it's only early this - they're not a unit. They, they are - they're called from wherever they are stationed or wherever their duties are, they're called away from their typical duties and then they're asked to perform that role on top of their duties.

Q. Of course it's a matter for families whether or not they want a FLO or want

to continue to work with a FLO, correct?
A. That's right.

Q. Different families will have different needs in those circumstances but from your perspective that's an important innovation in New South Wales policing, is that right?
A. It is, especially in a matter such as this, it has been such an important resource because of so many victims, not just - also the FLOs were deployed to the injured victims as well.

Q. I see, so there was a FLO for each of the 16 families other than Mr Cauchi's family, correct?
A. Yes.

Q. Then in terms of Mr Cauchi's family, individual police officers worked with them to keep them informed of the investigation?
A. Yeah I, I acted as the FLO for the Cauchi family.

Q. That's because currently the policy doesn't allow for an individual FLO to have been appointed to them, is that right?
A. Yeah that's correct.

Q. I've been asked in relation to that position of FLO to ask you some specific questions for Faraz's family, and I'm asked by Mr Fernandez to do this and he can ask any follow up questions if required, but could you tell us about the process of appointing a FLO for Mr Tahir's family?
A. Yeah so the process in relation to the Bondi Junction mass casualty event as a whole, there were a number of police called out. As you can appreciate, they hadn't been called to this scale previously and they came from throughout Sydney and also the Central Coast. The time they arrived was a little bit later than we anticipated but it took some time to gather all the FLOs. The FLO coordinator allocated a FLO to each family and one FLO was allocated to the Faraz Tahir family.

Q. I think that first FLO was allocated at 11pm on that night, is that right?
A. Yes that's correct. That FLO commenced inquiries in relation to the identity of Faraz Tahir, arranged for police to go around to the address of Faraz and there was no person at home. A number of inquiries were made on the COPS system and also attempts were made to get in contact with the Pakistan consulate here in Australia. And that continued up until about 7.30 in the morning. At that stage the officer involved had concerns for his own health and requested that he be taken off those duties and he was replaced sometime later with the FLO that's currently in existence now.

Q. In relation to the FLO who's currently assisting, you understand that FLO to have a very good relationship with Faraz's family?
A. Yes that's correct.

Q. There were 16 families - six families who had lost a loved one, and there was a particular complication in this case because some of Faraz's family and

of course some of Ms Cheng's family were overseas, is that right?
A. Yes that's right.

Q. Is there anything about the need to go through the consulate connections that caused delays?
A. Yes. When we are required to issue a death notice to the family, protocol will dictate that we'll have to contact the consular - it's not best practice to make a phone call overseas to tell somebody that their loved one has died. We prefer to have somebody in person deliver that message. So that, that again takes time.

Q. That was all I wanted to ask you at this stage but just to note that you'll be here throughout the whole of the five weeks, is that right?
A. Yes that's right.

Q. You'll be able to assist in following up any evidence as needed. Some other members of your team are here with you of course in court today and have been here throughout assisting?
A. Yes.

Q. When you return to the witness box in particular, we plan to have a set of draft recommendations by that period of time and I understand you'd be happy to assess those, particularly those that relate to New South Wales and Queensland Police and offer us your expertise in that regard?
A. Yes.

DWYER: Thank you your Honour. There might be some other questions.

HER HONOUR: Yes, thank you. Would anyone - first of all we'll start with this courtroom, have any questions? Ms Chrysanthou?

CHRYSANTHOU: Yes we have some questions but we've agreed with counsel for the New South Wales Police to put them in writing so as to assist Inspector Marks to consider the relevant documents and to answer more fully, so we thought that would be more convenient.

HER HONOUR: Yes, thanks very much. Mr Fernandez?

FERNANDEZ: I have no questions.

HER HONOUR: Mr Roff?

ROFF: I'm going to most likely adopt the approach my learned friend Ms Chrysanthou mentioned if your Honour would permit that. Thank you.

FRECKELTON: We have no questions, thank you.

SPEAKER: No questions.

RICHARDS: If I might be permitted to go last. I act for the--

HER HONOUR: Certainly, yes. Going into courtroom 2.

JORDAN: Yes can your Honour hear okay?

HER HONOUR: Yes, thank you Mr Jordan.

JORDAN: Thank you, we have no questions.

CASSELDEN: I have no questions your Honour.

HER HONOUR: Thank you Mr Casselden.

CLARKE: I have no questions.

GNECH: I have no questions thank you.

MATHUR: Likewise no questions.

PEN: No questions.

ROBB: No questions.

WILSON: No questions.

LYNCH: Likewise.

HER HONOUR: Thanks very much. Ms Richards?

RICHARDS: Nothing at this stage, noting that Detective Inspector Marks may be recalled.

HER HONOUR: Thanks very much.

Q. Detective, you may stand down now and thanks very much for your assistance and the hard work you've been doing.
A. Thank you your Honour.

<THE WITNESS WITHDREW

DWYER: That completes the evidence for today. We ask that we return at 10am tomorrow. We'll hear from Chief Inspector Amy Scott and from two civilians tomorrow.

HER HONOUR: Thanks very much.

AUDIO VISUAL LINK CONCLUDED AT 3.39PM

ADJOURNED PART HEARD TO TUESDAY 29 APRIL 2025