LTS:DAT

IN THE NEW SOUTH WALES STATE CORONER'S COURT

STATE CORONER O'SULLIVAN

TUESDAY 6 MAY 2025

2024/00139002 - BONDI JUNCTION INQUEST

NON-PUBLICATION ORDERS MADE

PART HEARD

AUDIO VISUAL LINK COMMENCED AT 10.06AM

HER HONOUR: Good morning. Dr Dwyer.

DWYER: Your Honour, I call - I beg your pardon, your Honour. Before I call the first witness, I think Mr Gnech wanted to put something on the record.

GNECH: Good morning, your Honour. Could I just bring to your Honour's attention that after the orders that you made yesterday in regards to my client, that pp 10 and 11 of the Courier Mail today has full frontal photographs of three of my clients walking into court. I appreciate there's not a lot your Honour can do at this stage, and my clients are focused on the primary purpose of these proceedings, but I thought it proper to put on record that there has, in essence, been a breach of your Honour's order, which carries with it a six-month maximum penalty as a criminal offence.

HER HONOUR: Yes, and that is regrettable that that's happened, Mr Gnech. And that is a reminder to all media outlets that there is an order in place and that there are penalties, and serious penalties, for breaching that order.

GNECH: Thank you, your Honour.

HER HONOUR: Thank you, Mr Gnech.

DWYER: Your Honour, I call QPS5. QPS5's statement is found in vol 23, tab 855A.

LTS:DAT

<QPS5, SWORN(10.07AM)

<EXAMINATION BY DR DWYER

Q. Could you please tell the Court your full name?
A. QPS5.

Q. You're a Sergeant in terms of your rank. Where are you currently located?
A. I'm currently located in Toowoomba in the Darling Downs police district. I operate out of the Domestic and Family Violence and Vulnerable Persons Unit as the Mental Health Intervention Coordinator.

Q. The Mental Health Intervention Coordinator, that's the MHIC, is that right?
A. That's correct.

Q. I'm going to ask you to explain a little bit more about that role shortly but first start with some of your background in New South Wales(as said) Police. You've been a police officer for 25 years, is that right?
A. That's correct, but before we go ahead can I please address--

Q. I beg your pardon. Please, thank you.
A. I wish to pass on my sincere condolences to the family and friends here today. I want to acknowledge the family and friends that cannot be here for whatever reason, and I'd also like to acknowledge the victim survivors, the witnesses and the first responders from that day. I'm sorry.

HER HONOUR

Q. That's okay. Thank you very much for those words. And take your time. Have you got some water there?
A. Yeah, I'm fine, thank you.

Q. Yes, okay. You just take your time.
A. Sorry.

Q. That's okay. Thank you very much.

DWYER

Q. You had no contact at all with Joel Cauchi prior to--
A. That's correct.

Q. And in fact, as we'll come to, you were in the substantive position that QPS4 was filling in for you on 8 January 2023?
A. That's correct.

Q. That's largely why you come to give a statement in these proceedings, correct?
A. Yes.

Q. But you're also able to talk to us more generally about the issues with mental health in the Darling Downs area that you are involved with?
A. Yes.

Q. And the role of the MHIC. Towards the end of your evidence, I'm going to come to the Coroner's function to make recommendations and what you see as the real needs for community members to keep people safe.
A. Correct.

Q. You've been in that position as the MHIC, the Mental Health Coordinator, on a part-time basis from August 2012 to August 2022, and then you've been full-time in that role since that?
A. That's correct.

Q. Prior to 2012 - I started off saying you've been a police officer for 25 years since the year 2000. Have you spent your time as a general duties officer out in crews like QPS2 and QPS3 were in January 2023?
A. Yes.

HER HONOUR: I'm sorry to interrupt. We've got a problem with the recording at the moment. I'm just going to see if it can be fixed immediately.

Q. Unfortunately we're going to have to take a short break just to make sure the recording's working. I'm very sorry.
A. No, it's okay.

HER HONOUR: So, if we just take hopefully only five minutes.

SHORT ADJOURNMENT

HER HONOUR: Thank you. We'll continue with the evidence.

DWYER

Q. I'll just go back a step. You've been a police officer since the year 2000. I was asking you about whether or not you had worked in general duties, and you said you had. So you had been in a van on callouts in a similar way to the way QPS2 and QPS3 were required to respond in January 2023?
A. Yes.

Q. For how long were you a general duties officer?
A. I was a general duties - I initially started my career in Mount Isa for two years. I did 12 months in Normanton, then seven years in Gladstone, and transferred to Toowoomba in 2010, and have been there since. General duties was for the first four years of my career, as a direct first responder.

Q. For the first four years, did you say, of your career?
A. Yes.

Q. Is it fair to say that in your time as a police officer, you are aware that a

significant amount of the work involves dealing with mental health issues or episodes in community?
A. Yes. And increasing.

Q. Have you had, as part of your role being on the ground in GDs, an experience of transporting somebody for an urgent mental health assessment?
A. Yes.

Q. Prior to that, when you were in GDs - I withdraw that, given you haven't been there for a while.
A. I can--

Q. Let me ask you about the increase--
A. Sorry, I can respond to that. Even though - you don't have to just be in general duties to respond to emergency - mental health incidents. Since I've been in my role, I've probably had more exposure as a first responder than previously in generals.

Q. Why is that?
A. My role as Mental Health Coordinator. I overview all the calls for service and I actively watch our job log, so basically all the jobs are outstanding that crews have to be detailed to, and if I feel that I can be of assistance or there are no other crews available, I will attend to those as well.

Q. I see. So you go out in person yourself?
A. Yes.

Q. Have you also been involved then in circumstances where somebody doesn't fit the strict criteria of an EEA, but nevertheless, they are mentally ill or disturbed and need to be referred or for follow-up treatment?
A. Yes.

Q. Have you been involved then in recommending to somebody that they have treatment, or asking if they will participate in voluntary treatment?
A. I always ask if they'll attend voluntarily, engage with their GP, attend the, the hospital where they can see an acute mental health clinician. I also explore the process of examination authorities for people who will not attend voluntarily.

Q. I'll come to what advice you give to your officers on the ground about that. But before I do, a change in community needs. You said that there was an increase in the number of callouts, or the requirement for police to engage with people with mental health issues. Is that right?
A. That's correct.

Q. Over what period have you noticed that increase?
A. I can speak directly to the last 13 years since I've been in my role. There's been a steady increase of calls for service, but I want to articulate that my role goes beyond people with mental illnesses or mental health issues. It's expanded so much to include all persons with vulnerabilities in the community.

So we're, we're engaging with people who have behavioural disorders, personality disorders, psychosocial issues, intellectual disabilities, elderly, dementia. So in the scheme of all the jobs that we attend with some sort of vulnerability, I would say mental illness is actually the lesser of the lot.

Q. I'm going to take Officer Quinlan to a draft MHIC document - some guidelines--
A. Yes.

Q. --and it just says this, "The mental health system and justice system" - sorry.

DWYER: For the benefit of my friends, this is at exhibit F to the statement of Officer Quinlan, p 131.

Q. I'll just read you the relevant portion. "The mental health system and justice system interact at many points often with police."
A. Yes.

Q. That's an obvious one. "As gatekeepers to the justice system police officers are increasingly engaged in responses to mental health crises." You'd agree with that?
A. Yes.

Q. "Police officers as first responders are a vital gateway for many people into mental health care and support." You'd agree with that?
A. Yes.

Q. It goes on to say, "In Queensland, mental health calls for service have increased by 51.3% between 2016 and 2020"?
A. Correct.

Q. That's even before COVID--
A. Yes.

Q. --an increase by 51% between 2016 and 2020. Does that fit with your experiences, anecdotally or actually, about the increase in callouts?
A. Yes. I would go on to expand on that that those stats would be - are relied on specific incidents where we're - it's coded as a mental health incident, or there is a report on QPRIME that has some indication of a subject or identifier as mental health. It may not take into account the multiple other attendances that are not reported on or have been dealt with in another manner.

Q. I'll ask Officer Quinlan a bit more about the structure of mental health supports for police callouts in Queensland. But you've had that part-time role since 2012. Was that the first time it was created, at least for the Darling Downs area?
A. No. It was held as a portfolio by officers prior to me taking on that role.

Q. And then why was it made full-time in 2022?

A. We obtained a Domestic and Family Violence and Vulnerable Persons Unit in Toowoomba, and then they've created the full-time position to fall in line with staffing for that.

Q. In terms of the MHIC, I've just got some information from documents available to us that say:

> "The Queensland Police Force uses Mental Health Intervention Coordinators (MHICs) as part of their mental health response strategy to improve police responses to mental health crises. These coordinators work to connect police with mental health services and supports, as well as provide training and resources for officers."

Is that correct?
A. Correct.

Q. The MHICs seem to have the ability to tailor their supports for their community and resources available. Is that right?
A. That's correct. And I can only speak to the Darling Downs district.

Q. This is described in documents for Queensland Police as some of the key aspects to the MHIC role. Can you tell us whether or not this relates to the Darling Downs area. I'm going to take you to five bullet points. First, "Coordinated strategies. MHICs help develop and implement strategies for response to mental health incidents." Is that part of your role?
A. Yes.

Q. "Training and support. They provide training and support to enhance the knowledge, skills and confidence of police officers in response to mental health crises"?
A. The training is a little limited. The actual training that I deliver is to first year constables or first response officers. But any - I'm happy to give any advice at any time, or if there is change in legislation, policy, procedures, I'll communicate with the general duties teams.

Q. In terms of giving advice to individual officers, would you get phone calls during your shift hours?
A. I get phone calls, emails, tasks, texts, anything.

Q. What are your hours a day?
A. I start early. I start at 6.30 and work until 2.30 each day. I get in that little bit earlier in case there's been a major incident overnight that requires reporting on or reviewing prior to the morning meetings by the district officers.

Q. That's working by yourself from 6.30 to 2.30?
A. Yes.

Q. Monday to Friday, I take it?
A. Yes.

Q. I'll just finish these bullet points and I'll come back to what a typical day looks like for you.
A. Yeah.

Q. Queensland Police say that, "The MHICs involve collaborating with various stakeholders, including the Tri-Agency Mental Health Steering Committee".
A. Correct.

Q. Is that something that you do?
A. Yes.

Q. Are you on that steering committee?
A. I participate in operational liaison committee meetings quarterly, so.

Q. Where are they based out of?
A. Queensland Health.

Q. The fourth one was, "Community Engagement." That you are expected to "engage with the community and mental health sector to build awareness and confidence in Queensland Police mental health's capabilities"?
A. Correct.

Q. Do you do that?
A. Yes.

Q. How do you do that?
A. I do a lot of outreach. I have built relationships within the Darling Downs district, that I'm a direct point of contact from - by not only Queensland Health, Queensland Ambulance Service, other government organisations like the Office of Public Guardian, Public Trustee, housing, but I also am a point of contact for numerous non-government organisations that might have NDIS participants or private patients that have given consent to communicate with me.

Q. MHICs can provide direct support to individuals in mental health distress connecting them with appropriate services and resources?
A. Correct.

Q. You gave an example of that where you might actually go out--
A. Yes.

Q. --if there is nobody else to assist?
A. And I go out proactively as well. So - I might address that in your next question, sorry.

Q. You are one person--
A. Yes.

Q. --in an office working from 6.30 until 2.30. What's the population size of the area you're covering?

A. Darling Downs district is approximately 220,000 people.

Q. Are you able to tell us roughly how many officers there would be in general duties?
A. General duties across Darling Downs district - general duties would have to be close to 300.

Q. You're obviously not going to be able to cover all of those officers to provide support and assistance--
A. That's correct.

Q. --but can you tell us what a typical day looks like for you?
A. So I commence duties. I will come in. I will review my emails, see if there's anything of urgency there. I review all the calls for service that occurred the previous 24 hours, or 72 hours if it's a Monday. I look at what has been reported on our police reporting system, QPRIME, that has a mental health as a subject or an occurrence. That is what emergency examination authorities police have completed. I audit those to ensure that they are articulate and accurate and within policy and procedure. I ensure that all the reporting around that is correct custody reports. We've got people flagged accordingly.

I look at all the calls for service that we've had where we've had to assist Queensland Health either to - as a request for police assistance, to go to assist with an examination authority, or to transport patients, and calls for service for authorities to transport, where there's been requests for police to locate people under treatment authorities or forensic orders in the community, to be returned to hospital for further treatment.

I review all the calls for service that don't fit the occurrence type. It might be a welfare check. We've assisted QAS with an emergency examination authority. We've attended to people with intellectual disabilities, dementia, vulnerable people. Anyone that sort of falls out of the scope of criminal policing that have some form of vulnerability, I review all those. And through that, because there's so much of it, effectively at times I have to triage my follow-up. I have to risk assess and identify who is repeatedly coming in contact with police, who do we know are a risk to themselves or the community, to, to re-engage with. Ideally, I would love to engage with every person the following day after police have had some sort of interaction. It's just not possible.

Q. You say ideally you would like to do that, because obviously then you're going to be able to skill up the police who attended, and make sure nobody falls through the cracks?
A. Yeah. It, it educates the community on police procedures. It - one of the things that I do is, what - I call it proactive preventative engagement. So, if I see an incident overnight where someone has had contact with police and it was a little bit adverse and we consider that there might be ongoing contact there, I'll go out and meet with them, set up a bit of a de-escalation plan if there has been uses of force by police. De-escalation plans are not for everyone, and I - it, it depends on the information they provide me. So I do enjoy that and, and try to engage with as many people that I can.

Q. If you were going to be able to follow-up each of those calls, what sort of resourcing would be required in your unit?
A. In a perfect world, in a perfect world I would love to have three extra staff under my banner of Mental Health Intervention Coordinator. That would provide us with a two-shift response to assist with mental health calls for service, second response to jobs assisting general duties, second response to jobs assisting QAS to free up general duties to go to other calls for service and follow-up engagements with people that themselves are not available during the 8 to 4, 6 to 2 type timeframe.

Q. You say in a perfect world, but actually that's a world in which we need to start thinking about how you resource police to adequately respond to community mental health needs that can prevent, hopefully, horrendous tragedies, which end up costing the community an incalculable amount of money. Is that fair?
A. Yeah, that's correct. With the preventative engagement, we want to stop people having contact with police and have contact with the most appropriate service. We know we don't go - police and mental health patients don't always go well together. So, if we can redirect them, wrap supports around them so that we are not the first port of call, and then that risk of police use of force there or misuse of powers is not happening.

Q. To make it clear that we're not just talking about money, you must be very aware of the trauma for families when somebody with a mental illness causes serious harm or death as in this tragic circumstance?
A. Yes.

Q. And also the trauma for families trying to get their loved ones help when they fall through the crack?
A. Yeah, it's extremely - not depressing is the word - feel powerless when we know we cannot use our powers to do anything. We have multiple calls for service where our legislation and policy does not fit. What we want to do and what we can do lawfully sometimes are two different things and I've - I always encourage our officers to, you know, act lawfully, "Do not misuse your powers" and we will always have those shortcuts where we can't have legislation to cover calls for service.

Q. I'll come to the specific legislation that you operate under in relation to the EEAs, but do you get feedback from police or have experience yourself that when police do transport an individual for an emergency assessment because they're having an acute episode, they are often frustrated that those individuals are not kept within the mental health system for long periods of time? They're back on the street in a short period?
A. Yeah, we get frustrated, but there's things beyond our control. As long as we are doing what we are supposed to do correctly and lawfully and acting in the best interest, taking a person to hospital, providing Health with as much information as we can. What Queensland Health do on their end is beyond our control.

Q. Sure, but the pressures on Queensland Health can in fact cause difficulties for Queensland Police if those people are back out in the community without the help that they need. Correct?
A. Yeah. We regularly have what we call repeat calls for service and I case manage numerous people who are already under the Mental Health Act. They're under a treatment authority or a forensic order and they're experiencing a lot of psychosocial issues, like homelessness and drug use or alcohol abuse, domestic violence, and they're still coming to our attention, even though they're medicated and treated. So when we have people that are not kept under an authority with Health or placed in a voluntary status, we, we effectively are just doing the same job time and time again.

Q. I'm going to come to what happened with respect to Joel Cauchi on 8 January 2023. You've prepared a statement in which you make some comments on that. Were you in court when QPS2 and QPS3 gave evidence?
A. I was, yes.

Q. And you were in court when QPS4 gave evidence yesterday?
A. Yes, I was.

Q. QPS4 gave evidence that he filled in for you for a period of approximately five weeks from December through to January?
A. Yes.

Q. December 2022 through to January 2023. How did that come about?
A. I, I actually had to solicit QPS4 - sorry, QPS4 to come do my role. I find it really hard to get people to relieve me when I am absent from my role, and right now no-one is doing the job because I'm here. A lot of people are fearful of the role and think there's too much risk involved, or they don't have the knowledge base to do that. I, I did approach QPS4 to do that role because I knew he had an interest in mental health, and I know him as a really good officer and his oversight on that email is devastating and it is not indicative of him as an officer or how he performed my role.

Q. The email itself, I'll just remind you, was from QPS2, sent at 9.07pm, the day of the job and he says:

> "Hello. We're looking for some assistance in relation to a DV job we attended. The incident involved a Joel Cauchi and his father, Andrew Cauchi. Both persons have limited dealings with police. However, Joel is flagged as having schizophrenia. Joel contacted police wanting to report his dad for stealing his collective knives.
>
> When we spoke with Joel's mother, it was clear that Joel had had a decline in his mental health. Joel was previously medicated for his schizophrenia and was very high functioning and was highly educated, studying in Brisbane. His doctors were slowly lowering the dose to the point he is not taking any medication at all now.
>
> Joel moved back to live with his mum and dad a year ago, and

recently he has been waking up at 3am in the morning, walking around the house, banging on walls. The father was concerned how he was behaving and has removed the large knives in case he tried to harm himself or them. When the father explained to Joel he removed the knives, he became fixated on them and believed that he would be financially broke as a result and would be homeless.

When police tried to explain to Joel that they were removed from him for everyone's safety, he was adamant that they were gone for good and that he would have to replace them. Joel could not articulate why they were having to be replaced and wanted his father charged for stealing.

If this is the start of Joel's decline in mental health, it's likely we will have further calls for service to the house. If a follow-up could be made with the family and Toowoomba Mental Health, that would be great. Please refer to the other DV for a DV report. Thanks in advance."

Is that the type of email that you might get in your inbox on a daily basis?
A. Yes.

Q. In those circumstances, what are the risk factors for either Joel or his family or in fact anybody else that you would pick up on?
A. Well, it's a diagnosed person - a person diagnosed with schizophrenia. It's not a self-diagnosis. It's not a perceived diagnosis by the family or witnesses. He is unmedicated. He's not open to any - he's not under a treatment authority or a forensic order. He had no criminal history. The biggest alarm for me was there was no further calls for service, but in relation to this, yes, he has changed his behaviour suddenly. He is becoming fixated on an inanimate item that he believes has value that really doesn't.

Q. It's not just any item. It's a large knife, as described here. So would that give you cause for concern that the fixation is on knives?
A. Yes.

Q. If you had received this email and been able to act upon it, would you have then done a search for Joel Cauchi in the system?
A. Yes.

Q. If you had done that search, you would have discovered a number of previous incidents in relation to Joel. There were three occasions of erratic driving where he had been pulled over and didn't realise that he was driving in an erratic manner. In July 2022, he was making repeat phone calls to a particular high school in Toowoomba, wanting to see girls - to go and visit girls in their sporting activities in 2022.

In May 2021, police had been called to the house when he was screaming and he was noted to be schizophrenic and off his medication, said he was slamming the fridge door. There's that incident and then there was this

incident. What does that tell you in relation to the risk factors with his mental health?
A. Clearly he's unmedicated. He is managing it reasonably, however, but any contact with police creates some sort of alarm. What I would do in follow-up with the family or I would definitely, yeah, I would review Joel on QPRIME. I would immediately reach out to my Queensland Health Mental Health Intervention Coordinator counterpart and we would discuss what history Queensland Health has with him, and then I would engage with the family. Give them a call, "Would you like to have a phone call? Would you like me to come out and visit you?"

I would discuss options. I would try to engage with Joel directly and try to get him to attend hospital voluntarily or go to his GP. If he would not attend voluntarily and I had sufficient information for an examination authority, I would have applied for an examination authority.

Q. One of the issues in relation to the knives is that they were described to QPS2 and QPS3 as pigging knives by mum. So Joel was describing them as collector's items, World War II collector items, but they were described as pigging knives. That descriptor rings alarm bells, doesn't it, in terms of the knives?
A. Yeah. Yeah.

Q. So for police, although the legislation, which I'll take you to shortly, refers to an EEA for immediate risk to self, you're always having to think of the risk to the community. Correct?
A. We do have to explore collateral harm there, and risk to the community there and then under the imminency part of the 157B of the Public Health Act.

Q. I've been asked by some family members to make reference to the particular knife that Joel expressed an obsession with. He talked about a KA-BAR knife, and the officers who went out on the day didn't ask to see an example of that or look at a photograph of that. I'm going to show you a photograph of that knife.

DWYER: Your Honour, I have that warning that there's a sensitivity about the photograph, but this is of particular interest to some members of different families.

HER HONOUR: Yes, thank you.

DWYER

Q. That's going to go up there on the screen. You see it's 30 centimetres long. The blade itself is about 20 centimetres. You've already said that you would have concerns about a knife. Does that knife in particular give you concerns? If somebody with schizophrenia, unmedicated, who has been up at 3 o'clock in the morning causing a ruckus and has pushed his father, if you had information that that knife was the type of knife that he was obsessed with, would that concern you in terms of the risk to others?

A. I think any knife would be of concern, not specifically that knife. Bear in mind we live in the Darling Downs district, and we have multiple people carry knives much larger, we have a lot of pig hunters, if it's described as a pig hunting knife. He had no need to have that knife.

Q. That's right.
A. Any knife would be of concern.

Q. That knife, it's immediately apparent, can cause deadly injuries. Correct?
A. Yes.

DWYER: That can come down now, I think.

Q. Do you agree that when officers actually attend a job like this, it's very important to get as much as information as possible at the time from people who know somebody with that mental health well, for example, mum or dad?
A. Yeah. We need to do holistic investigations on particularly domestic violence incidents, but also anything where there's vulnerability.

Q. For police officers they are just getting a snapshot of how somebody is presenting, it can be confused, can't it, if they are presenting in a calm way?
A. We are not mental health professionals and our, our attention and our resources are so drawn to people experiencing mental health crises that are actively harming themselves, that are actively attempting to commit suicide, that when we are presented with someone who, yes, does have a mental illness and, yes, is disorganised, but is so calm and personable, it can be a little bit confusing, and that's why the officers really rely on the legislation.

Q. Sure, and I'll come to the legislation shortly. But in terms of your knowledge, someone like you sitting in the MHIC has a much greater understanding of mental health than officers - general duties officers on the ground, your average general duties officer. Is that fair?
A. That's fair, yes.

Q. Have you done specific training in mental health presentations, or is it something that you've come to develop a deeper knowledge with through your experience?
A. It's more so a deeper knowledge because I work so closely with my Queensland Health Mental Health Intervention Coordinator counterpart. I engage daily with clinicians. I, I get their reasoning behind decision-making, so we can - I do have that larger knowledge base than the average general duties officer, but I don't want to criticise general duties because they - they're not exposed to what I'm exposed to.

Q. I'm not asking you to do so, but I'm making the point that you are an incredibly important resource for general duties officers, aren't you?
A. Yes.

Q. To do follow-up?
A. Yes, and one of my other roles is, if we're questioning my ability to

communicate with people, is I'm also a police negotiator. So, again, that's a different skill set above general duties as well. So comparing myself attending to a call for service, and I'm not slighting QPS3 or QPS2 at all, but compared to general duties crews, I would have a different lens and different insight to behaviours.

Q. Assume you are in the role of a general duties officer going out to this job around 7pm. You've seen the body-worn video of QPS2 and QPS3 because you sat in court, correct?
A. Yes.

Q. Joel presented in a particular way that we can make observations of: reasonably calm, but he has an obsession with the knives that doesn't make sense. He's not going to be bankrupt.
A. Yes.

Q. The police quickly worked out they've been called to a theft of the knives, but this is not what it's about, it's a mental health or domestic violence issue. They speak to mum, and they assess mum as credible, correct?
A. Correct.

Q. You will have heard mum say things like he'd been unmedicated for five years. He'd been diagnosed with schizophrenia first at the age of 17. He had been up until 3am and causing them disturbances. It was the first time that he had pushed dad, but that was of concern to her. They were 75 years old and vulnerable. They'd recently had COVID, dad had had open heart surgery. And he had an obsession with pigging knives that he wanted back.

In those circumstances, let me ask you, firstly, whether or not you would have thought that there was a capacity to do an emergency - an EEA? And I can put the legislation up for you if you need it.
A. I'm aware of the legislation, thank you. In my capacity with my expanded knowledge base beyond general duties officers due to my exposure of dealing with clinicians for 13 years, there would have been a possibility to expand on serious harm beyond harm to self, to collateral harm. There may have been an opportunity for an emergency examination authority, based on my skill set.

Q. Yes, understood. I know that you know the legislation backwards.
A. Yes.

Q. I'll just put it up for everybody else to follow.

DWYER: It's just perhaps at p 2 of Officer Quinlan's statement. That can be expanded and maybe we can read it.

Q. So, chapter 4A of the Public Health Act in Queensland is titled "Health of persons with major disturbance in mental capacity". Section 157B says:

> "If a police officer or an ambulance officer believes that a person's behaviour, including, for example, the way in which the person is

communicating, indicates that the person is at immediate risk of self-harm; and the risk appears to be the result of a major disturbance in the person's mental capacity, whether by illness, disability, injury, intoxication", et cetera, "and the person appears to require urgent examination or treatment or care for those disturbances, then they can be transported for an emergency examination authority".

What you're saying is that with your experience, knowing somebody was unmedicated with schizophrenia for five years, and given what mum was saying, you might have found a way to use that authority?
A. Yes. But I want to reiterate I have a completely different knowledge base and skill set than general duties officers.

Q. Yes, understood. If somebody had contacted you, if it had been in the hours that you work, or another officer, and been able to convey the information that mum was giving, along with the presentation of Mr Cauchi, is it likely you would have given them advice to use the EEA?
A. If this is an active job, I would have gone out to that, if I had the ability to respond. I would have - the sticking point would have been the imminency: does he really need to go right now?

Yes, we can look at serious harm beyond actual physical harm to self, intentional harm to self. We can explore - I know that clinicians explore collateral harm, unintentional harm, financial harm, reputational harm. But when we are posed with legislation where the example of serious harm is specifically threatening to commit suicide or acts of self-harm, I can see how officers read it that way.

Q. Yes. To that end then, before I move onto the next point, do you think that that legislation should be amended in Queensland so that--
A. 100%. Yes.

Q. Sorry?
A. Yeah, I, I do. And I'll give a reason behind that. To remove that ambiguity--

Q. Yes.
A. --of what - and, and not just harm to self. Unintentional harm to self, harm to others. And perhaps give a better scope of what unintentional harm or what serious harm is beyond physical harm to self.

Q. Yes.

DWYER: Your Honour, I pause to note that that is shaping up as a significant recommendation in this inquest, given that there's such unanimous support for that.

HER HONOUR: Yes.

Q. Police operate with the assistance also of an OPM?
A. Yes.

Q. An operations manual?
A. An operational procedural manual, yes.

Q. Thank you. In 2023 at the relevant time, there was a note with respect to voluntary referrals to authorised mental health services--
A. Mm-hmm.

Q. --that said:

> "When officers consider that a person may need an assessment or treatment by a mental health service provider, and where there is no immediate risk to persons or property, officers are to ask the person if they will voluntarily obtain an assessment or treatment before considering other options".

Would you have expected the officers to ask Mr Cauchi in these circumstances whether he would voluntarily attend for assessment?
A. I would hope in circumstances it crosses their mind, yes.

Q. In these circumstances, what QPS2 did was send an email off, expecting it to be followed up by the MHIC?
A. Mm-hmm.

Q. Had that been you in the hot seat at the time, would you have followed this up?
A. Yes.

Q. I think you've been at pains to say that QPS4, your assessment of him when you got back was that he had been diligent in the role, is that right?
A. He had been extremely thorough in his role.

Q. So, it's devastating that he missed this particular important follow-up?
A. Absolutely. And as I said before, it was - I can guarantee it was an unintentional oversight.

Q. Is it explained, at least in part, by how difficult that job is to do with the limited resources that are available?
A. Absolutely. On any day I could receive 30 to 40 emails. And once you miss one and go back to the top, they slide down, and then the next day you have got another 30, 40 emails. So, keeping on - in track of the emails, plus the tasks, plus the calls from general duties crews, Queensland Health, non-government organisations, it, it is - it's fast becoming an overwhelming role.

Q. It sounds then that you're constantly triaging and having to put matters that

need follow-up to the bottom of the list, or to lower down in the list than they should be?
A. Yes.

Q. You've already made the point, I think, for the period that you're down here giving evidence in this inquest, there's no-one to backfill your role?
A. No, that's right.

Q. You've got to get back to a whole load of emails that are going to require follow-up?
A. I've been trying to manage them while I've been here, but I definitely know taskings or reviewing of occurrences from when I finished work on Thursday to when I go back next Thursday, there will be in excess of 40 to review.

Q. When you next take leave, whenever that is, you're not sure that anybody will want to put their hand up to fill in for the role?
A. I again had to solicit another officer who did a short period of relieving earlier in the year, but she can only - I, I do have two weeks leave coming up plus a week of sick leave, and she's only been released for one week. So, there's going to be a period of two weeks where my role won't be covered specifically.

Q. I'm going to come back shortly to any other recommendations, but can I ask you, when you contact your Queensland Health counterpart, who are you contacting?
A. My Queensland Health Mental Health Intervention Coordinator is Paul Sheath. He's been in the role longer than what I have, and we're very fortunate in the Darling Downs district to have a Queensland Health person assigned that role permanently. There's other districts in the - in Queensland that don't have that role filled.

Q. What information are they able to share about an individual, such as Mr Cauchi?
A. Yeah. In accordance to the memorandum of understanding between Queensland Health and Queensland Police Service dated 2016, signed off in 2017, there is two schedules on who can share what. And had I contacted Paul Sheath, I would have been able to ask his history, any current engagement, and any referrals onto GPs.

Q. I just come to her Honour's recommendation function. You've already talked about the sort of resourcing that would be required to properly equip your office, and you've already noted the importance of an amendment to that legislation. Is there anything else that you think would be of assistance to the role that is performed by the MHIC, or are they the main issues?
A. Resources and legislation changes probably are the most important at this point. The resourcing of the more appropriate services would be extremely beneficial as well.

Q. What do you mean by those?
A. We have in, in Darling Downs district, a Queensland Ambulance Service

mental health co-responder team. They operate every day of the week from 1pm to 11pm. They are an invaluable use resource. We utilise them daily to come into the jobs where there might be some ambiguity or low acuity that they can take that job over and police can move onto other, other calls for service.

I do rely - personally I rely heavily on social workers based out of Toowoomba Base Hospital. We have a good avenue of communication where we look at supporting people that are falling between the cracks, mainly due to psychosocial issues as opposed to mental illness.

Q. Are there limitations in the resources for either or both of the social workers and the Ambulance Service?
A. Yeah.

Q. My final question was just in relation to an inquest that we became aware of in Queensland in 2017 where Coroner Ryan, the State Coroner in Queensland, made a number of recommendations relating to MHICs. Are you familiar with that inquest?
A. Not, not specifically, no.

Q. I'll save those for--
A. Mr Quinlan.

Q. --Mr Quinlan.
A. Thank you.

Q. Thank you very much.

HER HONOUR

Q. There may be some other questions.

CHRYSANTHOU: No questions, thank you, your Honour.

TOWNSEND: I have no questions, thank you, your Honour.

ROBB: I have no questions, thank you, your Honour.

CHIU: Nor do I, your Honour.

MATHUR: Likewise, your Honour.

HER HONOUR: Court 2?

CALLAN: No questions, thank you, your Honour.

JORDAN: No questions, your Honour.

CASSELDEN: No questions, your Honour.

CLARKE: We have no questions, thank you.

HER HONOUR: Thank you. Dr Freckelton?

FRECKLETON: Nor do we, thank you.

HER HONOUR: Mr Gnech?

<EXAMINATION BY MR GNECH

Q. In conference with me, you discussed the proposition that you, and as an organisation, you didn't want to criminalise mental health. Can you explain what you meant by that?
A. By inviting police into mental health incidents, we will always look at it from a policing lens. As much as we are trained in mental illness, there's the risk of people facing charges having - been subject to police use of force because of their illness, and that may lead to charges going through the court system when it's effectively because of their unwellness at the time.

Q. In short, you don't want to unnecessarily build the criminal history against a person that the underlying effects of that is simply because of their untreated mental health issues?
A. That's correct. We want the most appropriate services attending to the situation.

Q. Thank you. Just further, you often used the term "police being all things to all people is becoming overwhelming"?
A. Mm.

Q. Can you explain what you mean by that?
A. In my 25 years of policing, I've seen a significant change in what we call calls for service. What's the community's expectation of police to undertake as their core role. And it feels - and this is my opinion, your Honour - it feels that the attention is away from crime and domestic violence so much - not so much domestic violence - we're attending to people with so many vulnerabilities that have no other avenue to seek help other than to call triple-0. And if I can be a little bit frank, if it's not bleeding and it's not on fire, the police are the people that have to attend, and we don't always have the experience, the legislation or the policy to assist these vulnerable people in the community.

Q. Just finally, you've been asked some questions about recommendations in regards to resources, and as you appreciate, one of her Honour's tasks here is to consider any recommendations. If there are any recommendations in regards to resourcing - and you've outlined your opinion in regards to your specific office - do you agree that any staffing models needs to be attached to population demand?
A. Yes, absolutely. It doesn't seem feasible that you have one Mental Health Coordinator for my district of 220,000 and you might have one for a larger district of 400,000.

GNECH: Thank you. No further questions, your Honour.

HER HONOUR: Thank you.

NO EXAMINATION BY MS CHRYSANTHOU, MR TOWNSEND, MR ROFF, DR FRECKELTON, MR CHIU, MS CALLAN, MR JORDAN, MR CASSELDEN, MS CLARKE, MS MATHUR, MR PENN, MS ROBB, MR WILSON AND MR LYNCH

<THE WITNESS WITHDREW

HER HONOUR: Dr Dwyer.

DWYER: Your Honour, I call Inspector Bernard Quinlan. Inspector Quinlan's statement is found in vol 23, tab 863E.

LTS:DAT

<BERNARD QUINLAN, SWORN(10.59AM)

<EXAMINATION BY DR DWYER

Q. Could you please tell the Court your full name, your rank, and your station?
A. Certainly. My full name is Bernard Martin Quinlan. I'm an Inspector of police, and I'm currently attached as the manager of the Vulnerable Persons Group to the Queensland Police Domestic Family Violence and Vulnerable Persons Command.

Q. What is that command? We've heard a bit about it already, but could you give us an overview?
A. So the Domestic Family Violence and Vulnerable Persons Command was established I think in 2022. It is to promote the strategy development and the capability development of the Queensland Police Service broadly in responses to domestic family violence and vulnerable persons, so mental health, disability and elder abuse. There are some touch points with homelessness, and other emerging issues as they happen in the community.

Q. How long have you held that role?
A. I commenced the role in January of 2023.

Q. Just to be clear, you did not have any direct engagement as a police officer with Mr Cauchi at all, did you?
A. No. I did not.

Q. And neither were you asked to review, at any time prior to 13 April 2024, you weren't asked to review any of his actions?
A. No. I was not.

Q. But you've been asked to provide a statement where you review the interactions of Queensland Police with Mr Cauchi prior to these tragic events?
A. That is correct.

Q. What is your history in the Queensland Police force?
A. I was sworn in on 7 August 1998. I did my first year in the Brisbane area before being transferred to Mount Isa. I did two years at Mount Isa, including a six-month secondment at Mornington Island in the Gulf of Carpentaria. From there I transferred back to Brisbane. I spent some time in general duties. I then went into a tactical crime squad and then a criminal investigation role for about seven years.

I was then promoted into a role as a tactical crime squad officer, as a sergeant. And from there, I did relieving in a number of roles, including district supervision, tactician positions and in charge of a Domestic Family Violence and Vulnerable Persons Unit. And from there, in 2019 I took on the position of being in charge of the South Brisbane District Domestic Family Violence and Vulnerable Persons Unit in a full-time capacity. I was there for approximately four years in total prior to assuming my role in the Vulnerable Persons Group looking after mental health, disability and elder abuse responses.

Q. Can you just remind us where you were physically located for your work?
A. I'm in - there's a precinct near police headquarters in the CBD of Brisbane, and that's where I'm situated.

Q. You provided a statement to assist the Court which is dated 20 December 2024 and attaches a number of different documents, including the OPM - the procedures manual, and a document I'll take you to, which are draft guidelines for the MHICs that we've just heard something about. Before I do, could you explain, or can you give us a little bit of an overview of the landscape of mental health response and policing in Queensland?

We understand that there's a Mental Health Response Strategy 2023 to 2027. That recognises that mental health issues are a significant part of policing in Queensland and around Australia. Correct?
A. That's correct. And there has been a shift over time in relation to how mental health is treated in the community more broadly. We saw with the introduction of the Mental Health Act in 2016 and became in effect in 2017 a move away - a move towards community-based care, and with that, a focus on less restrictive practice. So, to prioritise the treatment wherever possible of persons with mental health into the community.

Q. What years were they, sorry?
A. 2017 that came into effect.

Q. That wasn't a decision of Queensland Police. That was a decision of government. Is that right?
A. That's - so it's - the mental health legislation - the Mental Health Act and the Public Health Act are outside of the scope of police to have significant input. It's led by the Department of Health.

Q. The motivation was to provide persons suffering with mental illness with the least restrictive care available?
A. That's correct. And that was later reaffirmed by the Queensland Mental Health Act of 2019. It poses a number of human rights that need to be considered for police, especially when making any decision, and that less restrictive practice is to be, wherever possible, sustained by police when dealing with people in the community.

Q. I'm not seeking to undermine that now, but do you recognise in your role that there can be a difficult balance between the human rights of an individual suffering mental illness, but also the need to keep communities safe if, in rare circumstances, that mental illness results in disturbed behaviours?
A. That's correct. And that's also included in the legislation. In section 13 of the Human Rights Act, there is an opportunity to pose limitations on people's human rights in certain circumstances, and when we need to detain someone or arrest someone for a reason, then there is an opportunity for us to restrict those human rights.

Q. And it's appropriate to do so to make sure that the rest of the community is

safe?
A. As long as there is a, a legislative provision to do so. Yes.

Q. Appropriate to do so, I should say, not just so the rest of the community is safe, but so that person themselves is safe from harm they're doing to themself, either physically or mentally?
A. Correct.

Q. I just want to ask you a bit more about the landscape and some of the fallout from what you just described. In the draft MHIC document you provided, at page 131 of your statement - I might just put that on the screen so you can read it - the last sentence of that first paragraph reads that, "In Queensland, mental health calls for service have increased by 51.3% between 2016 and 2020." That seems like a huge amount. I take it that there was no corresponding increase in services for police to deal with that?
A. There was not. I think we went from around 35 - it was in the low 30,000 calls for service relating to mental health, up to over 50,000 calls for service.

That level has very much sustained over the preceding period of time, noting that the mental health calls for service - and I was present when QPS5 provided her evidence - it doesn't include calls for services like disturbances and welfare checks. That's just matters pertaining specifically to mental health. So that actual role and scope of mental health in the community is actually far broader than what is indicated by those figures.

Q. What is the reason for that?
A. I know that there has been a change to mental health responses to be community-led, and there are a lot more people out in the community who have mental ill health from time to time, noting that mental health is on a spectrum. So there isn't a - and this is just from my observations. I don't have any expertise in mental health per se, but there are people in the community who have fluctuations in their mental health. Sometimes people have good mental health, sometimes not so good mental health. And it's when people experience that crisis in mental health is when police are generally called to intervene and assist.

Q. From what you are learning about in your role as an inspector of this important unit, you are receiving information that police are having to attend these jobs on a much more frequent basis?
A. Yes I am.

Q. You will have heard QPS5, in response to questions by my learned friend, Mr Gnech, that it's her perception that police feel that they are being required to be all things to all people, and that that is taking away - I'll paraphrase - from some of their core duties to respond to crime, because they're, in effect, being required to be the safety net for people with mental health issues--
A. And part--

Q. --or they're expected to be?
A. Yeah. And part of that too is the fact in - same as our friends in the

Queensland Ambulance Service - is the fact that we have - and the term used is boots on the ground 24/7. So at any time of the day or night, if people make a phone call to police or ambulance, there's generally a response that can be made. A lot of the other agencies that we work with are Monday to Friday during business hours. That's the time where, for example, a mobile response is required to people actually in the community, and it doesn't exist outside of those core services to the public in the form of police or Queensland Ambulance.

Q. It sounds like there's a number of push factors here, but one of them is a change in the approach to institutionalisation of people with mental health issues, that there is more reluctance to institutionalise people. Is that what you're hearing?
A. I think there's been a significant focus, and I don't agree with institutionalisation. However, there has been a push, and I think, with any push to move services out into a community, there needs to be a corresponding increase in the services and supports and case management and ongoing response to people in the community, if they're being treated in the community, to match those they would have received if they were hospitalised.

Q. Is that where there's a chronic shortage, the lack of services and staff to assist with case management in the community?
A. There are, there are small changes. I'm seeing some really positive examples of increasing of services to people who are escalating in the community. But overall, I think there is a shortfall. Just like there's resourcing issues for the Queensland Police. There are significant resourcing issues across Health and mental health services as well.

Q. There been a lot in the media recently about a crises - a shortage of psychiatrists, for example. Is that something that you think, as a snapshot, flows on to then the impact on police?
A. I don't even think it's just limited to psychiatrists. I think it's limited to supports in the community more broadly, and across the sector. Whether it be policing, ambulances or even mental health services in the community more broadly.

Q. We'll hear more about that from our expert psychiatric panel as well. I might return to it at the end. There was a change in legislation that I want to ask you about. You cover this in your statement. Perhaps I'll just have on the screen the legislation I just showed QPS5. It's paragraph 6. Firstly, section 3 is up there of the Mental Health Act, which says that:

> "The main objectives are to safeguard the rights of persons and the least restrictive of the rights and abilities of a person who has a mental illness, and promote the recovery of persons who have a mental illness."

Then if we could scroll down to the emergency examination authority that police have. Section 157B of the Public Health Act says that:

"A police officer can detain somebody for an emergency examination authority if the person is at immediate risk of self-harm, and the risk appears to be the result of a major disturbance in the person's mental capacity, and the person appears to require urgent examination, treatment or care."

Those are very rigid criteria, aren't they?
A. It is a very high threshold. It's very specific in its terminology, and as police, we are bound by the laws, the legislation, the policies and procedures that govern what actions we can take in particular circumstances.

Q. QPS5 just gave evidence that if it had been her, with her expanded knowledge about mental health issues, she would have been likely to find a way to ensure that Mr Cauchi had an emergency examination done in response to his presentation on 8 January. But she also said that the legislation is confusing for police on the ground, particularly because it gives an example in terms of the first limb of the criteria, that "a person's behaviour, for example, the way they're communicating indicates they're at immediate risk of self-harm", and the example given is "threatening to commit suicide". Do you agree that that is restrictive and, in some cases, confusing?
A. Yes. And again, the law needs to be interpreted, but we're given very narrow scope to be able to interpret that. If the example provided is a person threatening to commit suicide, well that then sets, basically, a, a principle of that is when police are to intervene.

So from my operational experience itself, it's normally - the normal time that we will execute the detention powers of section 157 more broadly is if a person is actually attempting to take their own life; if they are standing on the edge of a, a building; if they are climbing onto structures; if they have committed self-harm. That is generally when we will use the provisions in 157B to detain a person.

Q. Do some police get a bit more creative, and where there's a risk to other people, they might interpret that legislation more broadly?
A. I wouldn't say creative. It's just, I guess, coming up with alternatives of what actually - what does harm look like. So, for example, if a, a person is - confronts - you know, is self-harming and then is, say, confronted by police, the risk of them confronting police and trying to initiate a fight with police, the harm is then caused to them by police, say if it was a victim-precipitated homicide. So it's again - it's just looking at what are the consequences of those actions to the person.

So the actual Act and the rewording of the Act hasn't stopped police from being able to articulate the harm to a person. There might be criminal justice responses, so the actions of the person might see them incarcerated. The - it might see serious injury to them by other people. It's a way of, I guess, how we articulate our responses in the EEA document that is submitted.

Q. It sounds like you're saying that some police might interpret that legislation

more broadly, but it can be restrictive for police on the ground in a way that's not helpful?
A. To read it and to take it literally and to the word of the legislation, it is confusing and would need - yeah. If it's dealt with just the way it is printed on paper, it is a very high threshold that needs to be meet.

Q. We don't have to propose an amendment on the run, you will have an opportunity to reflect on this subsequently after we pose draft recommendations, but do you agree that it needs to change in two respects: one, that it should not just read the immediate risk of serious harm to self, but also to others?
A. Yes. We've already provided feedback via the Office of Chief Psychiatrist Emergency Examination Authority Working Group, and we've also supported a submission recently made by the Queensland Police Union of Employees suggesting that that change be enacted.

Q. The second change is to expand on that example, so the example is not just a person threatening to commit suicide?
A. And even potentially looking at the definition of what is significant harm.

Q. Can I ask you then about the MHICs? We just heard from QPS5 about how she runs her MHIC in Darling Downs. How many MHICs are there?
A. So there are varying different operating models across the State. There are challenges faced. So in the area next to QPS5, so in south west district, a different model is needed. So the MHIC role there is performed as part of a portfolio.

Then there's mental health liaison officers because, you know, from one end of the district to the other, you're looking at close to 1,000 kilometres. It's not feasible for the MHIC in Dalby, who is centred in Dalby, to attend meetings at Thargomindah or at Charleville or at Roma. There's specific hospitals and local responses developed lately and there will be generally a mental health liaison officer in those smaller locations to support the work of the MHIC more broadly.

But in most areas of the State I think there's - there's five or six permanent MHICs. There's five or six vulnerable persons coordinators, which take on the portfolio of mental health, and in the other areas, there's just those liaison officer roles. But across the State there is MHICs in either permanent positions or in portfolios.

Q. In the draft guide book that you've provided you note that the mental health intervention program, MHIP--
A. Yes.

Q. --was introduced in 2005 as a Tri-Agency initiative between the Queensland Police, Queensland Ambulance and Queensland Health to prevent and safely resolve mental health incidents in the community. Its objective is to prevent and safely manage those crises/incidents. How does the MHIP fit with the MHICs?

A. So part of the MHIP is a MHIP Working Group and a Tri-Agency Steering Committee, which is participants from Queensland Health, Queensland Ambulance and Queensland Police, and we've just started a new working group just to reassess how the MHIP functions and works together, because I'm always looking for new opportunities to work with other agencies to improve how we respond to persons in crisis particularly, because police don't have any clinical training.

And one thing the Queensland Police have advocated for is a clinically-led response because mental health is a health issue, and if you need a specialist response to a health issue, it should be coming from a health professional, not a police officer, and noting that there's been specific recommendations in the Victorian Royal Commission into Mental Health Responses, recommendation 10 is it shouldn't be police responding to those calls for service. It should be a health-led response.

Q. Is that where the co-responder model comes in?
A. So the mental health co-responder is one form of collaboration, whether it's - there's two variances to the model. There's a police officer and a mental health clinician that can attend calls for service, dependent on the resourcing by both sides, or the Queensland Ambulance Service where an ambulance officer, paramedic, or - attends calls for service with a mental health clinician. So they're the two operating models. It is a fantastic initiative and, having worked a few shifts with a mental health co-responder myself, I've seen the value of it. Just the skill set, the understanding, the knowledge and even the communication skills utilised by a clinician are completely different to what police use.

Q. It sounds like there's some significant changes in this area and further change required, but in terms of the co-responder model, looking at Darling Downs, which covered where Joel Cauchi was, was the QAS ambulance-led model, the co-responder model, available in January 2023?
A. No, it wasn't. So I understand it was initially kicked off in - a little bit later in 2023. I think it commenced operations in around March and then formally launched in May of that year.

Q. We heard QPS5 say if that had been available, that would have been a service that she would have thought of to get out to Joel Cauchi to review the situation in January?
A. Especially when there is some trepidation to - whether or not to detain someone or not. That's where that clinical knowledge comes to the fore and can be applied, and the clinicians actually undertake assessments as to whether or not a person needs to be detained or whether a referral to a GP or private psychiatrist is more appropriate, but they're more adequately skilled than any police officer to be able to make that determination.

Q. The Queensland Police-led co-responder model is a much more recent thing. Is that right?
A. A lot of them commenced at the same time. There were trials of PACERs and things. It's just we've seen a significant amount of money go towards the

Queensland Ambulance Service model. I think it's now established in 12 areas across the eastern seaboard, and it only goes as far west as Toowoomba at this point in time.

Q. So the Queensland Police co-responder model is being trialled in different areas. Is that right?
A. I wouldn't say trialled. It's, it's actually up and running and operational, but again, there's a very fragmented - Queensland Health is very fragmented. Its individual hospital and health services operate in 15 areas across the State. Each one of those is independent, is independently - has independent modelling and things. They have - generally they've got the basic core capabilities and functions of a hospital system, but the provision of those resources is subject to the provision of clinicians from Queensland Health. For example, we were provided clinicians on - in the South Brisbane Police District, but clinicians to support a police mental health co-responder to North Brisbane district weren't forthcoming.

Q. That must be very frustrating to work in that system, with some resources available in some areas and not in others?
A. It is. It is difficult, and it also comes back down to, to re-negotiating memorandums of understandings and things. So we're currently trying to re-negotiate and improve our memorandum of understanding that's been in effect since 2017, and prior to it being - so it's developed between, a collaboration between Queensland Health Legal Unit, ourselves having input, but prior to it being finalised, it actually has to be considered by each of the 15 hospital health boards across the State.

So, again, I think if there was an opportunity to pursue some information sharing, legislation just to govern everything, similar to - we've got a domestic family - Domestic Family Violence Prevention(as said) Act, and part 5A of that actually outlines when information can be shared and it's in black and white. So whether it be to assess risk or to manage a serious threat, the entities prescribed are able to share information. Again, the MOU is adequate for our needs at the present time that exists, but again, it's different terminologies and can be confusing for people, especially if it's police on the front line, to be able to interpret it and use it. Whereas if we talk about risk and managing threats, it's much easier to be interpreted and then there's no confusion about who is actually delegated and in what circumstances information can be shared.

Q. In relation to the duties and functions of a district MHIC, is that in part reliant on the cooperation of the health service in that district?
A. The whole, the whole reasoning for the MHIC is that collaboration, is that information sharing between organisations, because police are a conduit to if we have someone in crisis or there are people that - because police are on the ground 24/7, we will come across people that need assistance, and that MHIC role is vital in plugging people in, who aren't at that heightened crisis level, back into the system. If they need follow-up, then they're there.

There have been some really positive steps in alternate pathways to provide people with some support if they're not at that heightened crisis. There's a

couple of crisis stabilisation facilities that have recently opened up, one at the Gold Coast, one at Metro North Health, which is less confronting than an emergency department. If someone is detained and transported, these crisis stabilisation facilities are available. They're safe spaces, which were an initiative of the Primary Health Network, which is federally funded. We don't have access to those as police because our legislation does - we're only allowed to transport people to an authorised mental health service in the legislation, but there are other options.

And then Metro North have also got BERT, which is a behavioural response team escalation, so Behavioural Escalation Response Team. So it's a team of allied health professionals - psychologists, social workers, occupational therapists - to actually go out and meet with people in the community who don't meet those thresholds, and assess their needs and treat the causational factors, because it may not be mental health crisis that we respond to.

We respond to the behaviour that someone is exhibiting, and we can't tell if it's generally mental health, whether it's intoxication, whether it's impairment, whether it's a disability, whether it's an acquired brain injury. A lot of those, a lot of those behaviours are common and it's - we don't have that clinical knowledge to actually be able to make a determination. So our training, which is the minimum amount of force necessary to resolve the situation, and the Behavioural Influence Stairway Model, which talks about trying to de-escalate people through effective communication and then to achieve behavioural change, that's our, that's our key to trying to deal with people in crisis.

Q. I'm going to take you shortly to the individual interactions with Joel Cauchi that Queensland Police had.
A. Yes.

Q. Thinking about 8 January 2023, the police were given information that he was suffering from schizophrenia. He had been diagnosed when he was 17. He had been unmedicated for five years and he had been behaving in a way that was erratic; earlier that morning, had pushed his father and had an obsession with knives. I'll give you that scenario again shortly.
A. Yes.

Q. But in those circumstances, police accepted from mum that Mr Cauchi was suffering from schizophrenia. It was clear to them that he was not rational in terms of his obsession with knives, and they were concerned that the situation might escalate. Are you saying that what is available to Queensland Police in terms of backup and follow-up is different in the different areas?
A. 100%.

Q. That's of concern to you as an inspector, isn't it?
A. It is. You know, to me, mental health shouldn't just be a policing response. We aren't equipped with the skill sets and the clinical knowledge to be able to best help people in the community with mental health crisis. It's a no-brainer for me that there should be appropriate responses that are health-led that can go out and assist people in the community when they need help.

Q. It sounds like there needs to be an audit of what services are available and then those services need to made available, depending on the population need?
A. And, look, I've outlined some of the great initiatives that are happening in relation to safe spaces, crisis facilities, alternate pathways that could be taken as opposed to police attendance, which is a really high threshold for an EEA detention or a police watchhouse, and there was - the criminality of mental health responses was touched upon earlier by QPS5, and people shouldn't be criminalised because of an illness.

Q. You're saying either as an alternative to a callout by police in the first place, but also, as in Mr Cauchi's case, as a follow-up the next day?
A. Correct.

DWYER: Your Honour, is that a convenient time to stop? I'm about to move onto the topic of the individual circumstances of Mr Cauchi.

HER HONOUR: Yes. We'll take the morning adjournment and resume at 12.

SHORT ADJOURNMENT

DWYER

Q. Just before I move onto the instances involving Mr Cauchi, you referred in your evidence before the break to recommendation 10 from the Victorian Royal Commission into Mental Health Services. Is that right?
A. That's correct.

Q. The Royal Commission recommended to the Victorian government that it ensure, wherever possible, that emergency service responses to people experiencing real-time critical mental health crises are led by health professionals rather than police?
A. That's correct.

Q. It recommended various supports for police, including a 24 hour telehealth consultation system for officers responding to mental health crises, in-person co-responders in high volume areas and time periods, and diversionary secondary triage and referral services for triple-0 calls. Does that suggest that police services, at least to your knowledge in New South Wales, Victoria and Queensland, are experiencing some of the same pressure points around mental health?
A. I'd actually suggest it's more broad than that. There's ongoing issues in the United Kingdom. There's been the Right Care, Right Model or - sorry, Right Care, Right Person principle that occurred in Humberside. I know New Zealand has also been looking at different pathways to best provide responses to those in crisis as well.

DWYER: Can I hand up a copy of that recommendation 10? It's available obviously online. I just asked that it be marked for identification for the

moment while we distribute it to my friends.

MFI #D RECOMMENDATION 10 OF VICTORIAN ROYAL COMMISSION INTO MENTAL HEALTH SERVICES

Q. I note that the Royal Commission, in terms of what's available online, said that the current mental health system is not equipped to handle mental health emergencies; that police are often the first responders to mental health crises; that police-led responses can lead to poor outcomes for police and people in crises; police are not clinicians; their involvement can increase trauma and stigma, and the Victorian police has recognised this, and that they need to provide better processes to support people with mental health emergencies. You accept, don't you, that Queensland Police are still going to be the ones who are often frontline in dealing with mental health emergencies and sub-emergencies?
A. Correct. There will always be a need, where there is a risk to community safety or if an offence has been committed, for Queensland Police to attend.

Q. The sort of callout that police attended to in January 2023 is not entirely uncommon, is it, where police are first responders and have to funnel somebody into a system, hopefully?
A. It's far too regular.

Q. So it's always going to, in effect, be part of the core business of policing to deal with people who have mental health issues?
A. That's correct, and when I made the comments earlier about the statistics and the numbers that we were talking about rising so dramatically, there are actually other call for service types that may indirectly involve mental health. For example, this one came across as a stealing matter initially, and then inquiries were made along the domestic family violence pathway, with a significant intersection with Mental Health as well.

Q. It's not looking to remove police from the system of dealing with people with mental health issues, but to support them to take some of the burden off them and provide the best supports for people with mental health issues?
A. To provide - and as I also indicated earlier, to provide that clinical lead in any response to a mental health issue.

Q. Can I come then to the instances involving Mr Cauchi, starting with the driving instances. As you note in your statement from paragraph 16, Mr Cauchi was stopped for erratic driving on three different occasions, 6 October 2020, 6 November 2020 and 9 September 2021.
A. Yes.

Q. Looked at individually, you can't identify that there was any breach of Queensland Police Service policy and procedure in relation to how the police dealt with Mr Cauchi on those three occasions. Is that right?
A. That is correct.

Q. Because on those three occasions, there was no traffic offence that was

identified by the officers. Correct?
A. Correct.

Q. Mr Cauchi did not obviously fit the criteria to be forcibly assessed for an EEA, for example. Correct?
A. Also correct.

Q. However, by the last time that he was pulled over by QPS1, who gave evidence yesterday, 9 September 2021, when QPS1 pulled Mr Cauchi over for his erratic driving, he asked for an explanation for it and Mr Cauchi replied that he didn't realise that he was driving like that. Were you in court for QPS1's evidence?
A. Yes, I was.

Q. You will have heard him say that he tried to test him for alcohol. He then tested him for drugs because that was a possible explanation for his driving at the time?
A. Yes.

Q. When he asked Mr Cauchi why there was an M on his licence, Mr Cauchi was forthcoming. QPS1 recognised that, had he appreciated that this was the third time that Mr Cauchi was pulled over for erratic driving with no explanation, he could have made a follow-up to MHIC, asking for him to be assessed?
A. Possibly, but there's also an option 2, to create a mental health street check, which will then - generally our street check is when we stop and have a conversation with someone and we record that, record that interaction.

There's a mental health - there's an ability to add a mental health flag and create a mental health street check, which can either be followed up by a Queensland Police Intelligence Unit, who would see the mental health interaction or the flag, and then direct it to a Mental Health Intervention Coordinator, or if it's reviewed in the district by the Mental Health Intervention Coordinator.

Q. We appreciate that traffic police are doing many things on any one day, but it is striking, with respect, that on none of these occasions - not on October or November 2020 and not on September 2021 - on none of these occasions was that process followed through?
A. From my understanding, there were no - there was no use of a mental health flag for the street checks that would have been entered. That is something that probably comes back to just some more awareness of, and that actually the mental health flag is available for police.

Q. I'm not suggesting that anyone could have predicted in September 2021 the horrific events of 2024, but it could easily have been the case that someone who is unmedicated, schizophrenic, and not realising that they're driving erratically could cause a very serious accident. Correct?
A. Hence the need for a medical certificate. So, again, that medical certificate is issued by a doctor and is actually part of Queensland Transport's driver licensing requirements is that that certificate is there, that there is actually a

competency to drive in consideration of the medical condition.

There is an ability for Queensland Police - and I think it was articulated in the evidence provided yesterday that there is a review option, that we can actually have someone show cause in relation to their driver's licence as well. Again, that would have to be a significant violation of the road rules or a traffic incident for that to be followed up on.

Q. What about where there are three incidents in less than a year of somebody driving erratically with no explanation? Is that a good example of where you might follow-up?
A. There - unfortunately, there's lots of bad drivers - and I think most of the room could agree to that - that are on our roads at any particular point in time. Three incidents, and again, that haven't resulted in a traffic incident, so the main use of that show cause provision, from my experience, has been where an actual traffic incident has occurred, not just because of random or even a small pattern of acts where there is erratic driving.

Q. Classically, for example, someone who is elderly and driving and loses some sort of situational awareness and causes an accident, you might then be sent by police for a review to your doctor. Correct?
A. That is correct.

Q. But in this case, using it as a learning opportunity, you've got an opportunity here, at least by September 2021, to try and plug Mr Cauchi back into the mental health system if his behaviours are erratic. Is there room for reviewing the policies and procedures for traffic police, who then have an interaction with people in the community?
A. Look, I think not just traffic police, but general duties police. It's - the use of mental health street checks is in our operational procedures manual already and, again, it might just be that more awareness that could be followed up, just to ensure that we - and, again, organisational communication is very difficult to achieve across such a big diverse workforce who don't spend much time in the office. But, again, any opportunity to remind and to create that awareness would be an opportunity.

Q. I take it you would be happy to review a draft recommendation, if we create one in that regard, to see what might be of assistance for police on the ground?
A. Most certainly to assist the Coroner.

Q. I just come to another entry. This isn't in your statement, but you may be aware that on 27 May 2021, police were called. This is a couple of months prior to the last time Joel was pulled over for erratic driving. Police were called to a unit in Kangaroo Point, Brisbane in relation to a male screaming and the sounds of someone being hit. When they attended at approximately 12pm, they spoke to Mr Cauchi, who indicated that he was slamming his fridge door, and a profile check revealed that he had a history of schizophrenia. You don't make any comment that. In just thinking about it now, was that an opportunity to try and plug Mr Cauchi back into the mental health system?

A. Unfortunately, around the pocket of the South Brisbane Police District, where I've spent a large part of my career, that's normal behaviour, and we would see that occurrence occur on a regular basis, if not several times a day.

Q. Just bear that incident in mind, if you will, when I come to the next matter that you did review and that's at paragraph 29 of your statement. On 27 July 2022, an intelligence report was generated after information was received from a staff member at an all girls' boarding school. I won't name the school, but information was received from the staff member that Joel had been contacting the school and Toowoomba Netball via Facebook, telephone and in person, requesting permission to attend sporting events held at the school. The sporting events included a swimming carnival, netball and gymnastics. The staff member had become concerned due to the persistent behaviour of Joel on 26 and 27 July 2022. That was good work by that staff member to contact police. Correct?
A. Correct.

Q. She or he was right to be concerned with obsessive behaviour from a member of the public who did not have a child at that school?
A. Correct.

Q. And was exhibiting some level of obsession with seeing the girls in both sporting events. Correct?
A. Correct.

Q. An intelligence report was evaluated by the State Intelligence Toowoomba on 28 December 2022 and was finalised in this way. It said, "Nil offences committed as part of this report. Concerning behaviour only. Mr Cauchi does not appear to have been subject to any similar behaviour since." This is in December 2022. It said:

> "Mr Cauchi does have a flag from May 2021 indicating he's a diagnosed schizophrenic. Mr Cauchi linked to the intelligence submission and intel noted for any future reference as required. Attempts made to speak with Cauchi on his listed number without success."

Was that sufficient, do you think, to follow-up on that?
A. For me, good practice would have been to inform the Mental Health Intervention Coordinator locally of the incident. That would allow a more holistic review. Our memorandum of understanding with Queensland Health in section 5 describes a mental health incident as a series of events. So that, coupled with other information, would then inform the Mental Health Intervention Coordinator, who could seek further advice from Queensland Health.

Q. Yes, and, of course, the Mental Health Coordinator at that time was QPS5, as she is now?
A. Yes.

Q. Known to be dedicated in terms of following those matters up?
A. Yes.

Q. What she would have had by that time is three instances of erratic driving, an instance where he'd been slamming a fridge and screaming and police had attended, and this instance of showing an obsession with girls, and so you would think that that would have initiated follow-up with a mental health service?
A. So, as indicated in my statement, good practice would have been for that further follow-up to occur.

Q. We know that in 2022, regardless of how Mr Cauchi was presenting - and he might have presented differently on different days - he was actually researching some very disturbing material about serial killers. It shows, doesn't it - I'm not suggesting Queensland Police knew that at that time - but the importance of taking every opportunity to try and plug someone back into the mental health system where their behaviour shows up on the police radar?
A. Look, any opportunity to, you know, link someone in with the most appropriate form of support if available should be taken.

Q. Can I come then to your review of the circumstances of 8 January 2023. We've gone through this of course in some detail over the last day, and you were present in court?
A. Yes.

Q. The bare facts again include that on 8 January, police were requested to attend the address, which was Mr Cauchi's parents' address. They spent about 40 minutes there, the officers, speaking with Mr Cauchi and with the parents. They separated in order to do that. Was that standard practice, or do you have any comment on that?
A. So, again, there was allegations of domestic family violence, or there was a relevant relationship as per our legislation, and our practice generally is when investigating domestic and family violence, that the officers do separate, because the last thing we want is for one of the parties to intimidate or to manipulate the words of someone else. So it's about conducting that holistic investigation, about gaining independent versions of events.

And then, as you also would have observed, the police officers came back together after they had gathered that initial response from the parties involved, and that's where they make - that's where they articulated their decision-making processes based on the evidence and the information they were able to obtain.

Q. In terms of the information they were able to obtain, what QPS3 heard from mum included - I put these to you earlier - but that Joel was schizophrenic, had been diagnosed when he was about 17, he'd previously been medicated and had been well when he was medicated and was very high functioning, learnt languages, went to university. On this occasion, though, he'd had significant - he had deteriorated significantly. He was up at 3am causing disturbance, screaming, she described. She actually said that she thought he was hearing

voices. He'd pushed his father, and he was exhibiting an obsession with knives. He talked about the KA-BAR knife, and mum explained that it was pigging knives that had been confiscated. So obviously pigging knives, dangerous, and of some length, is that fair?
A. That's fair.

Q. Putting those criteria, or putting that information together, is it your view that it would have been open to a police officer to detain Mr Cauchi for an emergency examination authority?
A. In light of all that information, I'm still supportive of the decision taken by the police at the time with their knowledge and their understanding, and just with how direct that legislation is. It doesn't allow much - how could I say - you can't defer from that - the actual specific wording of the legislation, too much. And the presentation of, of Joel at the time was as such that their actions at that - on that day at that time were reasonable. In hindsight, with my level of understanding of mental health systems and behaviours, and in hindsight, the nature of the dangerous weapon, there's no ifs, buts or maybes about it. It was - a KA-BAR is a dangerous weapon.

Q. Yes.
A. No doubts about it. As also QPS5 indicated, that we could have potentially explored a different pathway.

Q. Okay. So, I don't have to put that photograph up again, but it's a very confronting knife, isn't it, the KA-BAR?
A. It is a hunting knife. As all knives, and, you know, when we approach a residence, the most dangerous part of a house is the kitchen, just because of the prevalence of knives and other weapons and sharp implements and things.

Q. Sure.
A. So from an officer safety perspective, any knife is - or any bladed or edged weapon is a significant threat. Not just to police, but obviously to the community more broadly.

Q. It's more about the obsession, can I suggest to you, Inspector. That he had an obsession with these KA-BAR knives that had been confiscated by dad. He had no legitimate - he couldn't explain any legitimate use of them. So he was not somebody known to be a pig hunter or to require those knives for camping or anything else. So it was the obsession with a knife, combined with the fact of the history of schizophrenia, that he was unmedicated, that he'd been screaming that morning, and that he'd pushed dad.

Can I suggest to you, again with the benefit of hindsight, that there are some officers who would have been capable of drilling down on the risk and would have used their powers under the EEA?
A. Again, not being present at the time with the information, with the behaviour demonstrated and things, and noting also too that Joel was intelligent, and you could see his thought processes. He was very measured and calculating, if I may say, in the responses that he was providing. So again, I'm still supportive of the decision made by police. Again, I wasn't there at the time, but in

hindsight and with the information that's now present, I may have pursued a different action.

Q. But even not knowing the horrific events of 13 April 2024, which I'm not suggesting anyone could have predicted, but with a greater understanding of the risk that is presented by a small number of people with schizophrenia who are unmedicated, who develop an obsession with knives, you personally would have exercised your powers under the EEA, wouldn't you?
A. In hindsight with all that information and knowing the type of knife it was, and again, other facts that I've come to learn after, especially in relation to the searches and things done, it paints a clear picture that there was a need for an emergency examination at some point in time.

Q. Do you agree that listening to mum, to Joel Cauchi's mum, she is pleading for help from anybody who will assist her to get her son plugged back into the mental health system?
A. That's right. Mum's exhausted. She is, she is tired, she has been putting up with someone who is - who has been, you know, suffering mental ill health for a number of years. And mum is seeking help, and I understood that she had - from being present during evidence and reviewing the body-worn camera footage - had reached out to a family friend to try and work out a pathway forward to get the assistance needed.

Q. Can I have on the screen, please, page 35 of your statement. It's the last time I'll take you to this emergency examination authority.
A. Yes.

Q. I hear what you say in relation to the officers who were there on the ground. The criteria that you described earlier as being restrictive are set out there at 1, 2 and 3. So the emergency examination authority is for police or ambulance who believe that a person's behaviour, including, for example, the way they're communicating, indicates an immediate risk of self-harm, eg, threatening to commit suicide, and it appears to be the result of a major disturbance and the person appears to require urgent examination or treatment in care. The example of Joel Cauchi underscores the need for that legislation to be amended, doesn't it, to provide greater opportunities for police to plug someone like that back in the system?
A. Correct.

Q. That can come down now. In terms of the involuntary, or dealing with somebody on an involuntary basis, that criteria is clear.

DWYER: But could I, sorry, have page 33?

Q. The OPM, the operational policing manual that guides police attached to your statement is October 2024, but police have subsequently provided the one that was in existence as at January 2023, and it reads the same in terms of this particular section?
A. Yes.

Q. So, you see under the subheading of "Voluntary referrals"--

DWYER: Sorry, could you just scroll down?

Q. Can you read that okay?
A. Yes.

Q. Under "Voluntary referrals" it says:

> "When officers consider that a person may need an assessment or treatment by a mental health service provider, and where there is no immediate risk to persons or property, officers are to ask the person if they will voluntarily obtain an assessment or treatment before considering other options".

Would you have expected the officers to at least ask Joel whether or not he was willing to be assessed in those circumstances?
A. Look, there was, there was an option to ask if a voluntary treatment was - you know, would be considered. That's - and it is in the OPM for that reason, yes.

Q. Mr Cauchi was not detained that evening, and neither was he asked whether or not he would voluntarily come for an assessment. But what QPS2 did do in consultation with QPS3 is write an email to the MHIC expecting that there would be follow up in a short period of time, correct?
A. Correct.

Q. What is your view of that in terms of QPS2 and QPS3's conduct?
A. I think the sending of the email was an appropriate means of follow-up to ensure that there was a connect between police and mental health support systems. The fact that it was missed was a missed opportunity, as already explored by evidence provided by other witnesses.

We have taken steps to try and put some additional safeguards in place with amendments to the OPM already in relation to using a tasking process on our QPRIME system so that there is actually a trail that can be managed, supervised and audited. So just to put that additional governance in place around that request, so it's recorded, it's time and date stamped. There's that integrity of process over the provision of the request, and then once the request is made, the task needs to be finalised and approved by a supervising officer.

Q. Does that mean it just can't slip off the radar, something has to happen to it?
A. Something has to happen. It sits on a work list. Obviously resourcing and timing and things dictates how soon that that task would be seen due to other competing priorities or a MHIC's role, but it is actually on a list and can't disappear. It has to be actually started, completed, finalised, with a supervisor check as well.

Q. I don't want to labour this point, but can I just take you to some of the conclusions reached by the psychiatric experts who will give evidence about this instance on 8 January. Dr Ed Heffernan, a psychiatrist who practices throughout Australia, says there were several opportunities, in theory, for police to have directed Mr Cauchi into mental health care. That's consistent with what you've said already today?
A. That's right. As I mentioned, in the memorandum of understanding of what actually constitutes a mental health incident, is defined in our MOU. In saying that, that is something that would be known by myself, my State mental health team, and MHICs, but it wouldn't be common knowledge to frontline police.

Q. Dr Heffernan says the police interaction with Mr Cauchi and his parents on 8 January 2023 was potentially an opportunity for involuntary transfer to a public sector mental health hospital for an examination. He says - at paragraph 7.4.3 for my friends:

> "An opportunity for an EEA was present, however, the framing of the risk criteria for an EEA, requiring a belief of immediate risk of serious harm to the person and a belief that urgent examination is required may have impacted the police perception that an EEA could be made."

Do you agree with that?
A. Very accurate.

Q. He goes on to say:

> "There was some indications from Joel and his parents that the situation would not escalate overnight, and also that Joel had some opportunities for assistance the following day. This may have influenced the view about the necessary criteria being fulfilled to undertake an EEA."

You'd agree with that?
A. Yes, I agree.

Q. But he says, again, "Contact with the PCC MHLS could have assisted this situation." So, he's suggesting that the Mental Health Liaison Service, the Police Communications Centre, might have been able to give some advice to police on the ground?
A. Definitely a possibility.

Q. He also says that, "While Mr Cauchi's involvement in one odd event with police might be explicable as out of character, four events could warrant examination", and he's referring there to the three driving events, as well as that incident?
A. Yes.

Q. Dr Anthony Harris, another psychiatrist, says that the attendance of police on 8 January 2023 when they were called to Mr Cauchi's parents' house over

the removal of several hunting knives from his possession provided an opportunity to assist or provide treatment. Dr Harris suggests that "A more assertive follow-up with the local mental health care team may have triggered a review by mental health services and care". You would agree with that?
A. I agree that the police took action to enable that to occur. And, again, the missed opportunity that has been discussed at length, was, you know, it was raised.

Q. Finally, Professor Nordentoft, who is a psychiatrist in Denmark, offers the view in her report at paragraph 90, that based on her assessment of the body camera footage and the transcript, she evaluates Mr Cauchi as suffering from psychosis. She says, "He's certainly psychotic", and in her view, he qualifies for compulsory admission. Can I suggest to you that that's the benefit of having a specialist mental health expert there as soon as possible, because they're much better equipped than police are to assess whether someone is genuinely psychotic?
A. I couldn't agree more.

Q. You summarise the other occasions when Mr Cauchi had interactions with Queensland Police, but there was nothing like that incident on 8 January that was a red flag to police after that event?
A. There was nothing more. I know there was a, a few other police interactions. There was a, a street check. There was actually a, a - an - police conducted a wanding operation where a search was conducted as part of the Jack's Law which is in Queensland where police have the power to scan people for possession of knives and things in certain public areas subject to declarations by police officers that the operation is to occur. That occurred, and from all accounts it was just a, a very short interaction with nothing by exception identified.

Q. Can I come now to the recommendations that her Honour may make that will improve the ability for police to assist persons with mental illness and prevent tragedies. You have already commented on the need for better resourcing in some areas--
A. Yes.

Q. --and we'll come back to you about that. Could I have on the screen please some recommendations from 2017. Is it fair to say that police have known for some time that there is an increasing pressure on them to deal with mental health crises in communities?
A. There's a growing area of vulnerabilities that require an increased police response. There's domestic and family violence. There's been a number of inquiries and inquests, and a commission of inquiry for that and how we respond. There's been mental health. We've seen the recent recommendation 8.20 come out of the Disability Royal Commission.

There's currently a parliamentary, a parliamentary inquiry ongoing in Queensland at the moment in response to people in the community as a result of elder abuse. So the vulnerable in the community are, unfortunately, in greater need of policing responses, or what I'd advocate for is a more holistic

response across support service sectors.

Q. Are you able to tell us what recommendation 8.20 was?
A. There's a, a few different limbs. One relates to the treatment of people in custody who have disability, from memory. There's increased awareness and training around people with disability and how to respond, and also the creation of disability liaison officers across the State and - it's actually a national recommendation.

Q. In 2017, Coroner Ryan in Queensland released recommendations that related to inquests into the death of persons from police shootings. Is that right?
A. Yes.

Q. There were a number of mentally ill people who were shot by police after police were called to an incident?
A. Correct, yes. So a number of recommendations were made. There was a training needs analysis - well, it was 2017 and then again a subsequent review of the Mental Health Intervention Program in 2020. There were recommendations in relation to the resourcing of regional Mental Health Intervention Coordinators and permanent district Mental Health Intervention Coordinators across the State.

Q. We've got those on the screen behind you, and hopefully in front of you. It appears that one of the early recommendations is that the Queensland Government conduct a comprehensive review of the MHIP to ensure revitalisation, as recommended by the Victorian Royal Commission recommendations. Is that right - the VCR requirement - recommendation 2?
A. There are recommendation - yes.

Q. And then "The review should consider the establishment of full-time dedicated MHICs in each police district". Has that happened?
A. I know that consideration was given. I know that there - and I can just give evidence to what is actually in existence, because I don't know if there was decision-making processes behind it. There aren't dedicated full-time MHICs in each region or district. However, there is at least a portfolio for a Mental Health Intervention Coordinator in each district across the State.

Q. Would you like to see the establishment of a full-time dedicated MHIC in each police district, as recommended?
A. I think you've seen the dedication and the passion of a dedicated full-time MHIC in the evidence provided by QPS5. I think the relationships that having that full-time role, the coordination and the service that's able to be provided by someone who does it in a full-time capacity is better than someone doing it in a portfolio-only capability.

Q. Other recommendations include the extension of the hours of operation for the mental health clinicians embedded within the Brisbane Police Communications Centre. That's not directly referable to Mr Cauchi, who was in Toowoomba, but can you tell us whether that has happened?

A. Look I know that there is - there's been ongoing communications between Queensland Health in relation to the mental health clinicians - the Mental Health Liaison Service that work in the Brisbane Police Communications Centre, and considering of expanding the role and function.

That includes numbers of clinicians, the potential hours and the use of technology to facilitate almost like a video conferencing capability so that the clinicians embedded in the Brisbane Police Communications Centre can reach out via a video link, or a link to a mobile phone, and actually have an interaction with the person that's in crisis. We're still trying to work out some technology solutions because, again, it's a Queensland Health-led initiative. So they're exploring the use of various applications that might be able to provide that service.

Q. Just one of these other recommendations I wanted to take you to is in relation to the governance framework in place. The Coroner recommended a review of the government's framework in place with respect to the MHIP, with a view to ensuring a level of consistency across the State and the exchange of information between QPS districts and hospital and health services. Does that get back to what you suggested earlier, that there is an inconsistency across the State in terms of what's available to police?

A. So since coming to the role, that's something that I have observed. What I really want to focus on is that capability and expanding the capability of our mental health responses across the State, that is, working better with our partners across agencies and improving the relationships at the appropriate levels to enhance the way that we can work together with the Queensland Ambulance Service, for example.

We've conducted reviews of training. We've come up with the drafted guide book to inform police performing the Mental Health Intervention Coordinator role with a goal to standardise practice across the State, because there is differing roles. And it's going to be, you know, a significant body of work because a capability isn't just coming up with a policy. It's making sure people are appropriately resourced; that they have the appropriate training; that they've got the appropriate community and relationships in place. So it's about building the capability more holistically, and once we can get the capability embedded down, then it gives us further argument then to increase the capacity, which is the actual staffing of those positions.

Q. Because you will have heard QPS5 say that what she would need to be able to adequately meet the demands for her services are three full-time additional staff?

A. And that sounds entirely appropriate to me. I think that the suggestion too of having a level of response, whether it be per capita or whether it be per number of matters that need to be reviewed, is realistic.

Q. Finally, was there another review in 2020, I'm not entirely sure of the name, but it related to Queensland Police services and mental health?

A. So it's also made by Coroner Ryan and it surrounds - I think it just - it looks at again the recommendations from 2017 and it's a review of the MHIP, and I

think the recommendations are around resourcing; a training needs analysis; and a review of co-responder models across the State between Queensland Ambulance and the Queensland Police.

Q. He made a series of recommendations in 2017, there was a review in 2020 that identified there was significantly more work that needed to be done. Is that right?
A. Yes.

Q. Our counsel assisting team weren't able to locate that report publicly. Do you have access to that report that could be provided?
A. I should be able to locate it. If I can, I'm more than happy to provide it to the Court.

HER HONOUR

Q. Thank you.

DWYER

Q. Thank you very much. Have I given you every opportunity to say what you would like to say in this space? Is there anything else that you--
A. I don't believe so. I think that I've had the opportunity to express my views on the legislation; about the resourcing; about alternative pathways of care; and the mental health system more broadly. So, thank you.

Q. You're obviously very passionate about this area, and you've offered to continue to assist us in terms of making sure the recommendations are comprehensive and targeted?
A. In any way that I can assist. I'm happy to give that assurance.

Q. Thank you, Inspector.

HER HONOUR

Q. Thank you Inspector. I'll just see if there's any other questions.

HER HONOUR: Ms Chrysanthou?

<EXAMINATION BY MS CHRYSANTHOU

Q. My name's Sue Chrysanthou. I act for some of the families.
A. Yes.

Q. The callout on 9 January turned out - and you've reviewed the footage - a domestic violence callout. Isn't that right?
A. Stealing with elements of domestic and family violence.

Q. You understood that one officer spoke at some length to Mr Cauchi Junior?
A. Yes.

Q. And one officer spoke to Mrs Cauchi?
A. Yes.

Q. But there didn't seem to be any interaction of any note with Mr Cauchi Senior. Did you notice that?
A. I did notice that.

Q. Did you feel that that was something that should have occurred given the domestic violence-related allegations that were being made by both Joel Cauchi and Mrs Cauchi?
A. I don't know too much about Mr Cauchi Senior. From my - from what I've been able to ascertain, he was present for a short time, and then went back into the house, and police obviously followed up with Joel and Mrs Cauchi, and I think they got as much information as they could out of both of those people that were at the scene at the time.

There was potential, potentially - there was a potential to speak with Mr Cauchi Senior as well, as he was present, but I think the opportunity was there for him to have a conversation with police as well. So obviously any communication, it's a two-way thing, and he, he had an opportunity to engage with police whilst they were present.

Q. The allegation was, wasn't it, that it was Mr Cauchi Senior who had stolen knives from Joel?
A. Yes.

Q. And so he was the alleged perpetrator of the offence that the police had been called out to look into?
A. Yes.

Q. And police were told that the knives in question had been taken elsewhere by Mr Cauchi Senior?
A. Yes.

Q. Did you think it would have been appropriate, at any time in that interaction, for police to ascertain where those knives were and what Mr Cauchi Senior's intentions were in relation to those knives?
A. I think it was appropriate to follow-up, and I think that certain inferences could be made from the behaviour being demonstrated by Joel at the time that there was a lot more to it, and that some of those assertations made were followed up with by Mrs Cauchi, who is also a parent of Joel, and they were followed up in that regard.

Q. Early on in the interaction between police and the Cauchi family, police became aware of Joel's diagnosis of schizophrenia. Do you agree?
A. Yes.

Q. There was little information, wasn't there, as far as the police were concerned, as to the details of that diagnosis?

A. It was very basic information that came up, from my understanding, as a flag on the officer's QLiTE device.

Q. Do you agree that it would have been helpful for police, in making an assessment as to what to do in that situation, whether from the domestic violence perspective, or from the mental health perspective, to have more information about Joel's diagnosis?
A. I agree that knowledge is power. We are only - we can only act on the information that we have, and that we have knowledge of. I have made some indication of potentially reviewing how we share information with Queensland Health, referring to part 5A of the Domestic Family Violence Protection Act. But again, it will always be difficult for police to have - especially from a private psychiatrist, due to information privacy principles and human rights, to obtain additional information in regards to a diagnosis.

Q. On what basis do the police have, as a record, the diagnosis of schizophrenia? Where did that come from?
A. I can't actually give you an accurate answer. I can give you a, a possibility--

Q. Yes?
A. --which is by admission. So in - the flag may have been created from an interaction with the police with Joel, and Joel may have - and as he indicated in his interaction with QPS1, that "I have schizophrenia", and he produced a medical certificate indicating the same as part of the conditions of his driver licence.

Q. Is it right that that indication of a diagnosis of schizophrenia would only likely be in the hands of police if something like that sort of admission had occurred in the past?
A. That's correct.

Q. Is it possible that if Joel had not had those previous interactions, and had not made that admission, police would have no idea that he had that diagnosis?
A. It's - I'll agree. Yes. And I say that predicated with the fact that we, as police officers, have no visibility over the treatment or the diagnosis of people that are engaged in the private system. It's disconnected completely from the public system. If we want to seek information, it would generally - we'd have to have grounds for a search warrant or a notice of production to be able to obtain information about a person in the private system with sufficient justification and with approval of an appropriate authorising officer, a magistrate for example.

Q. But do you agree that for the purposes of carrying out their day-to-day duties, it's important for police to have information about a serious mental health diagnosis in relation to people that they're dealing with?
A. As I indicated earlier, any information that can inform police is greatly valued, not just mental health. And in my other portfolio, which is disability, we're working with Queensland Health where people who have an acquired

brain injury that may impair their ability to interact with police, by consent, we can try and add a flag onto our QPRIME system to advise police when interacting with them that they actually have an acquired brain injury just to improve that awareness and understanding. But again, that is by consent and it's not something that we can ask for because of human rights and a person's right to privacy.

Q. What I'm suggesting is given the potential dangers that a person with a serious mental health diagnosis might pose to themselves or to other members of the public, do you think that police should be entitled to access to that information for the purpose of carrying out their duties?
A. It's difficult because, again, and my understanding of mental health is people's mental health fluctuates. It can be - people can be in good mental health, people can be in not so good mental health.

And there's the double-edged sword, and we saw examples of it in the Domestic Family Violence Commission of Inquiry in Queensland where mental health flags and information about a woman's mental health may be weaponised and used to, to basically impact the credibility of the woman involved in a domestic and family violence situation. Gaslighting is a term that's used for that.

So yes, it is fantastic and it's great to have that information, but it's how that information is stored and the accuracy of that information at the time. Because if there's historical information - so someone may have schizophrenia, may be well managed in the care of a professional health team, making an active contribution to society. The last thing we would want to see is that information then weaponised and used against that person.

So, having access to such information, it's something that needs to be dealt with very very carefully. Is information valuable to us? Is intelligence valuable to us as police? Yes, it is, but it's just how that information is used and managed, and how that information remains contemporary would have to be considered very seriously.

Q. You've just mentioned the nature of the fluctuating aspects of certain mental health diagnoses?
A. Yes.

Q. Do you agree that, for example, when it comes to a diagnosis of schizophrenia, it may well be the case that a person starts on a trajectory towards an escalated episode which, at the outset, maybe on the first day, doesn't seem so serious, but you would understand as an experienced police officer could go down a trajectory or a path that could become an extremely serious situation?
A. Again, fluctuations - and I'm not clinically trained, but from my understanding as a police officer is that people can fluctuate, and those fluctuations can be significant.

Q. That's why I want to come to ask you about the notion of immediacy in the

Public Health Act and whether or not you think, in addition to the changes that you've already answered questions about from learned counsel assisting, whether this notion of immediacy is too restrictive having regard to the fact that some mental health conditions might not require immediate action in the sense of within an hour, but might be flagged that demonstrates that that person still needs urgent medical care?
A. And, again, I agree that the term "immediate" is a point in time. It is a decision at that point in time. Not in five minutes, not in ten minutes, not in an hour, not tomorrow. Immediate is at the time. It's a point in time assessment that has to be made which is, again, restrictive in police responses.

So I agree with you on that point. It's again trying to determine whereabouts and how that system can support the person. So the mental health co-response, if it was in existence, would have been good because they can take that more holistic view and that informed - or that clinically informed assessment of a person's mental health after the event or shortly after the event, while police, you know - or shortly after the police attendance.

Q. But don't you think that any recommendation should consider whether the term "immediately" is too restrictive - "immediate risk" - and should be expanded to "or likely risk in the near future", or something to that effect?
A. "Likely risk in the near future", I would have no problem in supporting that. Bearing in mind just knowing the amount of time that it takes for police to respond to a mental health incident. I think my last - in my statement, I think 23/24 financial year it was about 4.6 officer hours. This year so far we're looking at about 4.7 officer hours to attend to a mental health response from start to finish.

If we broaden that definition too much, we won't have any other police left to be able to respond. So I understand there's a need, but then there's also a need for the relevant agencies that deal with mental health responses to be available to respond as well.

Q. Just looking at Mr Cauchi's situation, and we're looking at it from hindsight--
A. Yes.

Q. --you had an individual who had made an admission or there was a notation that he had a schizophrenia diagnosis and that he had been unmedicated for some time. Do you agree that police were told that?
A. Yes.

Q. Police were given many concerns by his mother about his behaviour, and her concern that it was going to escalate. Do you agree?
A. Yes.

Q. Although you said earlier that he was calm in his demeanour and how he was interacting with police, do you agree that there were a number of concerning aspects about what he said and what he didn’t say in that interaction?
A. It was odd. He wasn't, in my - I know normal can't really be defined, but he

was acting differently to what I would consider a normal person, and there was, as followed up correctly by the police, that email sent because of the concerns about his stability and need for further assistance in relation to his mental health.

Q. Well, he was standing outside on the footpath with a backpack on and didn't explain why. Do you agree?
A. Actually I didn't notice the backpack but I - he was standing outside the house, I, I, I do acknowledge that.

Q. I think the officer in fact mentioned the backpack and asked him if he was going somewhere because of the backpack and Mr Cauchi didn't explain why he had it?
A. And, and I think, if I'm correct, he didn't have anywhere else to go is part of the conversation.

Q. The police had been told that he had been behaving strangely and erratically that night, the night before?
A. Correct.

Q. Do you agree that in relation to his fixation over his knives, that that, combined with what his mother had said and the way that he was behaving, was something that should have alerted police to the fact that there was some sort of urgency in the need to deal with this man?
A. Again, going back to the evidence provided earlier, you know, the decision processes and things that were put in place by the police attending at the time, I don't think there was that immediacy. I support the decision that they made in hindsight, and then with the additional awareness that I have, there was the potential to consider an EEA, but again, that is in relation to information about the knife.

Quite often when we attend a domestic family violence situation, people will exit the house. People will separate because they don't want to continue the conflict in front of police. That's why we try and separate the parties to get the independent versions. So his removal from the house outside with the backpack, he may not have even felt welcome to be actually able to go back into the house, and there were discussions had between police and Mrs Cauchi on the evening saying that she was happy to have him back in.

Also it's the opportunity for police to apply their communication skills and to try and de-escalate as their training dictates, to try and I guess bring the emotions of the people involved down. That's our Behavioural Influence Stairway Model that's actually been quite well applied by the police who attended. So there's that opportunity from the start of the incident to the end of the incident in that 40-minute interaction for police to actually influence and to de-escalate the emotions and the behaviours involved.

Q. But you accept, don't you, that the explanation he provided as to why he wanted his knives back was irrational and made no sense at all?
A. I agree.

Q. Don't you think that that demonstrated, even to people who are not medically trained, that he was suffering some sort of break from reality?
A. Again, I go back to his behaviour, his communication, even his use of manners, I thought wasn't - yes he was, he was elevated. He was having, you know, whether it be a moderate mental health episode, again, I can't determine that, but to me, he didn't meet that threshold. When the, you know, attending police went he didn't meet that serious and imminent - he didn't meet that really high threshold that is required to detain someone and transport them to an authorised mental health service.

Q. Was it startling to you, when you watched the video, the way that his parents described the knives that they had confiscated as pigging knives?
A. Again, pigging, hunting, shooting and things are, are quite often popular recreational pursuits as - especially in Toowoomba and far - in western Queensland and things, so.

Q. I was about to say perhaps in Queensland?
A. No, not perhaps in Queensland. In parts of Queensland, especially the more rural remote areas, so the actual possession of firearms and pigging knives, and - it's not unusual to come across that.

Q. In those circumstances, knowing all the information that the police had at the time, would it have been relevant to the police to know that one of the reasons for his diagnosis when he was first diagnosed was because of tactile hallucinations that he had been having?
A. As I said, any information that we are able to get our hands on and be informed of can assist us in our decision-making processes. If we had had information like that, it could have been considered as part of a policing response.

Q. What if police had had information - and this is obviously hypothetical and in hindsight - what if the police had had information that one example of the type of hallucination that he was having was pigs coming out of his teachers?
A. If someone was saying that to me, that is then - that escalates significantly the behaviour, the - you know, and then could be included in the completion of an EEA form if needed. But having that sort of hallucination and having advice of that would definitely inform the decision-making processes taken by police and may influence their decision ultimately.

Q. Do you think you would support a recommendation that enabled - in some sensitive way to protect people's rights - police in those situations to have more information about the history of a person that has a serious diagnosis like schizophrenia?
A. I would support that.

Q. Thank you. No further questions.

TOWNSEND: No questions, thank you your Honour.

<EXAMINATION BY MS ROBB

Q. I understand an emergency examination authority in effect authorises a doctor or an authorised mental health practitioner to review a person?
A. Yes.

Q. Is it also the case that an examination authority authorises the same examination?
A. It does, although an examination authority is - it's a much more resource-intensive process, and then it actually has to - the actual application then has to be considered and approved by an authorising body to be able to, to take place.

Q. Is it your understanding that - and, sorry, this is in the context where you were asked some questions about the immediacy that attaches to an EEA.
A. Yes.

Q. Is it your understanding that the immediacy attaches to the EEA because of the emergency aspect?
A. And that's what the title of it is, emergency; the immediacy and that need because of the serious risk involved, and that immediate need for the person to be taken to an authorised mental health service.

Q. By contrast, an examination authority doesn't have that same emergent or immediate quality to it?
A. That's correct.

Q. But it may still be that there's a concern that's arisen that may indicate a person requires assessment?
A. That's right, yes.

Q. Is it the case that an examination authority is something that can be obtained, as I think you've noted, by way of an application to the Mental Health Review Tribunal?
A. Yes.

Q. Are you aware of who could bring such an application?
A. So, there's a range of people that could make an application for an examination authority. Police can, and have done, in the past. But from memory, and I haven't looked too much at the legislation in relation to it, one of the provisions, the person that the examination authority relates to won't know that they have an - a psychiatric condition or a, a mental illness. So there's--

Q. That's your understanding?
A. Sorry?

Q. That's your understanding?
A. That's my understanding, yes.

Q. Okay. Is it also your understanding that an examination authority is

something that could be obtained voluntarily where a person consents to be examined?
A. Yes.

Q. Thank you. They're all the questions I have.
A. Thank you.

HER HONOUR: Thank you. Mr Lynch?

LYNCH: I have no questions, thank you.

HER HONOUR: Ms Mathur?

MATHUR: Just one question. If the inspector could be shown vol 23, tab 835?

WITNESS: Tab 835?

<EXAMINATION BY MS MATHUR

Q. Is that a letter in the letterhead of Queensland Police Service dated 8 February 2021?
A. Yes, it is.

Q. Can I ask, are you familiar with that letter and its terms?
A. Look, I'm aware of certain sections. Again, I haven't gone back and reviewed this legislation, but I think there is that restrictions in relation to weapons licencing restrictions can be made and determinations can be made on a person's eligibility to hold a weapons licence or to obtain a weapons licence in Queensland on medical grounds.

Q. Are you aware of whether the terms of a letter of this nature sent out to medical practitioners as of today's date is in the same terms, or has there been a variation to the terms? For example, this letter speaks as to a risk assessment that is titled "virtually no risk"?
A. I couldn't accurately give you information relating to that weapons application and the currency of that policy. It's a separate area in the Queensland Police, the weapons licensing branch. I could - yeah, I would only be able to speculate as to whether or not it was the case. I can't give accurate information to inform the Court, I'm sorry.

Q. I understand, Inspector. Thank you.

HER HONOUR: Thank you. In court 2? Ms Callan? We just need the sound on.

<EXAMINATION BY MS CALLAN

Q. Inspector, my name is Sophie Callan. I appear on behalf of the New South Wales Commissioner of Police. Can I just ask in relation to one topic of your evidence, and that is the co-responder model that you explained in writing and

also orally in your witness evidence today?
A. Yes.

Q. In respect of that model, it appears, for instance, from the information that you provide about that model in your statement at tab 863E, that insofar as the Queensland Police Service is involved in a co-responder model with a mental health clinician, that that might, where available, be utilised by individuals from those two agencies to respond to a situation involving a person in mental health distress, is that right?
A. Yes, that's correct.

Q. In your statement, you refer, for instance, to the clinician being able to undertake, as it seems, on-the-ground assessments and otherwise assist with the prevention of the crisis situation. Is that a fair description?
A. That's correct. So, the clinician who sits in the car is a mental health trained, normally a clinical nurse consultant, and they have the ability to run through a number of various assessments to make a determination on the person's current mental state. And in some cases they can actually make a determination and complete a recommendation for assessment, which bypasses the need for a person to be transported to an emergency department and go straight to a mental health unit for a 48-hour examination period.

Q. Is another dimension of the presence of that clinician providing their clinical insight, judgment, advice to the police officer to assist the police officer in their execution of duty?
A. So, the mental health co-response involving police provides access to two significant bodies of information: the QPRIME information, which is on a police officer's iPad or QLiTE device, but then the mental health clinicians actually have access to their database known as CIMHA. I think it's Consumer Integrated Mental Health Application. I'm not 100% sure that I've got the terminology exactly right, but it's something like that.

Q. Okay. Insofar as the clinician has access to information about the relevant individuals, is its mental health records on that CIMHA database?
A. So CIMHA is mental health records from the public system. It doesn't generally hold a lot of information from private psychiatrists practicing outside of Queensland Health.

Q. Are you aware whether the CIMHA database containing those mental health records from the public system would encompass any and all such public mental health records as generated or stored throughout the State of Queensland?
A. I think CIMHA is - and I know that there's a number of different applications, and this is just from my experience, I haven't actually worked in Queensland Health to be able to give the evidence of the systems that they use - but it's my understanding that CIMHA is a statewide database that encompasses mental health holdings from around Queensland. It's not limited to a particular hospital and health service.

Q. Is it the case, or does it follow, where you talked about police having

access to their database of information and the clinician having access via CIMHA to the mental health database of information, that there can then be appropriate sharing of relevant information from those two repositories by the co-responders?

A. So co-responders can and do share information. We do need to do some work just in relation to who from the police can share that information, because it comes down to a delegation. But it's - the delegation is from a mental health response, and there is that discussion.

So, when police do respond to a call for service as part of a co-response, police have the information, relevant information from their holdings of information, and they can combine that with the information holdings from the mental health database as well. So prior to arriving at the call for service to provide response, there's the, I guess, the ability to be fully informed from both a health perspective and a law enforcement perspective as to a person's background.

Q. Thank you, those are my questions.

CALLAN: Thank you, your Honour.

HER HONOUR: Thank you. Dr Freckelton?

JORDAN: No questions, thank you.

HER HONOUR: I'm sorry.

CASSELDEN: No questions, your Honour.

HER HONOUR: Sorry.

GNECH: I'll try that again. No questions from me, thank you, your Honour.

HER HONOUR: Thank you. Dr Freckelton?

FRECKELTON: We have a number of questions, your Honour. I wonder if they might be posed after lunch?

HER HONOUR: Certainly. We'll adjourn and resume at 10 past 2.

LUNCHEON ADJOURNMENT

HER HONOUR: Yes.

CHRYSANTHOU: With your Honour's leave, and I've notified Dr Dwyer and also Dr Freckelton about a few more questions I want to ask just about one document.

HER HONOUR: Sure.

CHRYSANTHOU: If it could be put up on the screen, it's tab 853.

<EXAMINATION BY MS CHRYSANTHOU

Q. It's a document - I'll just ask you first. Could you just tell us what this document is?
A. Okay, so this is what's called a QPRIME occurrence report. This one relates to - so every time police go to an occurrence for a crime or a matter of domestic family violence, a report is generated on our QPRIME system, and this appears to be the, or a copy of the report for the incident attended on 8 January by the two officers that went for about 40 minutes.

Q. So, this is the Queensland version of a COPS entry? What we would call it in New South Wales?
A. I would assume so, yes.

Q. I just want to just ask a couple of questions about it, please.
A. Sure.

Q. Just the first question I had was in relation to the involved persons at the bottom of page 1.
A. Yes.

Q. We had understood just from all of the evidence that the person who had reported the alleged crime was Joel Cauchi, but here, it would appear that he is not the aggrieved person. He is identified as the referred person. Can you just explain that?
A. Okay, so DV other, referred person respondent. So a respondent is the person identified as being the perpetrator of the domestic and family violence. A referred person is the offer of referral. It, it doesn't necessarily mean that an offer has - an offer of referral to a referral service has been accepted.
DV other is a category where domestic family violence may have occurred, but it doesn't meet the threshold of necessary and desirable that needs to be achieved. We have a requirement that all matters of domestic family violence be recorded, and this is that recorded event in the occurrence format for that incident.

Q. Just going down to page 2, that's the description, a very short description, or a summary, of what occurred under the BOLO. Do you see that?
A. In the remarks of current incident?

Q. Yes.
A. Yes.

Q. Do you see there that it records that the understanding at the time was that Mr Cauchi Senior had "put the knives away in a safe place so that Joel cannot hurt himself or others with them, as he's no longer on his schizophrenia medication and his moods have become unpredictable". Do you see that?
A. Yes.

Q. Just further to the questions I was asking before lunch, do you think that that necessarily meant that the officers in question were concerned about the fact that Joel could have hurt people if he did have the knives?
A. I think what it does is it articulates, in relation to the domestic and family violence, that the matter was more mental health related as opposed to domestic family violence related. So, there'd be sufficient grounds in there to justify their decision from the ongoing mental health follow-up as opposed to following with action in relation to domestic and family violence.

Q. So that's in order to classify it away from domestic violence and into mental health?
A. Well, just the justification for the DV other. So for a DV other to be recorded, there needs to be a supervisor level approval, so there has to actually be some grounds that can be reviewed by the reviewing officer to get a context of what's happened to enable that approval process to be considered.

Q. Where it refers to Andrew Cauchi as an aggrieved, is it right that an aggrieved person means an alleged victim or a complainant?
A. So there's - one of the definitions of a relevant relationship in our domestic family violence legislation, an aggrieved person can be a person who is - another term is a victim survivor of the domestic family violence incident.

Q. Again, just going back to the questions I was asking before lunch. Just in hindsight, don't you think that it really was necessary for there to be a proper interview of Andrew Cauchi in connection with the domestic violence allegation, and also why he had felt the need to remove those knives from his son?
A. It was definitely a consideration that could have been made at the time by the police.

Q. I just want to ask you about one final aspect on page 13.
A. Yes.

Q. It appears to be a summary. Can you just explain what each of those terms mean underneath that "Protective Assessment"?
A. Okay. So we have a risk assessment framework that's utilised in relation to assessing risk in relation to domestic and family violence. There's various categories of risk, and that tool will generally come up with a, a summary of what the risks are, and the risks that are considered in relation to that domestic and family violence. It actually forms - or the protective assessment framework is - comes up in a - like a tri-fold card and outlines various risk factors to be considered when making the assessment. So for, in this case, they've listed the risk factors that they deemed present in relation to the domestic and family violence assessment, and they've listed them at the bottom of this report.

Q. What does it mean for the level of risk to be medium?
A. So medium is - they have - it's basically an assessed level of risk of domestic and family violence, not in relation to mental health. So that's an assessment of the risk of further harm via domestic and family violence.

Q. That risk assessment of medium is not in connection with the mental health concerns, but only in relation to domestic violence?
A. The holistic assessment of the risk factors relating to domestic and family violence.

Q. If it's a medium level of risk, what steps have to be taken, if any?
A. So high risk - for example, when I was in charge of the Domestic and Family Violence and Vulnerable Persons Unit, matters assessed as high and extreme risk would see a subsequent police follow-up. Matters - for example, if there was a way of police introduce - we had a - similar to a mental health co-response, we had an embedded social worker in our unit, so we would review and we would try and identify post-incident steps or services that could be provided to someone. For example, a victim survivor. We would actually take a social worker out and try and link in support services for matters identified as being extreme risk or high risk.

But for matters which are medium risk, as far as a domestic and family violence assessment, they would generally be overviewed in any event and just - if there were steps that could be taken as far as intervention from a social work perspective, or a domestic family violence support perspective, we would try and link - make some sort of linkage through a referral process as well.

Q. Having regard to all the information you have now--
A. Yes.

Q. --and looking at it in hindsight, do you consider that each of those assessments set out on page 13 were appropriate?
A. After - so mental health issues were present. Agree. Fear - not fearful. There was some element of fear, I believe, which was raised by Mrs Cauchi earlier on in the conversations, but I believe that that changed in comments made and things later on in the conversation in relation to them – her being happy to have Joel remain at the house. The level of risk. That's actually, I think, generated from the other factors that are present.

The referral decline. So in relation to police referral, so the Queensland Police has a referral service, Police Referrals. It's a means of linking people that we come to deal with. The majority of it, with the exception of domestic and family violence matters, is by consent, where we can offer referral for various services. So mental health is one of them.

If someone accepts a referral, a support service in the location - so there would be a couple of mental health support services in Toowoomba. I know that Arafmi, which is the Association of Relatives and Friends of Mentally Ill, are a participant in the Police Referrals process. Referrals can be offered. Not - they don't - it's done by, as I said, consent is a big thing, to people to then seek further follow-up support. And quite often, if the referral is accepted, the support service will make contact, best practice is within 48 hours, to the people involved in the incident to see what assistance can be provided.

Q. Do the police on the ground have the information to provide contact details for such referral services on the spot?
A. So we use a - and by "we", the Queensland Police uses a platform called Redbourne as a referral agency, and it's basically a computer system, or a plug-in, that links in to QPRIME, and there are a number of prompts that are filled in, and then it identifies the - the computer program identifies the best placed support service for the issues identified, and sends a message out with the details by consent to the relevant support service to reach out to those requiring support.

Q. Is that something that could have been offered to Mrs Cauchi on the evening?
A. Referral services, from memory, they were offered, I think, to Joel. I can't recall completely if they were offered to Mrs Cauchi as well.

Q. Just finally, on that question of fear on page 13. Do you agree that given Mr Cauchi is the one identified as the aggrieved person who removed the knives because of a concern that Joel could hurt himself or others, that the police weren't really in a proper position to assess the issue of fear, having not spoken to him?
A. I think there could have been - or there was an opportunity to explore that in further detail.

Q. Thank you so much for answering my questions.
A. Thank you.

<EXAMINATION BY DR FRECKELTON

Q. I'd like to start with the issue of the BOLO, Be On the Look Out for?
A. Be On the Look Out.

FRECKELTON: I wonder if document 853 at p 2 could be brought up on the screen again, please.

Q. Is this the situation: that Mr Cauchi Junior made contact a second time with police about the knives?
A. (No verbal reply)

Q. Let me orientate you this way. You can see page 2 of 853 now. You can see that the report time in relation to this is not January, but it's 25 February?
A. Yes.

Q. Is this Be On the Look Out for entry made after the second contact - the follow-up one - by Joel Cauchi?
A. So if it was in February, then yes, it would have been, and it was a, a supplementary action taken. Yes.

FRECKELTON: I wonder if the inspector could be shown tab 854A in volume 23, please. This is a transcript of the body-worn video of QPS3, your Honour.

HER HONOUR: Thank you.

FRECKELTON

Q. Do you have that now?
A. Yes. I do.

Q. Just to orient you in relation to this. You can see that it relates to the video that her Honour has seen on 8 January 2023, and you can see in the legend that letters are given to the various participants. Can I direct you, in particular, to the legend relating to Mr Cauchi Senior. Do you see that, namely "JD" - fifth entry down?

HER HONOUR: I'm sorry, Dr Freckelton. It might be - unless I'm wrong - a different tab.

DWYER: I think it should be 854, your Honour.

HER HONOUR: 854. Yes.

DWYER: 854A is the statement.

FRECKELTON: 854A. That's right.

HER HONOUR: That's the statement of one of the officers.

DWYER: 854 is the transcript of the body-worn.

HER HONOUR: There's two transcripts. It depends which officer's transcript you wanted.

FRECKELTON: This is QPS3. I apologise.

DWYER: Yes. That's 854.

HER HONOUR: That's 854.

FRECKELTON: I beg your pardon. Let's start again.

SPEAKER: 854.

FRECKELTON: 854. QPS3.

SPEAKER: There's nothing there. It's a blank bit of paper.

FRECKELTON: Are we able to bring that up electronically?

HER HONOUR: Do we have it electronically?

SPEAKER: We just need a moment to do that.

FRECKELTON: Yes. Of course.

HER HONOUR: We'll get that up.

FRECKELTON: I'll ask some questions about other matters and await being notified when that's available, your Honour.

Q. You have made reference in your evidence today to the importance and utility of interactions with persons with mental illnesses being voluntary?
A. That's correct.

Q. Why do you emphasise that as being significant?
A. Because of the considerations and the intent of our mental health legislation around the community - provision of community-based care and the emphasis on less restrictive practice, not only in the Mental Health Act, but also in the Human Rights Act.

Q. There's a specific provision, section 13, of the mental health legislation, I think, which articulates what's often described as the least restrictive principle?
A. I have looked at it, but I, I can't recall the exact specifics.

Q. If we talk about the need for everyone interacting with persons who have a mental illness to do so in as least restrictive a way as possible, how does that translate into appropriate conduct by police?
A. I think it can be interpreted by police that we are to use less restrictive practice. So the provision of our detention powers only when - I shouldn't say as a last resort, but only when absolutely necessary. And the less restrictive practice also relates to the provision of appropriate care in a least restrictive way by the system as a whole.

Q. The very essence of an EEA is that police coercively, if necessary, can take a person for assessment if the preconditions are met?
A. That's correct. And that's actually articulated further in one - in, in that piece, I think, in a further subsection as well, that police may use reasonable force.

Q. Yes. The way in which that provision is constructed is that the power to compel detention and assessment is subject to a series of preconditions?
A. Correct.

Q. As you've described, the person must be at immediate risk of serious harm, so not something minor, but harm that is of some consequence, shall we say?
A. Yes.

Q. Next, there has to be a connection between that risk and a major disturbance in the person's mental capacity?
A. And I note the major disturbance. Yes.

Q. And finally, the person must appear to require urgent examination, treatment or care for the disturbance which is causing the immediate risk?
A. Correct.

Q. It's all about the individual, as the legislation is currently written?
A. That is right.

Q. There's only the one example in relation to suicide, which is present in the legislation?
A. That is right.

Q. You've given examples so far about people who cut themselves, or are standing on the edge of a building, or somewhere that's manifestly dangerous. From your extensive experience, are there other examples that come to mind of when this assessment is activated to compel detention and then assessment?
A. I have looked at harm from different perspectives as well. Without identifying the individual involved, I came across a person that was at risk of financial harm. For example, there was a - what appeared to me to be a delusion for this individual to be pasting $100 notes and $50 notes all over the windscreen of his car, which was Korean, manufactured by Hyundai, because of a belief or delusional belief that the people of Korea were in cahoots with the Americans that were corrupting a broad societal system of oppression.

So there was that financial harm and then subsequently, to prevent that financial harm, I secured the money and I made sure that my camera was running whilst doing so and had cause to go into the house and I could see the house was squalid. There was, there was a number of concerning things in the house, which indicated that the person was incapable of providing care for himself, which in my mind triggered the fact that there was a serious risk. There was imminent need for him to be able to be assessed because he could not provide and look after his own wellbeing, and that if he continued, then there was a risk of significant harm, so.

Q. So that's an example of where the harm wasn't of deliberate self-harm, but it was a risk of serious physical harm and also serious financial harm?
A. Correct.

Q. That's very helpful. Thank you, but are there examples that spring to your mind of where this provision has been utilised to mandate assessment where the concern is not so much about the individual, but about others?
A. I think there's been some violent confrontations where an individual has, for example, a lone individual has tried to pick a fight with a larger group of people and, taking into account the stature of the individual who's making the threats against a larger group of people, it's obvious that the individual making the threats would come off second best and would face - yes, there's a risk of harm to others, but there's also the retaliatory effect of the others inflicting harm on the individual.

Q. Yes, so consequential harm to the person who might, as a result of their

mental illness, be an assailant?
A. That's right.

Q. So, that secures the constructive agenda of they're being able to be taken away from where the confrontation might occur and the difficulties that they might cause to others on the basis of the risk to themselves?
A. That's right.

Q. Is it your evidence that you would prefer to revert to the pre-2017 legislation so that there is a clear message to police who deal with persons with mental illnesses that they can utilise the detention and assessment power if they conclude that there was a risk to others, as well as to the individual?
A. I think the clarification the term "and others" provides would simplify the decision-making processes for police.

Q. Is it your evidence that this removal of the "or others" provision has caused concern and confusion amongst first responder police?
A. Most definitely, and I have seen and received emails from the State Mental Health Team, which is the unit that I now oversee. I've seen emails come out raising the concern amongst a network of Mental Health Intervention Coordinators across the State, highlighting and bringing it to their attention that the "and others" provision no longer exists.

Q. I've asked you about the least restrictive approach by police. In viewing what occurred on 8 January from the two officers, is it your view that they took quite active measures to try to de-escalate the tensions that existed within the household?
A. I think you can see from the tone, the demeanour and the communication, even the language used, that there was an active attempt to utilise the de-escalation training that's provided by police, to establish that rapport and to try and achieve that behavioural change to de-escalate the situation and to minimise the opportunity or the reliance on force to bring the situation under control.

Q. That relates to Mr Cauchi Junior?
A. Yes.

Q. But also to his mother, who was quite anxious on first presentation to police. Is that right?
A. That's correct. It's not a, a single use. It - we try and utilise our communication skills to everyone that we deal with, because we want to resolve the matters as, as peacefully as we possibly can.

Q. We've got the right document in front of you now, I think, 854, which is in volume 23. You can see from the page which is on the screen now, I think - are you looking at the screen or the page?

HER HONOUR: I think it's on the screen.

FRECKELTON: Yes.

Q. It might be easiest to do it by the screen.
A. Yes.

Q. If you look at that, you can see the legend. Do you see that?
A. Yes, I do.

Q. And the various people which are listed there and you can see that the fifth of those is Mr Cauchi's father. You see that?
A. Yes.

Q. I'm going to ask now that you be shown page 15 and scroll down a bit further down the page please. That's 14. The next one if you would, please. That's it. You can see in the middle of the page, as it's presenting to you now, "JD". Do you see that?
A. Yes, I do.

Q. That relates to Joel Cauchi's father?
A. Yes.

Q. Can you see there a record of the conversation that the officer has with him in relation to whether he has stolen his son's knives and similar?
A. Does it begin with, "I just came out to know if I'm going to gaol tonight"?

Q. Yes. Keep going down there. You see, "I stole his knives. No, you didn't steal his knives, no" and then he explains what he was doing. Just take your time and read through that. He gives an explanation, "Well, he's upset me so much because he won't go to sleep. I thought - I mean when he came here and I saw all those knives, I said, 'No, no, sorry, Joel, you can't keep those knives'", et cetera.
A. Yes.

Q. Just read that through. You can see this page and then going onto the next one, if you would, that there's a discussion by police with the father about what's talked about in relation to the knives and at the top of that next page, the top couple of lines, the father says that he's got angry?
A. Yes.

Q. Having worries about his son, a variety of different things, and that COVID has made it all worse?
A. Yes.

Q. It's apparent, is it not, that the father is worried and distressed as well about what has been taking place?
A. He appears to be very concerned.

Q. Yes. Just keep going. Scroll down that page if you would, please. He says there about eight lines from the bottom, "I want to look after my son, but I also need to look after me and my wife", and he describes what had been taking place that day; three lines from the bottom, "We were both slightly

hitting each other today." Do you see that?
A. Yes.

Q. Go onto the next page if you would, and the officer says, "We'll make a note of it and, hopefully, hopefully, we can get him some help, or whichever. If you have any dramas, let us know."
A. Yes.

Q. There's reassurance to him that the son has a mental health flag and then about again ten lines from the bottom, the father says:

> "All I want, the only thing I want is for my son and I to be able to get to a doctor. He can help us with the sleep patterns. If that's all that happens and we get - we all get sleep at night, he can make all the bloody noise he likes at night. He can bang a floor. He can do what he likes, but in the day, not at night."

You see that?
A. Yes, I do.

Q. So the father is communicating some wishes to the police, is he not?
A. Yes.

Q. There seems to have been a dialogue of some consequence between police and the father, as well as with the mother, of course--
A. Yes.

Q. --and with Joel as well?
A. Yes.

Q. So this is all part of the quite complex and prolonged interactive process that takes place with police endeavouring to deal with the family issue that has emerged?
A. That's correct.

Q. As you look at that and the videos that you've seen, how would you describe the adherence by the two officers to what is expected of them in the context of issues related to dealing with a mental health issue?
A. So, again, they have explored in more detail with Mr Cauchi Senior. They have explored and investigated the matters with Mrs Cauchi, and then they've also had the conversation with Joel, and then, after those conversations, they have got together, and together, the officers have basically outlined the information and evidence, if I can put it that way, that they have gathered and then they've considered what the most appropriate response is.

Q. They have incorporated input from Joel, the mother, and the father as well?
A. That is correct.

Q. As part of the process of assessing whether there is immediacy of serious risk, the need for assessment and so on?

A. That's correct.

Q. It's quite apparent that, given Joel's fixation with knives and his father's having taken knives that he wants to have, that there was reason for concern that evening in relation to Joel. Is that right?
A. Definitely reason for concern, and enough reason for concern that a mental health follow-up is warranted.

Q. Would you be critical of them for not utilising their coercive powers?
A. No.

Q. Just explain why, if you could encapsulate it, please?
A. Well, as I articulated earlier, with the knowledge and the experience of the police involved, the lack of clinical training, the lack of specialist development and working in a mental health role, they have considered the various options. They have assessed the behaviour. They have utilised less restrictive practice by sending the email out, and exercising their detention powers there and then based on the assessment that the officers made at the time as to the criteria of section 157B.

Q. There are occasions, as her Honour has heard, when an EEA power is utilised by police and where force has to be used to take the person for an assessment by mental health clinicians, and that can yield useful information for everyone concerned and follow-up action?
A. Yes.

Q. However, can it also come at a cost?
A. It can. So any interaction that police have will, I guess, form or set a precedent for police actions into the future.

Q. With the individual concerned, do you mean?
A. With the individual concerned. So, if a significant amount of force is used against an individual at a first instance of a mental health response, then it may well and truly be expected that the person may be escalated in subsequent dealings down the track because they will expect the police to utilise or exercise force on future occasions.

Q. Have there been instances where there have been violent confrontations between persons with a mental illness and police in the aftermath of other interactions by police with the individual previously?
A. Yes.

Q. Do you say that this is another good commonsense reason why as little force should be employed as possible by police, lest it generate problems down the track?
A. I think, you know, the minimal amount of force necessary, which is the Queensland Police policy, is relevant for that reason, because we - it's the behaviour that I guess - people that we respond to will be informed then of police will do this. It's - and I even considered the use of, you know, our highest level, which is our, like our tactical response team, our SERT, it's a

Special Emergency Response Team.

Q. Yes.
A. Generally if they are required to deal with the highest level of, probably our highest level of force that we have to utilise to bring a situation under control, once they have been utilised, there's generally a flag created that "previously subject to SERT action", because of the expectation or the understanding that that level of force may be required again to bring the person under control.

Q. So, it could be self-perpetuating?
A. That is correct.

Q. What about, so far as you were aware of it, the complexities of a clinical assessment and then formation of a clinical relationship when police have had to use force to get them to be assessed in the first place?
A. A number of times I have had to use force to take a person for assessment, and unfortunately they are that heightened that the means of chemical restraint have had to be used by hospital staff, which then impairs and impedes the ability of a mental health assessment to be done. And then it's usually delayed for a significant period of time.

Q. Let me ask you about that issue of delay and police resources. You made reference to what is required of police when they take someone to be assessed. Do police generally stay at the place where the person is to be assessed, to avoid them just leaving voluntarily?
A. There's that, and it's not just, we don't just have, as police, have a duty of care to the person that we have conveyed, but community safety as a whole. So, there will be generally other patients present in an emergency department. There's the staff members, the doctors and the nurses and things. There's limited - from my experience, there's limited security services provided by hospitals, and if a person is escalated and elevated in their behaviour, then it is a requirement for police to stay and to maintain a level of safety for those in the vicinity.

Q. Of course, there are usually other demands on the clinician's time at the place of assessment. And I think you said this morning that during a time period that you've measured, the average period for attendance by police at the place of assessment was 4.6 hours, and it's grown a little bit since then?
A. So, the, the average time taken for a mental health response in general, so that's across the, across the range of calls for service with mental health, or a mental health nature, is 4.7 officer hours.

Q. Okay. There are some like the one in January of 2023 where the officers stayed for a little while and spoke to people and didn't utilise their powers ultimately?
A. That's right.

Q. And I haven't measured how long that took, someone else probably has, but it was--

HER HONOUR: I think it was 40 minutes.

FRECKELTON: 40 minutes, thank you very much.

WITNESS: Yes.

FRECKELTON

Q. So that's at the low end as against the four hours plus?
A. Yes.

Q. And there are times, no doubt, where police have to stay longer and try to calm things down and talk through things in a complex way with different individuals?
A. So mental health responses are very challenging as far as the amount of time they take to complete from start to finish.

Q. And presumably the longest periods of time are when the individual is taken for assessment?
A. That's correct.

Q. And police need to stay at the location?
A. Yes.

Q. Okay. I think you mentioned 4.6 hours on one measure. Was that over a three-year period?
A. So that's calculated over a financial year.

Q. I see.
A. So the average times taken. So, we've got, we've got our call for service data, that's the time taken from the start of the call service to the finish. And noting that officer hours is two officers, so that's a total.

Q. Yes, right.
A. So, you'd probably have to divide that time--

Q. By two?
A. --by two.

Q. I see, yes. Nonetheless, what impact does it have on the capacity for police to provide services broadly to the community when 4.6 or seven hours are taken away for dealing with a mental health call?
A. Any sort of response that takes a significant amount of time plays on the back of your mind, especially later in the evening or on night shift or when there's a large volume of calls for service, because there might be a limit, especially on night shift, there might only be a very limited number of police crews on, and you don't know what other calls for service are going to be coming in and what other emergent responses are required by police. So the amount of time taken at a job, so there may be some sort of activities that may not be undertaken when there is limited resourcing to ensure that there is a

capability of responding. If that makes sense.

Q. Yes, it does. On a standard night shift, how common is it for there to be a mental health job that needs to be attended to by general duties police?
A. Regularly.

Q. Can you just flesh that out a little bit more? Once a week or for - given police who are working say in Brisbane or Toowoomba on a night shift, how common is it for them to have to expend that amount of time on a mental health call?
A. I'd say it would be common for them respond to a mental health call for service on their shift.

Q. Each night?
A. And again, it, it - it's - it ebbs and flows.

Q. Yes, yes. So, the whole design and allocation of cars and manpower is influenced by the amount of time that is required on a daily and nightly basis to attend to mental health issues and consideration to be given to mandated assessments?
A. So, police roster to demand. So, when we assess the demand, the calls for service, the amount of time taken, we try and allocate from, you know, historical patterns. Or for major events we try and assign resources available or the appropriate resourcing to be able to effectively provide a policing response to that particular period of time.

Q. I've asked you questions about the legislative criteria for mandated assessments. At a pragmatic level, is the fact that these assessments are going to prolong the period of time that police have to spend dealing with a mental health job factored into the practice of police?
A. As part of demand more broadly, yes, it's taken into account.

Q. I want to move to a different topic now with you. You've been asked a number of questions about the utility of police having access to clinical information about persons with a mental illness, and you've described how some information can become available to police. For instance, the police MHIC talking to the Health MHIC?
A. Correct.

Q. Is that right?
A. Yes.

Q. But even when that occurs, are there constraints upon the information which the Health MHIC gives to the police MHIC by reason of the human rights legislation and section 25 privacy under that, and also the protocol that you've described to her Honour?
A. From memory, our memorandum of understanding is very specific about the types of information that can be shared. There's a number of criteria, and again, it's very specific as to what can be shared because of the need to comply with those information privacy principles.

Q. It was put to you that police need information about people's mental illness to make appropriate decisions. Do you remember that being put to you?
A. Yes, I do.

Q. I think your response is knowledge is power; the more information that there is, the better police can do their job?
A. It informs decision-making processes.

Q. Nonetheless, if the privacy constraints didn't apply and if the memorandum of understanding wasn't there, what kind of a position are police in to discern clinical information with which they might be provided to assist their decision making?
A. Limited, because police aren't clinically trained.

Q. Okay. Professor Nordentoft, amongst the other experts, made reference to something that was raised by our learned friend, that at a much earlier time, Joel Cauchi had delusions about pigs coming out of the ears of his teachers, and about being eaten by a giant frog. All right?
A. Yes.

Q. I'm not sure of the exact timeframe, but it was in the order of two decades before?
A. Mm.

Q. In terms of evaluating whether there was a serious risk two decades later from the time of those delusions, if they were given that information about what had happened a long while before, would that have been useful information for police to have?
A. Recency is important when assessing any sort of information and intelligence, and something from two decades before may paint a picture of a previous state. But as I've also tried to articulate, a person's mental health, it fluctuates, and it's - there are, there are good periods of, you know, functionality within the community, and there are periods where a person needs additional medical help, as far as their mental ill health goes.

Q. Is it your experience that symptomology of mental illness can wax and wane both in terms of its focus, for example, the content of delusions, as well as its severity?
A. Yes.

Q. What is your level of comfort about the current regime in which limited information is provided by health personnel to police about information to which they are privy by virtue of being clinicians?
A. The opportunity exists for the information to be shared in relation to incidents, and the current MOU, it's not too bad. I think that, as I think I've already said before, there may be scope to further expand that, particularly around concerning behaviours. But for the most part, the memorandum of understanding currently works. Could it be improved? Yes.

Q. So, to summarise that, would you be supportive if the Coroner recommended that those issues be, in relation to information sharing, be revisited by a suitable working group?
A. Yes.

Q. One of the ways in which police who are first responders can secure assistance from clinicians is via the Mental Health Liaison Service, is that right?
A. Yes.

Q. Roughly how long has that been in existence within the Queensland Police?
A. I believe - yeah, I believe it was the late 2010s that the Mental Health Liaison Service was established in its current format.

Q. Just say a little bit more to her Honour if you would, please, about who staffs that liaison service and its availability for frontline police and how it's used?
A. Certainly. So the Mental Health Liaison Service is a team of mental health clinicians, and I think one of the staff members is actually a trained psychologist, from memory. They provide a service from 7am in the morning until 11pm at night. And that is, they have some visibility of our computer aided dispatch system, where they can view text around a mental health call for service. They are also available for phone advice in relation to a person that police may be dealing with. They also have access to the Queensland mental health database CIMHA. And they have the ability to share information via the memorandum of understanding with police, either via radio or via telephone if needed.

Q. In principle, in a situation such as that with Joel Cauchi, had they been contacted, had they been available and contacted, they could have given guidance about questions to ask and approaches to take to the first frontline police?
A. That as well as any relevant holdings they may have had in relation to Joel.

Q. But as you describe it, there are a couple of limitations. The first is that the access to information that they will have of a clinical nature will be information that exists on State holdings, namely not with private practitioners?
A. That is correct.

Q. And also there's a limitation in terms of their hours of availability, not after 11 o'clock at night?
A. That's right.

Q. Would you like to see a change to that, if it were feasible, in terms of securing personnel so that they're available in the early hours of the morning and very late at night?
A. The Mental Health Liaison Service is a valuable service to police. It provides us the ability to seek advice, support and information in relation to mental health of a person that we may be dealing with, or a person in crisis.

So any information that we can get, and any level of expertise or clinical expertise that we can obtain, whether it be by - via phone, is invaluable, and that's - I'm very welcoming of the proposal from the Queensland Forensic Mental Health Service which provides the clinicians to review and, hopefully, expand its use to the provision of the telehealth service as well, and expanding the hours. But any expansion would be, would be greatly welcomed.

Q. Does it go further than that? Is it necessary to enable better informed first responder work with persons with mental illnesses out of hours?
A. Yes. It also aligns with the intent of the Mental Health Act with less restrictive practice, because we are suitably informed as - on our front line, and it also provides that clinical lead for the response as well, even though it's remote.

Q. It transforms the principal basis of decision-making, for instance, of that mandatory detention and assessment away from police to being at least significantly influenced by clinicians?
A. That's right. They - you know, clinicians with their expertise, they can provide that clinically-led lens over the incident and provide advice accordingly.

Q. Is it right that discussions are taking place with Professor Heffernan about just these issues?
A. The proposal to expand the service was actually from Professor Heffernan.

Q. At the moment, when the Mental Health Liaison Service is used, is that principally done by telephone?
A. Principally done by telephone or provision, so there's - they have the ability - so the communications room supervisor is the State duty officer, and the mental health clinicians can have conversations with the State duty officer, and the State duty officer can convey that information over radio as well, if needed. So it's not just restricted to use of a personal mobile phone.

Q. You've described that there are moves to extend that interaction in a virtual way. Can you describe that to her Honour?
A. Yes. So the, the initial proposal was there's an application called GoodSAM - "good" and then "Sam"; it's short for Good Samaritan. I think New South Wales Police use it in a different context, to provide real-time support. So it enables the police to - the mental health clinicians, I should say, to send a link that they can access on their mobile phone, and allows for a face-to-face interaction, utilising technology, for a discussion to take place.

Now, again, there'd have to be considerations around information, privacy and security and consent that they'd actually wish to partake in a conversation with a clinician. But it allows for the potential for a conversation, and an initial assessment and conversation to take place about the person's mental ill health.

Q. And again, that's subject to further discussion with clinicians--
A. That's right, and there may even be an alternate platform that's being explored, because with - there's significant concerns from police about

information security, about assessing of applications. So I think there may even be a - another potentially already approved application utilised by Queensland Health that may be more suitable to the process and achieve the same thing.

Q. I've asked you questions about clinician-led responses to mental illness, rather than their coming principally from police. You refer in your statement to the co-responder model, and you've been asked questions about that. You identify in your statement that, in essence, there are two different versions which are being utilised by police in Queensland at the moment. Tell her Honour if I'm getting this right, please.

The one is that first responder police, such as those who attended at Cauchi's residence in January of 2023, might seek assistance from clinicians who are part of Queensland Ambulance, and so the clinicians come to the location and work with the first attending police. Is that right?
A. That's correct.

Q. That's a co-responder model initiated by the police who have arrived, identified the issue and considered that they could benefit from clinician assistance?
A. That's right.

Q. Is it right that that's available in certain parts of Queensland, but not everywhere?
A. That's right. I - from my understanding, there's 12 locations along the eastern seaboard and out as far west as Toowoomba currently where the Queensland Ambulance Service Mental Health Co-responder is in operation.

Q. You make reference at paragraph 67 of your statement to a "rapid joint response". Is that what you're talking about?
A. Is that the rapid real-time response?

Q. I'll read you what you said in paragraph 67: "A police officer and a mental health clinician from Queensland Health providing rapid joint responses to those experiencing mental health crises in the community on scene"?
A. Yes.

Q. Is that what you and I have just been discussing, or is it something different?
A. No. That's what we've been discussing.

Q. The second option of the co-responder model which exists in Queensland is where the initial response is by police and also by a clinician. Correct?
A. So--

Q. With them arriving pretty much at the same time, and being the first response team together?
A. So generally the - a crew of two police officers will attend first, just to make sure that the situation isn't dangerous and there is no risk to the safety of the

clinician.

Q. Is that just any police officer under this model, or is it particular police officers?
A. So, so it'll just be - our first response car will attend the call for service as a routine attendance, and then if a further response from a clinician would be of assistance, a police officer and a clinician in a car, instead of a paramedic, like the ambulance model, can attend in a second vehicle. If the situation is safe enough with the presence of one police officer providing a security overlay, the opportunity for the crew of two other police can attend another--

Q. To go back to ordinary duties?
A. That's right.

Q. First responder police first up, and then the joint exercise from one police officer and one clinician?
A. That's right.

Q. When it's that model, is it a particular police officer who has been allocated, received some training, and acquired some skills in relation to mental health issues?
A. It varies from location to location, noting that each of the Queensland Police co-responses have been set up independently of one another. So each district mental health co-response may have a slightly different name, and a slightly different model of operation. To give you some context, in the Logan Police district they generally try and utilise people who have received training as police negotiators to go into a vehicle with a mental health clinician, because they have received additional training for tactical communication and - and de-escalation techniques.

Other areas, it might be staff from the Domestic Family Violence and Vulnerable Persons Unit who may have some additional exposure to mental health calls for service, and reviewing mental health matters on a daily basis, whether it be as the MHIC role in a portfolio, or just to provide assistance.

Q. You have two different co-responder models running at the moment in Queensland, no doubt depending upon resources and location?
A. That's correct.

Q. Both of these are comparatively recent in their implementation. Is that right?
A. Yes. That's right. There's been significant expansion over the last two or three years of the Queensland Ambulance and Queensland Health model. I know that we started our South Brisbane model, I believe it was 2019.

Q. Sorry, when you say the South Brisbane model, what do you mean?
A. So when I was in charge of the South Brisbane District Domestic Family Violence and Vulnerable Persons Unit, there had been conversations from our local hospital health service and the unit with, with a view to establishing a police and Queensland Health co-response in that area. So it was subject

mainly to local relationships with the local hospital and health service to provide that clinician. And then my role as the officer-in-charge was to try and secure the resources locally in the form of staffing and a vehicle, and then provide a place for that service to operate out of.

Q. What I've heard you say to her Honour so far is that it's important that responses to mental illness be clinician-led, first up?
A. Correct.

Q. There are some real benefits in having a clinician in Queensland Ambulance attending when requested?
A. That's right.

Q. But there are perhaps - now you tell her Honour what you think - more benefits in having this co-response model where there is a trained, sensitised police officer in company with a clinician attending a second phase usually?
A. Certainly. So - and again, my opinion. There are benefits of police attending with a clinician in the sense that the police have the ability to provide a security platform, and provide a safe environment, and the - I'm trying to think of the correct term. The seriousness, or the level of crisis, can - the calls for service with significant crisis can still be attended to by a clinician because the security can be provided to the clinician to attend and assist.

The Queensland Ambulance Service model doesn't necessarily have that, unless police are already in attendance. That being said, there are often co-morbidities, so other factors influencing a person's behaviour. Whether it be drug and alcohol consumption; whether there is injury sustained. And a paramedic, teamed with a clinician, can provide that medical response. So there are pros to both, and both services are very valuable and - yeah. It provides that - both services provide an additional level of response to people in mental, mental ill health.

Q. From your informed perspective, if money were not an important consideration, which of course it is, and resources, what would your preference be in terms of how the system evolves?
A. Look I think there is - if money wasn't an object, and resourcing wasn't an object, ideally for both, because the Queensland Ambulance Service receives calls separately and independently from the police, and there are a number of calls for service that the Queensland Ambulance Service attends to that police may not have (as said) any knowledge of at all. So it's still a valuable service for them to meet their requirements of provision of services to the community.

But then there's also the matters which come to both agencies' attention, or just the police attention, where the police have access to that as well. So there are pros of both services, like I said, and I think both have, if resourcing wasn't a constraint, an ability to improve our level of service to the community.

Q. Both models of the co-responder response are comparatively new, as you've described?
A. Yes.

Q. Has there been a systematic analysis of the advantages and disadvantages of them and how they can be improved within the Queensland Police Service as yet?
A. Yeah. So I think it was - one of the recommendations from the 2020 MHIP review was an evaluation of co-responder models across the agencies. That's been conducted by the Queensland Ambulance Service, and I understand a draft report has been completed. As an independent organisation, and reviewing some of the findings that have been put forward, my state mental health team and I have reviewed and just have considered that there may not have been a like for like comparison, because some of the recommendations are more favourable to the Queensland Ambulance response.

Q. If her Honour were to consider recommending an independent review not dominated by police or by ambulance, would you see some advantage in that, in providing guidance as to the evolution of mental health response in Queensland?
A. I think it would further highlight the benefits of reduced tension, improved service responses, improved response times to the people that need the service the most, which is what we've already seen from evaluations in the past.

Q. Her Honour's been told by you and other witnesses about the lost email--
A. Yes.

Q. --and about the change to QPRIME which, in essence, will provide recurrent reminders in a Cauchi situation to the MHIC to attend to an issue that's been raised by general duties police?
A. It - the changes made will provide improved governance over that process of informing the MHIC of a need for further follow up.

Q. Nothing's foolproof, but will it go a very long way to avoiding a situation where a person falls between the cracks?
A. Yes.

Q. Thank you very much for answering all of those questions. Is there something that you would like to say in closing to family members of--
A. I'd just like to offer my condolences to the families and the impacts this tragic event has had on you, and I understand that. Thank you.

HER HONOUR

Q. Thank you, Inspector.

FRECKELTON: Thank you, your Honour.

HER HONOUR: Thank you, Dr Freckelton. Anything arising?

DWYER: No, your Honour. Thank you.

LTS:DAT

HER HONOUR

Q. Thanks very much Inspector for your evidence today. It's been enormously helpful.
A. Thank you.

NO EXAMINATION BY MR TOWNSEND, MR ROFF, MR CHIU, MR JORDAN, MR CASSELDEN, MS CLARKE, MR GNECH, MR PENN, MR WILSON, AND MR LYNCH

<THE WITNESS WITHDREW

DWYER: Your Honour, those are the witnesses for today. We switch tomorrow to a focus on the security response at Westfields on 13 April 2024. There's a slight change in order, but not in witnesses, so we can expect to hear tomorrow in this order: from Joseph Gaerlan, the centre retail manager; Jerry Helg, the Glad security officer and security supervisor; and Andrew David, Glad security project and training manager at Westfield Bondi, or at least he formerly was. He's now left that position. And we'll commence at 10am tomorrow.

HER HONOUR: Thanks very much. We'll adjourn till 10.

AUDIO VISUAL LINK CONCLUDED AT 3.17PM

ADJOURNED PART HEARD TO WEDNESDAY 7 MAY 2025