LTS:DAT

IN THE NEW SOUTH WALES STATE CORONER'S COURT

STATE CORONER O'SULLIVAN

MONDAY 12 MAY 2025

2024/00139002 - BONDI JUNCTION INQUEST

NON-PUBLICATION ORDERS MADE

PART HEARD

AUDIO VISUAL LINK COMMENCED AT 10.09AM

HER HONOUR: Good morning. Ms Sullivan.

SULLIVAN: As your Honour knows, we now turn to the segment where we explore issues relating to the mental health treatment of Joel Cauchi, as was foreshadowed by Dr Dwyer. The first witness in that respect is registered nurse RN2, and I call RN2. Your Honour, her statement is at tab 792C of vol 19 and the relevant medical records are at tab 793 of vol 20.

HER HONOUR: Thank you.

LTS:DAT

<RN2, AFFIRMED(10.10AM)

<EXAMINATION BY MS SULLIVAN

Q. Could I please ask for your full name for the record please?
A. It's RN2.

Q. What's your occupation?
A. I'm a registered nurse.

Q. You're currently self-employed as a behaviour support practitioner. Is that right?
A. That's right, yes.

Q. Before we proceed any further with your evidence, I understand there's something you would like to say?
A. Yes. I'd like to offer my condolences to everybody that was affected by the tragedy, especially those who have lost loved ones.

Q. Thank you, RN2.

HER HONOUR

Q. Thank you.

SULLIVAN

Q. You prepared a statement for these proceedings dated 4 April 2025. That's right?
A. That's right, yes.

Q. Are there any corrections you wish to make to the statement?
A. No.

Q. True and correct?
A. Yes.

Q. You've also had an opportunity to review the clinical records from The practice at Toowoomba that relate to Joel Cauchi. Is that right?
A. That's right, yes.

Q. You were involved in Mr Cauchi's care over two different periods which we'll come to. Is that the position?
A. That's correct, yes.

Q. But in short, you knew him over a nine year period from 2011 to 2019. Is that the position?
A. That's right, intermittently, yes.

SULLIVAN: Pausing there, your Honour, I just would note that there is a

non-publication order over RN2's name at this point in time. There is also a non-publication order over other clinicians at The practice, certainly the treating psychiatrist, Dr A, and also registered nurse RN3, who I will refer to as we go through your evidence.

HER HONOUR: Thank you.

SULLIVAN: There's also an NPO over the name of the clinic itself at this point in time.

Q. Can I start with your background in qualifications, please. We have a copy of your CV that is attached to your statement and at paragraph 7 you say, "I'm solely qualified in the area of mental health nursing". That's right?
A. That's correct, yes.

Q. You, in fact, trained as a nurse in the United Kingdom from 2000 to 2003?
A. Indeed.

Q. Is that correct?
A. Yes.

Q. Thereafter, you obtained certain mental health qualifications, including a Bachelor of Science in Mental Health Practice in 2005 from the University of London?
A. Yes.

Q. And subsequently, a master's degree in cognitive behavioural therapy from London Metropolitan University in 2010?
A. That's correct.

Q. Then you worked as a nurse in the United Kingdom for around seven years in the mental health space before coming to Australia. Is that correct?
A. I did.

Q. Came to Australia and started working in around May 2011--
A. Yes

Q. --in the Darling Downs Hospital in the mental health space again?
A. Mm-hmm.

Q. Correct?
A. Yes, yep.

Q. Then your longest period of work in Australia was at the private practice known as The practice. Is that correct?
A. It was, yes, that's correct.

Q. And we know there's the two periods. The first six years is from October 2011 to October 2017. Is that right?
A. Yes.

Q. Then you went off and did something else in the intervening period for a couple of years and came back to The practice from August 2019 to November 2021. Is that right?
A. Yes, that's correct.

Q. From November 2021, you commenced working as a behavioural support practitioner in a slightly different area. Is that accurate?
A. That's accurate, yeah.

Q. So, as we go through your evidence we'll divide them into the two periods.
A. Mm-hmm.

Q. That is the first period and the second period--
A. Yes.

Q. --of employment at The practice. Just dealing with the setup at The practice, can you just explain the role of a primary care nurse providing mental health treatment there at that clinic?
A. The role was, was quite varied, but predominantly, it would involve the monitoring, assessment, and sometimes treatment of people with various psychiatric conditions. In addition to that, we also had some clinics as well. For example, we had a Clopine clinic that Mr Cauchi was involved in.

Q. During that first period, how many psychiatrists were there?
A. During the first period, I believe there was just two.

Q. Is that Dr A?
A. Yes.

Q. And another clinician?
A. Yeah, Dr B.

Q. Dr B?
A. Yes.

Q. How many primary care nurses were there?
A. There were - it changed over time. I was the first one, and there was two or three at any given time during that first period.

Q. During that first period, how many days were you working?
A. I was, I was part-time during the first period, approximately three or four days a week. It, it varied over the, the, the time that I was there because of sort of family commitments and everything.

Q. What was the caseload like; how many patients did you have on the books? That is, you personally?
A. Yeah, I couldn't say exactly, but approximately 35.

Q. Did that change during that six-year period, or did that maintain, did it stay

fairly stable?
A. It, it fluctuated somewhat, but not significantly.

Q. Were you specialising in any particular mental health area whilst you were there?
A. No, I tended to get referrals for people that had conditions that I had sort of a clinical strength in, and that's the way that we worked in general at the practice.

Q. What were those areas that you had a clinical strength in?
A. For example, people with eating disorders and people with psychosis. Lots of different areas, yeah.

Q. But you had--
A. Personality disorders as well.

Q. Personality disorders?
A. Yeah.

Q. Had you had particular expertise with schizophrenic - patients with schizophrenia, diagnosed with schizophrenia?
A. I'd had a lot of training.

Q. If we could have your CV brought up, please?

SULLIVAN: That's at tab 792C, vol 19, p 8, please.

Q. There we see a summary of your duties whilst at The practice. It looks like we're having some technical issues. There it is. No. I can read them out. We'll do it the old-fashioned way. Summary of your duties, which you note at page 9 in connection with that initial period from October 2011 to October 2017, that summary applies to that first period as well, and you refer to care, coordination and case management, triage and assessment of mental health behaviours of concern and risk, monitoring of client's mental and physical health. You also refer to the provision of clinical supervision, liaison with and education of other healthcare professionals, and working as part of a multidisciplinary team. So that was whilst at The practice during both those periods?
A. Yes, yes.

Q. How did it work in terms of the multidisciplinary team function?
A. We, we would work alongside the doctors. So, they would support us with the treatment and monitoring that we provided to the patients that we worked with, yeah.

Q. Did you sometimes see the patients together?
A. Occasionally, yes, yeah.

Q. Only occasionally?
A. It was--

Q. That was not the normal course?
A. No, it wasn't standard for everybody all of the time, but occasionally we would. It was more common during my first employment at The practice.

Q. That you would see the patients together?
A. That's right.

Q. Let's come to your experience with Joel Cauchi.
A. Mm-hmm.

Q. You indicate at paragraph 12 of your statement you cared for Joel Cauchi whilst employed at The practice as a credentialed mental health nurse under an initiative funded by the Darling Downs and West Moreton Primary Health Network. What's a credentialed mental health nurse?
A. Credentialing as a mental health nurse is a process that you undergo with the Association for Mental Health Nurses, and it requires that you are educated at a certain level and have certain experience of working in the mental health sector. The process involves an application and evidence to prove that you have the requisite skills and experience, and then if - that's assessed, and if, if it's, if it's suitable, then you're, you're awarded credentialing.

Q. When were you awarded your credentialing?
A. I, I can't think of the exact dates, but it was prior to my employment. Just, just prior to my initial employment at The practice, because--

Q. In 2011?
A. Yeah, it - you, you were not able to work in the role unless you had that credentialing at that time.

Q. When you first came to work with Joel Cauchi - we can see from the clinical records that happens in around 2015, August 2015 - do you remember your first involvement with him around that time?
A. I, I do. Vaguely, but I do remember.

Q. You took over from a previous nurse, registered nurse, RN1, is that right?
A. That's correct, yes.

Q. She had been his Clopine coordinator up until that point in time when you took over?
A. Yes, yeah.

Q. What's the role of a Clopine coordinator? Can you explain that to us?
A. Of course. Clopine is a very closely monitored antipsychotic medication because of the potential harmful and life-threatening side effects that can occur when people are prescribed that medication. Yeah, so the, the - our role was to ensure that he had all the correct physical monitoring conducted prior to him having the medication dispensed.

Q. I see.

A. Yeah, and, and that meant that he'd, he'd had his blood tests conducted and that all of the results of the blood tests were within normal ranges.

Q. Were you conducting the blood tests or--
A. No, no. So he--

Q. You were just looking at - reviewing the results?
A. That's it. So, they would go to the pathology and get the bloods taken, and then we would have access to the results of that. And we then had to upload the results of that onto a database, and then, and then results being on the database would then trigger the pharmacist's ability to actually give them the medication, to release the medication.

Q. Were there other things that you were monitoring in your role as Clopine coordinator?
A. Yeah, we would also, we would also monitor their mental health and general wellbeing.

Q. How would you do that?
A. Through, through interviews, through asking questions during the appointments that we had with them.

Q. Would you conduct a mental state examination yourself when you would attend in your role as a Clopine coordinator?
A. Yeah, yes, yeah.

Q. You would always make a clinical note in relation to the physical observations and the mental state examination, is that right?
A. Yes, yes.

Q. Did you get a handover from Registered Nurse RN1 when you assumed the role as Joel Cauchi's Clopine coordinator in August 2015?
A. Yes, I did. And I also - I'd seen Joel on occasions when she was on leave as well, so I did already know him before I took over as his Clopine coordinator.

Q. What can you remember about that handover?
A. I can't honestly - I can't remember the specifics, but I do know that there was a, a handover. Yeah.

Q. Joel would attend monthly, is that right?
A. Yeah, at least monthly.

Q. Did you understand him, when you took over his care in August 2015, to be compliant with his treatment?
A. Very much so.

Q. Why do you say, "very much so"?
A. He was, he was, he was someone who was very compliant. Yeah, he was very - he was never even late for appointments, and there was no having to

chase him up. He was, yeah, he was very compliant.

Q. We'll come to some particular notes in relation to your role, but after you had, in the ordinary case, taken your physical observations and undertaken a mental state examination, was it the position that Joel would then go and see Dr A?
A. That's correct.

Q. How long would your assessment generally take?
A. Generally half an hour. We had half an hour allocated for the assessments.

Q. Do you know how long Dr A's assessment of him would generally be?
A. I believe she had the half an hour allocated to see him as well.

Q. On the occasions when you saw him together with Dr A, do you recall how long that would generally take?
A. Approximately half an hour. Yeah, sometimes a little less, yeah.

Q. Was Joel someone who was quite forthcoming in those consultations with you, he would provide a lot of information, or was he someone who was fairly succinct and wasn't necessarily loquacious or effusive?
A. Yeah, he was quite succinct. Yeah, he wasn't, he wasn't overly chatty.

Q. What was your understanding - if I can take you back to August 2015 - what was your understanding of his diagnosis?
A. I was aware that he had a schizophrenia diagnosis, and I also believe he had an OCD diagnosis as well.

Q. Is that quite common to have those going together?
A. I wouldn't say it's common, but at the same time, it's not unheard of, yeah.

Q. Did you have an understanding of his complexity as someone diagnosed with schizophrenia, as in where he was on the spectrum?
A. I think so, I believe so.

Q. Where was he on the spectrum of complexity?
A. I think that he was - the fact that he was prescribed Clopine at the time that he was indicated that he had treatment-resistant schizophrenia, so that obviously meant that his condition was quite severe. However, because he was so compliant, he wasn't difficult to manage, and he was stable during that period as well in terms of his mental state, mental health.

Q. Had you had in your experience managing patients diagnosed with schizophrenia who were on Clopine or Clozapine?
A. Yes, yeah.

Q. What's the difference, just assist us with that?
A. It's a trade name. We, we say Clopine because that's the brand that we were using and we were using their systems to monitor it. But, yeah, there's different trade names and that was just the one that, that was prescribed at the

clinic that I worked at.

Q. Okay. Had you had patients that were on Clopine or Clozapine who were on a reduction regime previously?
A. Yes.

Q. How common was that scenario, in your experience?
A. It was relatively common, because it's best practice not to have someone on a dose of that medication because of the potential side effects that's too high. So, the aim generally is to - for people to have the minimum effective dose.

Q. The minimum effective dose?
A. Effective dose, yes.

Q. How is that determined, how do you get to that point?
A. Yeah, through reduction and monitoring, yeah.

Q. Over what period of time, in your experience, would that generally occur?
A. Over quite a lengthy period of time. A number of months at least.

Q. Was there, in your experience, a specific decrement or reduction in the drug per month, or did it depend on the amount that the person was on?
A. I think it was - yeah, it was, it was dependent. But as a medication, because of the fact that it is prescribed for treatment resistant schizophrenia, it - caution is definitely needed. Yeah.

Q. Just explain for us, would you, treatment-resistant schizophrenia? How is that diagnosed?
A. The - having had two - failed trials of two other antipsychotic medications that were not effective in, in symptom reduction, or as effective as, as needed, yeah.

Q. Did you have an understanding as to how long Joel had had treatment-resistant schizophrenia for?
A. I think--

Q. That is, when you started?
A. From, from a young age, yeah. From that very early adulthood, I believe. Yeah, he was, he was.

Q. Was the reduction of Clopine in accordance with a particular protocol, to your knowledge?
A. Not that I'm aware of, but as I'm, I'm not the doctor, I, I wasn't aware that there was a specific protocol for that. There was a lot of protocols around the use of medication, but the, the reduction of it I'm not, I'm not aware of a protocol for that specifically.

Q. You would get the direction from the psychiatrist around the reduction and then follow that in terms of how his mental state--

A. That's right.

Q. --each month based on the reduced amount--
A. That's right.

Q. --follow his physical observations, report that to Dr A, would you?
A. Yes.

Q. In notes or in a conversation?
A. Yeah, well because of the, the system that we had in place there at the clinic, what would happen would be that I would see Joel and then the doctor would see him directly after. So I would write my notes and then she would review mine when she saw him straight afterwards.

Q. You would do your notes contemporaneously or at the end of the session with Joel?
A. During - for the Clopine clinics, we would have to do them during the session because - knowing that the doctor needed the information that we were providing for her session that was directly after ours.

Q. Is that going into a particular specialised Clopine database, or is it going into the medical software system that we understand is called Genie?
A. The, the notes would go into Genie and there was additional information regarding the results of the physical examination, more specifically the blood tests, that would go onto the Clopine database.

Q. We'll come to some examples of notes, but in this first period, shortly after you've taken over the role as Clopine coordinator for Joel, were there multi-disciplinary team meetings in relation to him at that time?
A. Yes.

Q. How often were those meetings held?
A. The meetings were held each week on a weekly basis, most weeks, and he would have been discussed on occasion. He wouldn't have necessarily been discussed at every meeting, but if there was something happening, like his medication had just been reduced, then that would be generally when he, he would be discussed.

Q. Who attended those? We take it the nurses and the psychiatrists?
A. The nurses and the psychiatrists, yeah.

Q. Only patients who were having particular treatments of note at that point, or an issue, are raised. Is that an accurate summation?
A. That's right.

Q. Were there notes kept of those weekly meetings?
A. Yes. There was.

Q. How were they kept?
A. There was a, there was a - they were handwritten in a, in a A4 book.

Q. Who would handwrite the notes?
A. Generally the nurses would take it in turns to make entries.

Q. Were those team meetings continued into that second period you were working, from 2019 to 2021?
A. Yes. They were.

SULLIVAN: Your Honour I can indicate, we've made some inquiries about those notes. We don't have them, but we'll update the parties once we have further information.

Q. Do you recall, during that first period that you were engaged with Joel, speaking to his mother at all?
A. I believe I did, but I can't remember the specifics of the first period.

Q. Did she ever attend any of his consultations?
A. Not with me. No.

Q. Do you recall speaking to his father?
A. No, I, I - I've never spoken to his father.

Q. To be clear, is it the position in that first period that Dr A was Joel's treating psychiatrist throughout that six year period?
A. Yes.

Q. But on occasion, Joel might see Dr B when, for example, Dr A was on leave?
A. That's, that's correct.

Q. We'll go to some clinical notes. I'm not sure if we've got IT difficulties, which means we might be back to an old hard copy volume.

SULLIVAN: Tab 793, vol 20, p 65. Perfect.

Q. If we can just look at the bottom of that page, the entry on 12 August 2015. Do you have that entry?
A. Mm-hmm.

Q. That suggests that you would be Joel's case manager from 12 August 2015. That's in effect RN1 noting that you would be the contact point, or the case manager, from that point?
A. Yes.

Q. Then we see your first entry on 26 August 2015 under "Clinical" at 9.21am. Do you see that?
A. (No verbal reply)

Q. At the top of the page, top of page 65, 26 August 2015, under the heading "Clinical"?

A. Yep. Yes. Sorry, I, I saw the doctor's name at the top and got confused. Yeah.

Q. We see a timestamp there of 9.21am. Do you see that?
A. Mm-hmm.

Q. What would the timestamp indicate in your experience?
A. That would be when I made the, the clinical entry.

Q. That's the time the note goes in?
A. Yes. Yeah.

Q. We can see from that particular entry that at that point in time, Joel is on 250 milligrams of Clozapine?
A. Mm-hmm.

Q. What level was that dose? Was that a high dose or a moderate dose, or where did that fall?
A. Moderate.

Q. The next entry we see relating to you is on 23 September 2015. That's on page 64. We can see a clinical note from you:

> "Joel reports that his cognitive function and energy levels have improved since his dose of Clopine has been reduced. He denies any psychotic symptoms and says he has been physically very well."

Do you see that?
A. Yes.

Q. At that point in time, you understood that there was a general plan to reduce his Clopine on a gradual basis each month?
A. Yes. Yep.

Q. Were you particularly alive to the potential emergence of early warning symptoms?
A. We - I was monitoring for them. Yes.

Q. What types of things would you be looking out for?
A. Pronounced changes in behaviour, anything to indicate that he was experiencing delusions or hallucinations.

Q. Anything else?
A. It might - there might be a decline in his functioning - overall functioning, like his self-care, that kind of thing, cognitive decline. Yep.

Q. A decline in self-care could be indicative of an early warning symptom?
A. Yep. If he's - he was quite well groomed, so if he sort of came looking dishevelled then that could've potentially been an indication. Obviously it's not

as straightforward as that, but, yeah, they would be the sort of things that I would be looking out for.

Q. To be clear, at this time, you understood the plan was to reduce the Clopine to the most effective level relative to the side effects. Is that right?
A. That's right. Yes.

Q. As opposed to cease the Clopine?
A. Yeah. At that point, yes. Yeah.

Q. Had you had experience with patients who had been medicated with Clopine, or whatever permeation of it, and then entirely ceased Clopine medication and not gone into any other form of antipsychotic medication?
A. Personally I haven't. No.

Q. Have you had instances of patients ceasing Clopine and going onto other types of antipsychotic medication?
A. Yes.

Q. That was always the case?
A. In my experience. Yes.

Q. Approximately how many patients would you have experienced, firstly who had gone off a Clopine regime and onto other antipsychotic medication?
A. It's difficult to say having worked in mental health for 20 years, but as it is - it's not, it's not a hugely common medication because of the monitoring. So I would say just a handful, maybe five. Maybe even less. Yeah.

Q. And none of that cohort of five, or even less, that had gone off the medication and not onto anything?
A. No.

Q. If we go to page 62 you can see an entry from you on 27 January at the top of the page:

> "27 January 2016. Joel reports that he's doing well. Better eye contact and more reactive than he's been in the past. Spoke about early signs of relapse, but he could not identify any as he has been well for so long."

Do you see that note?
A. Yes.

Q. Those are the early signs of relapse that we spoke about?
A. Yeah.

Q. Was that a concern for you, or would that likely have been a concern for you, that he seemed unable to identify the early warning signs of relapse?
A. I think - I, I would assume that I meant that he hadn't identified them within - as occurring within himself. Yeah.

Q. By this stage you've been his Clopine coordinator since August 2015, so just over six months. Do you recall, around this time, or indeed at any point in time during that initial period when you were treating him, what you thought about his insight into his illness?
A. I actually thought he was relatively insightful, and he was also concerned about his illness.

Q. What do you mean by that?
A. In that he was quite diligent in monitoring for signs of relapse. He, he didn't want to get unwell, and he was very conscientious with regard to his mental health, which is, I think, that was evidenced by his punctuality and, and engagement with our service. Yeah. He had anxiety around it, so he--

Q. Around management of his mental health?
A. Yeah. Yeah. He wanted, he wanted to get the support and make sure that he did the right thing. So if he - if - like I, I would've been very confident that if he had experienced symptoms, because he was concerned, that he, he, he would've been open about them. That, that was my impression. Yeah.

Q. Just speaking more generally, in your lengthy experience as a mental health clinician, how do you safeguard against the risk that a patient may present a particular way, but in fact have the emerging signs of psychosis that they're trying to conceal from you?
A. Yeah. Yeah.

Q. How do you manage that scenario?
A. I think the - it's, it's easier when you've known someone for a period of time because it's easier to see the changes in their behaviours, even during the consults. And it can be quite - it, it - they're quite difficult for people to mask, these type of symptoms. It's just thoroughness, I suppose. Yeah.

Q. As you say, it gets easier to identify those potential signs the longer you've known someone?
A. Yeah. Definitely.

Q. On page 61, on 10 February 2016, there's a further note from you - the history - "Joel said that he feels physically better on the reduced dose of Clopine. He also reports that he remains mentally well." That's consistent with him reporting that he was benefitting from the reduction in Clopine?
A. Mm-hmm.

Q. Did that continue to be the trajectory the entire time that you were involved in his care during the first period?
A. Yes. Yeah. Yeah. I, I did definitely see an improvement in terms of his energy levels and functioning. He, he seemed to get more quality of life.

Q. We see that again on page 60, on 6 April 2016 your note is:

"Joel reports feeling mentally and physically well. He's noticed a

recent improvement in his cognitive function that has made studying easier. Seems more relaxed than previously."

That's consistent?
A. Yeah. Yes.

Q. By that stage he's on, we see, 200 milligrams of Clopine. That's a reduction of 50 milligrams over that period?
A. Yes. Yeah.

Q. Also on page 60, we see there's a reference - I withdraw that. Let's go to page 50 please, we'll just move forward in time. On page 50 we see there's a note from you on 4 May 2017. This is a note, rather, from Dr B?
A. Yeah.

Q. Who she says "Seen with RN2 Clopine coordinator", and there's notes from you further down on page 51?
A. Mm-hmm.

Q. "History: mentally feeling well, feels constantly improving in mind, clearer, denies perceptual disturbance, mood good", et cetera?
A. Mm-hmm.

Q. That's an example of where you had seen Joel with the psychiatrist?
A. Yes.

Q. And again, he's reporting being well?
A. Mm-hmm.

Q. In fact, having a clearer mind as a function of the reduction of the Clopine medication?
A. Yes.

Q. The last note in that first period that you worked with him, I think we find on page 46 from 19 October 2017, and there's a note from you, "Had influenza, recovered now, mentally reports feeling well". Do you see that?
A. Yes.

Q. That's shortly before you resign and go off and do something else for a period?
A. That’s right.

Q. At the point, that last consultation, that last period of time before you left, were there any concerns that had been raised about his treatment that you can recall?
A. No, I personally didn't have any concerns.

Q. The trajectory was just of improvement?
A. That's - yeah, that’s what I'd seen. Yeah.

Q. Notwithstanding the reduction of the Clopine?
A. Yeah. He was - he seemed to be functioning better but without the emergence of any symptoms.

Q. You have no recollection, just to be very clear, during any of the team meetings about any issues being raised as to his medication reduction regime?
A. No.

Q. Let's go to the second period that you were at The practice. This is from August 2019 to November 2021. At this time when you come back, Registered Nurse RN3 is his case manager, do you recall that?
A. That's right.

Q. And by this stage, Joel had entirely come off the Clopine?
A. Mm-hmm.

Q. Do you recall that?
A. Yes.

Q. We know that he came off in June 2018 and we also know that he came off Abilify for the OCD--
A. Mm-hmm.

Q. --in June 2019. Do you remember being aware of that when you came back to the clinic in August 2019?
A. I do, yes.

Q. How did you first become aware of the fact that he'd come off both those medications?
A. It would have been in discussion at the team meetings. Yeah, and I, I specifically remember him coming off the Clopine.

Q. How do you specifically remember?
A. I think it's because it's, it's more noteworthy, like, it's a little bit more unusual, so, yeah.

Q. We know that when he came off the Abilify he was taking 5 milligrams per night.
A. Mm-hmm.

Q. How does that dose fit on the spectrum? Is it a low dose, a moderate dose?
A. It's a low dose, yeah.

Q. Can you recall during team meetings that related to Joel during this period - and let's just take it up to February 2020--
A. Okay.

Q. --when we know that there was an interaction - do you recall any concerns being raised by anyone in relation to him not taking any medication?

A. Not specifically, no.

Q. At paragraph 19 of your statement, you refer to having occasional contact with Joel during this second period through the peer support program that he had become engaged with at The practice?
A. That's, that's correct.

Q. What's the peer support program?
A. So, this was a program that was funded by the Primary Health Network in the Toowoomba region for people that resided in the Toowoomba region, and it provided support worker assistance for, for people with mental health issues, and Joel was accessing a support worker.

Q. Did you have a particular role in relation to that program?
A. For a relatively brief period, I was managing the program, yeah.

Q. How long was the program running at The practice?
A. I believe it was a year, but I'm not, I'm not exactly sure, yeah.

Q. We might just take you to the referral form that relates to this program.

SULLIVAN: That's in the notes at 793, vol 20 at p 143. If we could go there, please.

Q. Is that the referral form that was completed for Joel to participate in the peer support program?
A. Yes.

Q. That wasn't completed by you. That was completed by RN3, we see?
A. Yes.

Q. Are you able to decipher what is written in the box there under--
A. "Help get structure"--

Q. --"Support required"?
A. --"in his day in his home".

Q. Could I ask you to speak up please?
A. Yes, sorry.

> "Help get structure in his day, in his home, more detailed organisation, cleaning of his duplex unit, exercise with PSW" - peer support worker. "Likes hiking and cardio weights, going to World Gym and walking, budgeting, shopping lists, increased meals for cooking."

Q. Thank you. Then we see the number of hours requested and frequencies, I think is that two hours Monday, two hours Wednesday?
A. Yes.

Q. Then there's "Additional information, comments". Does that say "Joel is open to further discussion on what support is available"?
A. Yes.

Q. And it's dated 24 October 2019?
A. Mm-hmm.

Q. Do you recall discussing this referral with, firstly, RN3?
A. Not specifically, but it doesn't mean that it wasn't discussed. I just don't recall it. It was a long time ago.

Q. Do you recall discussing the referral with Joel?
A. I, I don't specifically recall a discussion, but there would have been one because that was the process, and it generally would have been discussed in the team meeting, yeah.

Q. What came of this referral, to the best of your recollection? Was he connected with the peer support--
A. Yes, he was. He had a support worker for a period of time, and I think it was that the interactions that were successful. However, Joel decided to not continue with it when he had plans to move to Brisbane.

Q. It was his decision, not--
A. Yes, yeah.

Q. Was this program available in Brisbane, this peer support program?
A. No. This particular program was only available for - people who lived in the Toowoomba region were only able to access this the program.

Q. Was it a Commonwealth-funded initiative, do you know?
A. It was funded by the Primary Health Network. I don't know. I'm assuming that's local, State-funded, but I'm not entirely sure. Yeah.

Q. A paragraph 19 of your statement you say, "I recall that Joel engaged well with his peer support worker"?
A. Yes.

Q. What gave you the impression that he had engaged well?
A. Feedback from his peer support worker, and from Joel himself. They, they seemed to get on well, yeah.

Q. Did you have any involvement with Joel, any clinical involvement with Joel beyond the peer support program during that second period?
A. Not clinical, no.

Q. And I may have asked you this, I apologise if I have. But prior to February 2020, do you remember any issues being raised regarding Joel at a team meeting, a multi-disciplinary team meeting?
A. The reduction of his medication and his mental state would have - like, was raised definitely within the meetings. I don’t, I don't recall any, any concerns

per se, but I know that it was discussed.

Q. Do you remember anything about the nature of that discussion?
A. I remember - all I remember is that his medication had been reduced and that there was feedback to say that he was actually responding quite well, or ceased even, yeah.

Q. And Dr A was present at those team meetings?
A. Yes, most of the time, unless she was on leave or something.

Q. And Dr B, was she present as well?
A. Yeah, the same, unless, unless she was on leave.

Q. Coming now to this discussion that we know you had with Michele Cauchi, Joel's mother--
A. Yes.

Q. --on 14 February 2020. I'll take you to the note that you made in a second.
A. Yep.

Q. But before we do that, can I just ask for your best recollection of that conversation on the 14th?
A. Yeah. I, I think Joel's mum called and spoke to our - the - one of our administrators at the clinic.

Q. Is that the Receptionist?
A. That's right, yes. And expressed some concerns around Joel's ability to keep his unit tidy, and the administrators - because I knew Joel, I believe that his nurse at the time was on leave, so - and I was free, so they asked if I'd be willing to have a chat with Joel's mother. And she, she expressed concern that he was - like his unit was really untidy, and that when she broached him about it, he would, he would become a bit irritable about the topic, and - but she asked that I not let him know that she'd called. I offered to a joint appointment so that they could both come, because sometimes if someone's likely to get irritable, that can diffuse situations if, if there's another person present, and I also mentioned re-referral to the peer support program, yeah.

Q. Do you have a clear recollection of that conversation as you sit here now? It seems that--
A. Not, not clear, no.

Q. How long was the conversation approximately, you think?
A. I don't know for sure, I would say, maybe ten minutes, five, ten minutes. Probably about ten minutes.

Q. Where were you when you had the conversation if you can recall?
A. I was in my office.

Q. The call was put through by the Receptionist?
A. That's right, yes.

Q. We'll go to her note and see if she--
A. Yes.

Q. --conveyed any of this information that we see, at tab 793 page 19, please. We see on 14 February, what the Receptionist writes is this:

> "Michele rang to say that Joel is not well and she's worried about him as her husband went around to his flat and said it was a mess and she's worried about him moving to Brisbane as he can't seem to look after himself. He was to see RN2 re peer support, and he put her off, and now he's lost his spot with peer support, and she said Joel has said that he didn't put her off and that it was not - that it was only not convenient that day for him. She's worried if he moves to Brisbane, he may become homeless. Put Michele through to RN2 for further discussion".

A. Mm-hmm.

Q. You see that note?
A. Yeah.

Q. Before you took the call, did the Receptionist say to you, "I've got Michele Cauchi on the line" and any of the content of that note, or was it just put straight through?
A. She would have explained the context. I remember she did ask me if I was happy to take the call, yeah, and explained that his mum had some concerns about--

Q. And so RN3 is on leave at that point in time and she's Joel's usual case manager, is that right?
A. That's right.

Q. What's the arrangement when a nurse who is the case manager for a patient goes on leave?
A. If there are - it depends on, it depends on the patient. If it was, for example, someone that was accessing the Clopine clinic, provisions would be made to ensure that there was another nurse to be able to see them for those appointments, because they can't, they can't be given the medication unless all the processes are followed. If someone is quite unwell as well, then provisions would be made to ensure that they were seen by another nurse. However, if it was someone that was traveling quite well, that might not have been done as a matter of due course. It would just be that if they called and expressed problems, then they would be booked in. But we would sort of cover each other.

Q. Cover each other?
A. Yeah.

Q. On the next page, page 20, we see your note. Your consultation notes?

A. Mm-hmm.

Q. And under the heading "History", "Mother Michele called to express her concerns about Joel's functioning at home, and his probable move to Brisbane". Pausing there.
A. Mm-hmm.

Q. Do you recall understanding prior to that time, that is 14 February, that Joel was moving to Brisbane?
A. I, I knew he was planning to move, because that was his rationale for not continuing with the support worker. But I think - yeah, I don't know how firm it was, and I think the plans changed. I can't recall the specifics after that point.

Q. It goes on:

> "She said that his self-care is poor. His father went around there to put his bins out and the place was a mess. There were dishes in the sink and mess everywhere. She also said that there are renovations happening at his place and that he's staying with them for two weeks. He appears more isolated and irritable, and is occasionally swearing".

Pausing there, had you ever known Joel to be someone who was prone to swearing or irritability, in your experience of him?
A. No. That was out of character.

Q. The reference to poor self-care, is that the type of thing that could be an emergent early warning sign?
A. Potentially. However, as Joel had always lived with his mother and wasn't skilled in this area as well, it's, it's not unusual for someone doing these things for themselves for the first time to struggle to some degree as well, which is - yeah, which is why he had the support worker assistance, yeah.

Q. It goes on, "She then said that she did not want Joel to know that she's called, and I said that we cannot address these issues with him if that is the case". And that's what you've just referred to; you were in a difficult situation in terms of confidentiality, is that the position?
A. Yeah, that's right, yeah. It's, it's hard to address things directly when you're not supposed to know them, yeah.

Q. Was this a scenario that you encountered not infrequently, that someone would tell you information about a patient but then say, "I don't you to let them know that I've told you this"?
A. It would happen occasionally.

Q. What are the options available to you in that circumstance?
A. I think - well, to offer supports around it. So have a direct conversation with the patient and ask how they're, how they're coping. But also, like, like in that instance, to offer a joint appointment or other supports as well.

Q. What types of other supports?
A. In that instance, re-referral for the support worker, because the issues were around his ability to be able to function in terms of looking after his unit.

Q. Was there anything else that might have been available to provide support to him?
A. Not that comes to mind straight away. I don't think that there's much by way of other services that would have been able to help him at that point.

Q. All right. It goes on to say:

> "Offered joint appointment with myself to discuss these issues, and she said that she did not think Joel would agree, and if he did, she does not feel comfortable discussing this as he may get annoyed. When asked what happens when he is annoyed, she said he gets irritable and has sworn recently."

Pausing there, that's twice she's referred to the swearing. Was she signalling to you that that was significantly out of character for him?
A. I believe so, yes, and it was out of character.

Q. Was that a particular concern that she was conveying in this call?
A. My, my sense from the conversation was that she was more concerned about his functioning in terms of his ability to look after his unit, but it wasn't - it was a concern.

Q. It goes on:

> "I also said that he had been re-referred to the peer support program and advised that there is a waiting list currently. Acknowledged her concerns and his self-care, and she said she did not have any concerns about his safety".

So that's the potential option of re-referral to the peer support program?
A. Yes.

Q. But you understood that he was moving to Brisbane where there wouldn't be such a program?
A. Yes. I'm not entirely sure, because I think it was a bit up in the air at the time. It was he was going to move and then he, and then he wasn't. So I'm not entirely sure of the specifics at that particular point.

Q. You expressly asked her whether she had concerns about Joel's safety?
A. Yes.

Q. Did you ask her about whether she had concerns about her own safety, do you recall?
A. Not that I recall.

Q. At the time you entered this note, would it have been your practice to

review previous clinical entries to refresh yourself as to the status of a patient?
A. Yes.

Q. So, you likely read the other entries?
A. Yes.

Q. In light of that, do you recall reading that Michele Cauchi had raised a number of concerns over the previous months about Joel's potential deterioration?
A. I don't recall that specifically.

Q. Okay.
A. Yeah, I might - and I wouldn't go back through all of the notes. Yeah, I would go - I would generally go back for, you know, like three or four.

Q. After you had this call with Michele Cauchi, what did you do next?
A. I had a conversation with Dr A, an informal one actually. I remember going out, and the Receptionist - who put the call through to me - and I having a conversation with her, not within the team meeting, at that point, and just letting her know what had happened and his mother's concerns.

Q. Do you think you did that immediately, or did some time elapse? I mean are we talking at the same day?
A. It was the same day.

Q. Yes.
A. It was the same day, yeah. It was - I think it was - because I think it was around lunchtime. It's hard to be sure because it was quite a long time ago.

Q. Yes. You have a recollection from your statement of a conversation with Dr A and the Receptionist in the reception, is that right?
A. Yeah, that's right. Yeah, the - and that's why I think it was lunchtime, because it was empty. And I remember going out there and sort of catching her to let her know so it didn't get missed.

Q. Do you recall being concerned yourself based on what Michele Cauchi had told you?
A. I was - I wasn't involved clinically, so I didn't know exactly where he was at. I thought it was definitely worth mentioning, given the reduction in medication. However, it's not unusual for someone who is moving out of home for the first time, bearing in mind that Joel had been - he was in his 30s at that point, but for all intents and purposes, because of the medication and because of the illness, he was developmentally delayed in that area.

Q. Yes.
A. So, much like someone who's a teenager moving out of home for the first time, you do expect a little bit of conflict as that separation happens from parents. So, I thought that that might be what was happening at that point, but I wasn't clinically involved, so that's why I passed on the information to someone that was, so that they could, they could put that into, into context.

Q. I think you said reduction in medication, but in fact it was cessation of medication?
A. Yes. At that point, yes.

Q. Yes, at that point?
A. Yeah, yeah, yep.

Q. Do you think that you were aware that, in light of his cessation of all medication, that another explanation for this could have been the emergence of early warning signs of relapse?
A. It could have been, yeah, yeah. I was aware that that may have been what was occurring.

Q. That was part of the reason you were raising it fairly immediately with his treating psychiatrist, is that right?
A. That's right, yeah, yep.

Q. What's your recollection of Dr A's response to this information?
A. I, I remember her just taking the information on board. I don't remember her being - expressing concern or lack of interest, you know, it was just a standard sharing of information and an acknowledgement of that.

Q. In fairness to both of you, I assume you receive calls like this not infrequently during the course of any day?
A. Occasionally, yeah.

Q. Occasionally?
A. Yeah. They're not, they're not frequent, but they do occur. They're not completely unusual, yeah.

Q. Is this accurate: that family members who are conveying information about their loved ones with mental illness are usually very well placed to give you an accurate account, or at least an insight, into what's going on?
A. Yes.

Q. And that information has to be taken very seriously?
A. Yes.

Q. Is that a fair assessment?
A. Yes.

Q. Do you recall directing Dr A to the note that you prepared?
A. I don't--

Q. Or she would just have an expectation that there would be one?
A. Yeah, I don't recall specifically directing her to it. She would have known I would have made a note, because we, we always noted things like that.

Q. Do you recall whether this information was then discussed at a team

meeting post 14 February 2020?
A. I don't specifically recall it, but I would imagine that it was.

Q. When did you first come to understand that Joel had been discharged from The practice?
A. I think it was shortly after, after that phone call. Yeah.

Q. What's your best recollection of how you came to understand he had been discharged from the clinic?
A. I believe, I think that I was aware because of it was mentioned in a team meeting. But I can't remember the exact day of that meeting.

Q. What do you recall being told about his discharge?
A. That he, he was discharged because he had moved to Brisbane and he wasn't - I believe that it was he wasn't eligible for, for Skype appointments, and the - because he lived in the metropolitan area. So, when I say eligible, he would have had to pay for those appointments, because of the structure of the funding system. So, he had said that he didn't - he - I think he said that he didn't want to go ahead with that. That's my understanding of--

Q. That's your understanding.
A. Yeah, and--

Q. This is just around the time that the COVID pandemic is ramping up?
A. Yeah.

Q. Do you remember--
A. Yes.

Q. --that period back in February/March 2020?
A. Mm-hmm.

Q. What were the changes to practice in general terms at that time?
A. We were, we were doing a lot more over Zoom and Skype. Skype in fact, I think it was, yeah.

Q. By February and March 2020, a lot more by Zoom and Skype?
A. We started doing that pretty early on, yeah.

Q. Was there more flexibility, in your experience, in the early days of the pandemic, around Medicare eligibility requirements because of the pandemic, or you can't recall?
A. I can't recall. And that was because we - with the mental health nursing program, we could do that anyway and there was no cost to the patients. Whereas the availability for the access of psychiatry was different, and I wasn't overly involved in that.

Q. When you say, "we could do that anyway, there was no cost", what do you mean? Could Joel, for example, have continued to see RN3 through that program via Zoom--

A. No.

Q. --after discharge?
A. Had he have lived in, had he have lived in the Toowoomba region, he - we could see anyone in any way, via Zoom or via - like face to face, even through--

Q. At no cost to the patient?
A. At no cost to them. However, it was a program that was only available for people that lived in the Toowoomba region, so if they moved out of the area, then they were no longer eligible to access the program, yeah.

Q. Once you came to understand that Joel had been discharged because he'd gone to Brisbane to live, what was your understanding about what his - which clinicians he was seeing, what support mechanisms he had, that type of thing?
A. I wasn't aware.

Q. Do you remember anyone raising issues or concerns about whether he was plugged in with a psychiatrist or a GP at the team meetings?
A. Not specifically.

Q. How does the discharge process work for a patient like Joel who's been a longstanding client? What's the ordinary pathway to discharge from The practice, how does it work?
A. Generally, patients are discharged to their GP, and then it's the GP will make a referral onto a different psychiatrist.

Q. It's done through the GP as the--
A. Yeah, that's the model as it is at the moment. That's my understanding.

Q. Had you ever had involvement, or do you have involvement, in the discharge process generally in your role at The practice during that second period?
A. Did I have involvement in Joel's discharge, or just in general?

Q. Not in Joel's - in the discharge process generally, would you have a role as a mental health clinician working at The practice during that period, August 2019 to November 2021. Would you ever have involvement in the discharge process?
A. We would - if someone was - because there was two separate programs, if you like. There was the mental health nurse program and then someone that was underneath the psychiatrist. If someone was discharged from the mental health nurse program, which was actually quite rare, then we would be involved in, in that. In terms of discharge from the practice from a psychiatric perspective, we would only be involved if the doctor had asked for us to, to do some tasks in relation to that.

Q. What type of tasks might the psychiatrist ask you to do in relation to discharge?
A. Well it depends on the situation, but it might be to follow certain things up,

to look to see what services are available in the areas that they're going to. That kind of thing.

Q. That is the type of thing you might be asked to look into?
A. Yes. On occasion.

Q. Did you experience a scenario where a patient had been referred back to a GP, that is a patient with a mental illness, but then had difficulties in coordinating their care through that referral back to the GP, and then they come back to the clinic and you can see that they've had problems?
A. Not that I can think of off the top of my head. But it wouldn't, it wouldn't be unusual because there's such a long waiting list for psychiatrists in a lot of areas. So someone could want to see a psychiatrist privately and there could be a wait of six to nine months before they were able to be seen. In some areas - Toowoomba area has quite long waits for access to psychiatrists.

Q. Was that the case at The practice, that there were long waiting lists to see the two psychiatrists there?
A. There was. Yes. It varied throughout the years how lengthy the wait was.

Q. Given your extensive mental health background, do you see a difficulty with leaving the coordination of care with the patient who is referred to the GP, that is, it becomes their role solely to coordinate their care by the GP? That is, for example, someone who might be a disorganised person with a diagnosis of schizophrenia, it solely falls to them to coordinate their care through the GP?
A. Yeah. I think it's, it's not an ideal system. It's not an ideal model.

Q. Can you expand on that?
A. I think that given the barriers to accessing psychiatry, in terms of cost and timeframes, and also, as you were saying, if someone's quite disorganised, as a lot of people with various mental health conditions can be, then it's - yeah, it, it puts a lot of barriers in place and, and it may ultimately result in them not accessing services that they would benefit from.

Q. Had you seen that before, where someone had effectively sort of been lost to follow-up because they had been discharged to a GP and then they'd been incapable of managing the process from there?
A. Not specifically, but I think we wouldn't see them if they were lost and not getting support, you know, yeah.

Q. Had you had a scenario where a patient had been discharged from the clinic because they've moved out of area, for example to Brisbane or another area in Queensland, and you had had to coordinate a referral to another GP or psychiatrist in that other area?
A. I do recall having a patient who had - was moving to New South Wales and trying to access - trying to support them to access a - like a mental health nurse incentive program like the one that we worked under across the border - just in the Tenterfield area, so it's quite close to the border of Queensland - and not being able to do that because they didn't have the same structure in place, because it was, it was a - yeah, it was just - it was run differently in

different areas and the funding was used for different things.

Q. Do you recall if there were any concerns raised - coming back to Joel--
A. Yep.

Q. --and the team meetings after 14 February - if there were any concerns raised about him moving to Brisbane and away from his support network, in light of what Michele Cauchi had told you on 14 February 2020?
A. I, I can't recall any specific concerns, but I'm - I - I'm pretty confident there was discussion around the fact that it's less than ideal that he's moving; it would've been better if he had stayed where his supports are currently in place.

Q. Less than ideal. Do you remember who was conveying that view?
A. I don't actually, no. It might've been a conversation that I had with RN3. It might've been discussed at the team meeting. But the - yeah, I do recall having some discussion around it, but I don't know the context and--

Q. Do you recall ever seeing his discharge letter to a Toowoomba GP, Dr Grundy?
A. Not at the time. I've, I've seen it when I since reviewed the notes, but at that point, I don't recall seeing that.

Q. Is that a curious scenario to your mind, that Joel's moving to Brisbane but yet he's discharged to a GP in Toowoomba?
A. It's curious, but I can understand why it would happen in that if he hadn't secured a GP in the Brisbane area, then a letter would have to go to whoever is his current GP. But again, it's not ideal, but if he didn't have another GP in place, I don't see how it could have been conducted in any other way.

Q. Had you ever seen the scenario with there'd been a referral from a psychiatrist to another psychiatrist directly?
A. Yes.

Q. Was that fairly commonplace?
A. No, it wasn't. And I could be wrong, but my understanding is that if a GP makes a referral to a psychiatrist, the referral's for a 12 month period. But if a specialist makes a referral to another specialist, it's only for 12 weeks, which is why it's avoided. Yeah. Because by the time - especially if there's a waitlist, by the time they're seen the referral's expired. Yeah.

Q. After Joel had been discharged, do you recall any other concerns - beyond the less than ideal that may have been said by RN3, do you recall any other conversations around Joel's progress or treatment?
A. I don't. I don't.

Q. When you found out that it was Joel Cauchi that was responsible for the events on 13 April, what was your reaction?
A. I was, I was incredibly shocked. Yeah. I wouldn’t have ever thought that that was something that he would've done. Yeah. I had a very visceral

response to that.

Q. What do you mean by that?
A. I - for context, we've had, we've had issues with people being murdered in our family, and it was just a year before. So I turned - I saw it on the TV but I turned it off because I didn't want my children to see it, because they were still dealing with those issues, and, yeah, someone texted me to say that the person was from this area and I, I asked them if they knew the name. And when they said it was Joel, I looked it up and then I vomited when I saw it was him. But, yeah, because I was just - and it still feels like it - it still feels - like it's odd, because it just doesn't - it's incongruent with what I know of Joel. It doesn't - it really doesn't make any sense. Yeah.

Q. You had never seen any suggestion or indication whatsoever of a predisposition to violence, or the like?
A. No. No. None. None.

Q. Can I ask you finally about your reflections on where we find ourselves now. We know that Joel was lost to follow-up.
A. Yes.

Q. You understand that the Coroner has an important systemic review role, in terms of identifying public health and safety issues?
A. Yes.

Q. Are there some reflections that you would wish to offer from your perspective as a very experienced mental health clinician?
A. I think the - having worked in different countries as well, and specifically when I worked in the UK, when I, when I trained - at the time that I trained and, and, and first started working as a nurse, there was a system in place called the Care Program Approach, which was actually put in place because of similar scenarios to this, whereby people with certain diagnoses and people that had had admissions to acute psychiatric units were - had a prescribed, a prescribed follow-up.

And as a case manager for that person, if they disengaged, you had to find them or contact the police to find them. And then if they moved areas you, you had to ensure that another suitably qualified case manager took over their care. That was a system that worked incredibly well.

So when I moved here and I - for example, I did a, a little bit of casual work on an acute unit - an acute psychiatric unit, and I saw that people were discharged to their GP. I was quite shocked at, at that system. However, saying that, I believe that the - that has - because I've been in Australia for 15 years now, I believe that that system they had in the UK has slowly disbanded over time with a re-emergence of problems, so, yeah. I think that support for the right people is very important.

Q. Thank you, RN2.
A. Thank you.

HER HONOUR

Q. RN2, there may be some other questions, so we'll take the adjournment and we'll come back at 12 o'clock.

SHORT ADJOURNMENT

HER HONOUR: Yes, Ms Chrysanthou?

<EXAMINATION BY MS CHRYSANTHOU

Q. RN2, my name is Sue Chrysanthou. I appear for the families of Ashlee Good, Dawn Singleton and Jade Young. I just want you to think back to March 2020 please at the time that Joel Cauchi was discharged from the clinic that you worked at?
A. Yep.

Q. As at that time you understood, didn't you, that he had been a diagnosed schizophrenic for over 15 years?
A. That's right. Yes.

Q. You understood that for a large portion of the time that he was at the clinic, he had been on the antipsychotic drug known as Clozapine, which you've also called Clopine, which is the brand?
A. Yes. Yes.

Q. That is not a first line drug of choice, is it?
A. No. It's not.

Q. What that means is that it cannot be used unless the patient has failed to see any significant benefits on two other antipsychotic drugs. Isn't that right?
A. That's right. Yes.

Q. That's what made Joel treatment-resistant?
A. Yes. Yes.

Q. The Clozapine was a significant drug for him to be on?
A. It was. Yes.

Q. As far as you understood it, in March 2020, he had been on it for over 15 years?
A. That's right.

Q. He had been monitored from the time he was at the clinic you worked at at least once a month by a psychiatrist?
A. Yes.

Q. And at least once a month by a psychiatric nurse?
A. That's right.

Q. And sometimes more often?
A. Yes.

Q. That had happened right up until March 2020?
A. Yes.

Q. Monthly monitoring by both a doctor and a nurse?
A. Yes.

Q. You now know that, as at March 2020, he went from monthly monitoring by a psychiatric nurse and a psychiatrist to zero monitoring by anyone. Isn't that right?
A. Yeah. I know that now. Yes.

Q. You agree, don't you, that it was inappropriate for Joel to go from monthly monitoring, by both a doctor and a nurse, to zero monitoring?
A. Yes. I think it's--

Q. As at March 2020 you understood, didn't you, that he had been off the Clozapine for about nearly two years. It had stopped in June 2018?
A. Yeah. Yes.

Q. He'd been off the secondary antipsychotic drug that he had been taking for a long time, Abilify, for less than a year - for about nine months. Isn't that right?
A. Yeah. I'm not sure of the exact timeframes, but roughly. Yes.

Q. As part of your training, you knew, didn't you, in March 2020, that the risk of relapse in someone who had the condition that Mr Cauchi had was high?
A. Yes.

Q. And that someone in his position needed to be monitored closely for signs of relapse?
A. Yes.

Q. Learned counsel assisting asked you about some signs of relapse?
A. Yes.

Q. Is it right that sleeplessness is an early warning sign of relapse?
A. It can be. Yes.

Q. Any major behavioural change is an early warning sign of relapse?
A. Yes. Yeah.

Q. Being untidy or disorganised can be an early sign of relapse?
A. Potentially. Yes.

Q. Having anger management issues can be an early sign of relapse?
A. Can be. Yes.

Q. In your experience with Joel Cauchi, his mother was a highly concerned and attendant parent in relation to his illness?
A. Yes. She was, she was very supportive of him.

SULLIVAN: She just needs to speak up.

CHRYSANTHOU

Q. Could you just speak up for us, if possible.

HER HONOUR

Q. RN2, just keep your voice up please.
A. Sorry. Yes. She was very supportive.

CHRYSANTHOU

Q. It's hard. I'm very loud and you're not as loud as me, so it's an unfair comparison. I'm sorry about that. She wasn't just supportive. She, to your observation over the time that you worked with Mr Cauchi, was a very attentive parent in relation to his care?
A. Definitely. She, she cared for him very well. Yes.

Q. Do you agree that anything she raised, insofar as relapse was concerned, was something that needed to be taken seriously?
A. Yes.

Q. You've already given evidence about what happened during your phone call with Mrs Cauchi in early 2020, and you said you may have had a look at some of the notes?
A. Yes.

Q. Do you recall either reviewing a note, or being told in a conversation at about that time, or during a team meeting, that in November 2019 - so just a couple of months before your conversation with Mrs Cauchi - that she had communicated with the clinic and had reported that she had noticed a gradual decline in Joel's condition since going off Abilify?
A. I don't recall that specifically.

Q. Do you remember being told that she was concerned that he was now hearing voices?
A. No. I don't recall that.

Q. If you had been told that Mrs Cauchi had expressed a concern about Joel hearing voices, what would you have said or done in relation to that?
A. I would've informed his psychiatrist.

Q. In your experience, would that have been an early warning sign, a report like that from his mother?

A. Yes. Yes.

Q. If a person has come off antipsychotic medication, or has had it reduced, what, in your experience, would a psychiatric nurse or a psychiatrist do in response to those early warning signs?
A. I - a more thorough assessment to see if it was early warning signs or to see if there - because obviously there's context generally, but a more thorough assessment. And then if it - there is an indication that it is early warning signs, then potentially review of the medication, and maybe even reinstating or increasing the medication.

Q. At that time, Dr A prescribed Abilify--
A. Yes.

Q. --in response to the concerns raised by Mrs Cauchi in November 2019. Is that something that sounds reasonable to you?
A. Yes.

Q. Mr Cauchi refused to take it?
A. Okay.

Q. What does a psychiatric nurse or a psychiatrist do in circumstances where a previously compliant patient, someone who had been taking his medication for over 15 years, is told he needs to go back on his medication and refuses. What is the next step?
A. The next step would be to try and find out why he's refusing the medication. It might be that there was a potential side effect that he - that was resulting in his refusal, and then maybe consider trialling other medications.

Q. There were some terrible side effects to these antipsychotic medications, weren't there?
A. Yes.

Q. Particularly for a young man like Joel?
A. Yes.

Q. Such as affecting his cognitive reactions insofar as perhaps a feeling of fuzziness in his mind was concerned?
A. Yes. Yeah. Potentially, yeah.

Q. What other side effects can you tell us about that Joel might have experienced, or that you remember him experience, while he was on the antipsychotic drugs and before he was taken off them?
A. Well when I was - because I didn't see him clinically during his - my second employment phase at the clinic, but when I saw him and he was taking the Clopine, he - his main side effect was sedation. The - although some of the side effects of the Clopine are very severe, generally the other side effects can be less severe than some of the other antipsychotic medications. And he didn't - he wasn't someone that experienced, or didn't - he certainly didn't report a lot of side effects from the medication other than the sedation, which

was - and the sort of cognitive cloudiness, which was somewhat disabling for him.

Q. In your experience, a person who has come off long-term use of antipsychotic drugs might not wish to go back on them, having experienced a life free of side effects?
A. Potentially.

Q. It's your experience, isn't it, that such a person could lie about early warning signs in order to avoid going back on the antipsychotic medication?
A. Yeah. Anyone can, you know, make false statements.

Q. That's not an unusual situation, is it, for a person who has a diagnosis of schizophrenia to not be honest with any treating physician about an onset of warning signs?
A. I'd say, I'd say that depends on his relationship with the treating physician. I think it's more likely if they've got an established relationship and they know that their concerns around side effects are going to be taken seriously. But my experience of Joel specifically was that he was actually quite concerned, at the time I saw him, about anything that could even potentially be a, a symptom of his illness.

Q. That was when, wasn't it, you were first seeing him clinically--
A. Yes.

Q. --in that first period of dealing with him--
A. That's right. Yes.

Q. --at around 2015?
A. Yeah. That was quite far back. Exactly.

Q. Clinically, if you had still been monitoring him in 2019 and 2020 and you observed that he was reluctant to report how he was going, that would have been something that could've been an early warning sign in itself?
A. Yeah.

Q. A change in his willingness to self-report to his treating doctors and nurses?
A. Yes. But I suppose it's one of those things that because it's an omission, you wouldn't necessarily know that it was occurring.

Q. You would know, wouldn't you, if his mother was telling you something over the phone--
A. Yeah.

Q. --about her observations as to his behaviour--
A. Yes.

Q. --and that he was not making similar admissions when he was speaking to you?

A. Yes. Yeah.

Q. That's why it's important, isn't it, in treating a patient like Joel, to be very careful to listen to someone like Mrs Cauchi as to her concerns?
A. Definitely. Yeah. Yes. It is important.

Q. Did you observe in the notes that at his last appointment in December with your colleague, RN3, that there had been a discussion about how he would continue to attend his appointments if he moved to Brisbane, and he said, as at December, he was happy to catch the bus to Toowoomba to have face to face appointments?
A. I don't specifically recall that.

Q. Would it have been a concern to you if, in December, Joel expressed a willingness to catch the bus from Brisbane to Toowoomba to have face to face appointments, but by March, he changed his mind and did not agree to do that? Would that have been a concern to you?
A. Yes. Yeah. Unless he - obviously unless he'd engaged with support elsewhere, but if he didn't have other supports, yes.

Q. Reflecting on everything you knew about Joel in March 2020, particularly that he had been under the care of the clinic since 2012, don't you think that it was incumbent upon the clinic to ensure that Joel's psychiatric care continued uninterrupted despite his move to Brisbane?
A. I agree that that would've been the preference, but that's difficult with the way that the systems are structured in the, the - yeah, generally the GP needs to make the referral and the services have to be available in the other areas.

Q. But don’t you think the clinic should have followed up with Joel after March to check that he was or had found a new psychiatrist?
A. Ideally, it - that would have been, that would have been ideal.

Q. Whose job was it, if it wasn’t the job of the clinic you were working in--
A. Mm-hmm.

Q. --given Joel was an adult--
A. Mm-hmm.

Q. --whose job was it to make sure that he was seeing a psychiatrist?
A. Well, the way that the system works here is that the referral's made to the general practitioner who then is the one that is responsible for referring Joel to other services. However, it's not something that, that Joel could have at that stage been forced to do. So, he, he had a right to, to say that if he wasn't symptomatic to the point that he was presenting in a way that was - he was detainable under the Mental Health Act, then his rights also are taken into consideration. So, it's - whilst I agree, I think, that the best system would absolutely be to ensure that there's continuity of care, there are a lot of other factors that come into play.

Q. What would he have to do? What symptoms would he have to have shown

for the Mental Health Act to kick in to ensure that he was being treated?
A. That he would have had to have shown that he was a risk of harm to self or others, and to be displaying pronounced symptoms of mental health deterioration, yeah.

Q. If a patient refuses to take medication as occurred with Joel in November 2019, how can a psychiatrist or a psychiatric nurse take steps to make him take that medication?
A. It's a - it is a challenging scenario. But the, the - if there was, if there was quite - if there was very significant concerns, then the individual would be referred for an assessment by the public mental health system, who have the capacity to be able to conduct an assessment around that and establish whether it was at the level that meant that he was detainable under the Mental Health Act and therefore he could - you know, he could be in a, in a, in a, in a sense sort of forced to take medication to comply with a, an order.

Q. What do you need to see just in order to make that referral to the public health system?
A. It, it varies, but risk of harm to self or others.

Q. You know now, reviewing the notes - not at the time, but now--
A. Yes.

Q. --that there were certain indicators in October, November, December, which would have indicated that Joel was suffering a relapse, early warning signs of relapse. Do you agree?
A. There were, there were symptoms that could have been that, but may have also been attributed to other factors as well. So, I - whilst it, you know, it's possible, it is not definite.

Q. Well, thinking of the discharge letter to the GP - you have seen that now?
A. Mm-hmm.

Q. You didn't see it at the time?
A. No, I didn't see that at the time.

Q. Don't you think it would have been appropriate in the discharge letter to the GP, given apparently the GP was the only doctor left, to say:

> "We have been seeing Joel over the last six months since he has come off his medication. He has exhibited the following signs and symptoms. So, we don't only suggest that he be referred to a new psychiatrist, we insist that that occur, given where he is in his treatment, having only recently come off his second antipsychotic drug"?

A. Yeah.

Q. Don't you think that's something that the GP should have been told?
A. I--

SULLIVAN: Your Honour--

WITNESS: Yeah, I, I--

HER HONOUR

Q. Just one moment.

SULLIVAN: --I object at this point. In terms of the referral letter, it might be of utility if it's brought up because--

CHRYSANTHOU: Sure.

SULLIVAN: --it actually says "Alternative psychiatrists, if required".

CHRYSANTHOU: Yes, we'll put that up.

SULLIVAN: It's tab 793, vol 20, p 136.

HER HONOUR: Thank you.

CHRYSANTHOU: Thank you.

Q. Sorry, we'll just wait for that to come up.
A. Yeah.

Q. Having a look at that. you agree, don't you, that there's nothing in that letter hinting at the issues that had been reported to the clinic by Ms Cauchi since about September or October 2019. Do you agree?
A. I do, yes.

Q. You see there it's been left to the GP--
A. Mm-hmm.

Q. --"to organise an alternative psychiatrist if required". Do you see that?
A. Yes, yeah.

Q. Do you agree, in the absence of further information from Dr A the GP, that he would not know that a psychiatrist was required at that time?
A. Yeah. I can see how they might read that and not see the urgency of the situation.

Q. Well, doesn't it suggest, doesn't that letter suggest that he doesn't require a psychiatrist at that time?
A. It's--

LYNCH: I object to that. The letter speaks for itself, your Honour.

CHRYSANTHOU: Well, your Honour--

HER HONOUR: I think it does speak for itself.

CHRYSANTHOU: All right.

Q. In the last appointment, in your review of the notes, in the last appointment with Dr A, she recommends - and this was in February 2020 - that Joel continue his monthly monitoring with her. Have you seen that in the notes?
A. Yes.

Q. In your view, given in February 2020, his treating psychiatrist of some eight years considered that he needed to have monthly monitoring with her, do you consider it appropriate that by March, there was no recommendation of monthly monitoring by his treating psychiatrist?
A. I think it would have been appropriate to recommend it.

Q. Well, she had recommended it in February.
A. Mm-hmm.

Q. Are you aware of anything in your review of the notes which would mean that that recommendation in February that he had monthly monitoring with his psychiatrist should change by March?
A. No.

Q. You haven't seen anything in the notes?
A. No, no. I, I think it would have been a good idea to have that continued monitoring.

Q. You've given a description of Joel, in your statement in paragraphs 23 and 24, of your interactions of his personality over nine years, and you described him as a very polite and courteous man?
A. Yes.

Q. You reported, didn't you, to Dr A, your conversation with Ms Cauchi in February, as you've already given evidence?
A. Yes.

Q. Did you report to her the fact that his mother had said that he had been swearing?
A. Yes. And it was also in my notes.

Q. Did she give any--

HER HONOUR

Q. RN2--

HER HONOUR: I'm sorry to interrupt, Ms Chrysanthou.

Q. Can you please give your voice up?

A. Sorry.

Q. I missed that answer.

CHRYSANTHOU: It was also in the notes.

HER HONOUR: Thank you.

CHRYSANTHOU

Q. Did she have any reaction to you reporting that to her, the swearing?
A. Not an adverse reaction. It was - I think I mentioned earlier that she - it was - you know, she noted it, but didn't appear overly concerned.

Q. You have given evidence, before the morning tea break, about your reaction to hearing that Joel was the person responsible for the deaths at Bondi last year. Thinking about your experience as a nurse dealing with schizophrenic patients, in your view, had Mr Cauchi been on his antipsychotic medication and had he been compliant in taking it as he had in your experience--
A. Yep.

Q. --would he have behaved in that manner?

LYNCH: I object. It's impossible for this witness to speculate to that extent four years after, more than four years after the events that she's capable of giving evidence about.

HER HONOUR: I think that's right, Ms Chrysanthou.

CHRYSANTHOU: All right.

Q. When he was medicated, did he at any time tell you that he had thoughts of being violent towards anyone?
A. No.

Q. Did he report hallucinations to you?
A. No.

Q. Did he tell you that he was hearing voices?
A. No.

Q. Did he discuss with you at any time having any sort of knife collection?
A. Not at all, no.

CHRYSANTHOU: No further questions.

FERNANDEZ: No questions, your Honour.

ROFF: No questions, your Honour.

HER HONOUR: Ms Mathur - sorry?

SPEAKER: No questions, thank you, your Honour.

HER HONOUR: Couldn't see you.

SPEAKER: No questions, your Honour.

HER HONOUR: Ms Mathur?

MATHUR: Yes. I just like to, if we could pull up vol 19 p 125, tab 788.

<EXAMINATION BY MS MATHUR

Q. I understand in your role as a registered clinical nurse with expertise in psychiatry, in treating psychiatric patients, that you were monitoring his Clopine levels?
A. That's right, yes.

Q. We have on the screen now a document which I hadn't expected. I'm just going to take you to his pathology results. Volume 19, page 125. I might just attempt reading them to you to see if you can follow and if you can't, by all means, we'll get that document on the screen.
A. Okay.

Q. But can I ask you to assume that the pathology testing which came back on 10 July 2012, so prior to your engagement with Mr Cauchi, the Clozapine serum reading is 410 micrograms per litre. Is it your understanding that a therapeutic dose needs to be at 400 micrograms or above?
A. I can't specifically recall what the level is for a therapeutic dose.

Q. If you'd assume for me that the therapeutic dose is between 400--
A. Yep.

Q. --and 1,000, and if that document been located, no? Can you read that on the bottom half of the page. You've got two readings, 10 July 2012 and then you have 9 April 2013?
A. Yeah, I can see that.

Q. You see the 2012 reading is at 410 and in brackets at the end of the same line, we've got a range of 400 to 1,000?
A. Yes.

Q. That tells us, doesn't it, that the therapeutic range is between 400 and 1,000 micrograms per litre?
A. It does, yes.

Q. So, we know then, don't we, that on 9 April 2013, his reading is subtherapeutic, at 290--

A. Yes.

Q. --micrograms per litre? I'd like to now take you to his readings on 24 September 2013 and that's found at page 123. Actually, it's over the page on page 124. Do you see there that his reading's gone down to 250 micrograms per litre? Again, that's a subtherapeutic range, is that correct?
A. Yes.

Q. Turning then to 6 June 2014 and that's on page 115. On 3 June 2014, his readings are at 160 micrograms per litre?
A. Yes.

Q. Again, does that inform you in your role as a clinical nurse that he was receiving a subtherapeutic dose of Clopine at that point in time?
A. Potentially.

Q. What do you understand the effect is of a subtherapeutic dose on a patient with treatment-resistant schizophrenia?
A. It, it does depend on the individual. For some people it might mean that there is an increase in symptoms of, of their schizophrenic illness, and for, for others who might be more sensitive to the medication, it might mean that they, you know, that they don't have the same emergent. So, it's a guide, but it's not - it doesn't definitely prove whether the medication is effective or not, because some people respond to different levels.

Q. Do you understand that the symptom it is there to treat at a therapeutic dose is their delusions and/or hallucinations?
A. That's right, yes.

Q. It doesn't treat other symptoms of schizophrenia?
A. It can do, yes. It can help with the other symptoms, the more negative symptoms such as the low mood and what, and whatnot.

Q. But do you understand its primary purpose is to treat their delusions and/or hallucinations?
A. The - my understanding is it's to treat all of the symptoms as a whole.

Q. Is it correct that after that date and when you first commenced treating Mr Cauchi, that you were not receiving pathology readings in relation to his Clopine levels?
A. Sorry, can you say that - I don’t quite follow.

Q. Do you recall seeing any further pathology testing which tested his Clozapine serum levels?
A. I'm not entirely sure. It wasn’t something that we had to record to have the medication dispensed. That was more around the, the, the white cell count and other markers. So, it's possible.

<EXAMINATION BY MR LYNCH

Q. RN2, can I ask you to assume my arithmetic is correct and I've added up the number of consultations that you and the other clinical mental health nurses had with Mr Cauchi from at least the period from 2015, from December 2015 to February 2020, and could I ask you to assume that, firstly, you saw Mr Cauchi on 26 occasions over that roughly five year period, that credentialed mental health nurse RN3 saw Mr Cauchi on 26 occasions in the same period, that RN4 saw Mr Cauchi on five occasions, that Dr A saw him on 47 occasions, that another psychiatrist in the practice, Dr B, saw Mr Cauchi on five occasions, and there was another psychiatrist employed at The practice, Doctor, was there not, for a short time?
A. There was, yes.

Q. If you assume that Doctor saw Mr Cauchi on one occasion, that provides a total of, on my arithmetic, 53 consultations with psychiatrists in that roughly five year period, 77 consultations with a credentialed mental health nurse over the same period, a total of about 130 separate consultations, and can you also assume at none of those 130 consultations did any of the clinicians identify any psychotic symptoms on Mr Cauchi's part? That's consistent with your reaction in your 26 or so consultations with Mr Cauchi in the period, is it not?
A. Yes.

Q. If he was suffering a relapse of any psychotic symptoms in the period, you would expect the highly experienced staff working at The practice to have identified them, would you not?

CHRYSANTHOU: I object to this. He was medicated until mid-2019. So you can't have relapse until you stop being medicated. So, there's only a six-month period that my friend's question should apply.

SULLIVAN: There also are some clinical notes that, on one view, are open to the interpretation that they are early warning signs, and we have an expert panel that will be coming to explore those issues.

HER HONOUR: That's probably the most appropriate place to go into any detail about this, Mr Lynch.

CHRYSANTHOU: You can't relapse until you've come off.

LYNCH: Your Honour--

HER HONOUR: You're asking about psychotic symptoms?

LYNCH: Yes. I thought my learned friend Ms Chrysanthou was asking this witness about the presence or absence of psychotic symptoms.

HER HONOUR: Yes.

LYNCH: I'm entitled to, I would have thought.

CHRYSANTHOU: I was asking about a specific period of time, sorry.

HER HONOUR: I mean I'll allow the question, but it's in the context of what we know is that he was, when he was medicated.

LYNCH: He was medicated, your Honour, on subtherapeutic doses for a period of some five years between 2012 and 2019, and the significance of the low doses which he was receiving are subject for expert psychiatric evidence.

HER HONOUR: It is.

LYNCH: If it doesn't assist your Honour, I won't press the question.

HER HONOUR: I don't think you need to press that question any further, Mr Lynch.

LYNCH: As your Honour pleases. That's all I have.

HER HONOUR: Mr Wilson?

WILSON: No, your Honour.

HER HONOUR: No questions. Ms Robb?

ROBB: Your Honour, assuming nothing from the second courtroom, I have no questions.

HER HONOUR: Sorry. Does anyone in court 2 have any questions?

CALLAN: No questions, your Honour.

HER HONOUR: Thank you. Mr Chiu?

CHIU: No questions, your Honour.

JORDAN: No questions, your Honour.

CASSELDEN: No questions, your Honour.

ROBB: Thank you, your Honour, I have nothing.

HER HONOUR: Anything arising, Ms Sullivan?

SULLIVAN: There's nothing arising, your Honour, although I call for the notes that have been referred to by RN2 in the team meetings.

HER HONOUR: Yes, okay.

Q. Thank you very much RN2, you're free to go.
A. Thank you, your Honour.

NO EXAMINATION BY MR FERNANDEZ, MR ROFF, DR FRECKELTON, MR CHIU, MS CALLAN, MR JORDAN, MR CASSELDEN, MS CLARKE, MR GNECH, MR PEN, MS ROBB AND MR WILSON

<THE WITNESS WITHDREW

LYNCH: Your Honour, we've been asked to make some enquiries in relation to those books, set in train those enquiries, but I'm not in a position to tell your Honour whether the documents that have been identified in a cursory way are available. They're certainly not here.

HER HONOUR: All right. As long as those enquiries can be made.

SULLIVAN: I don't think they've been identified in a cursory way. I think they're a very specific class of documents that relate to team meetings that the witness has given evidence about.

HER HONOUR: Yes.

SULLIVAN: We understand they are in a hard copy volume that is grey in colour, and we can even provide some specifics about where they may have been located at a point in time.

HER HONOUR: Thank you.

LYNCH: We'll certainly pursue those enquiries, your Honour.

HER HONOUR: Thank you, Mr Lynch.

SULLIVAN: Thank you, your Honour. Dr Dwyer will take the next witness.

HER HONOUR: Dr Dwyer.

DWYER: Sorry, your Honour.

HER HONOUR: That's all right.

DWYER: I call RN3. RN3 statement is found at tab 792B.

HER HONOUR: Thank you. That is in vol 20, is it? Volume 19.

DWYER: Thank you, your Honour.

LTS:DAT

<RN3, AFFIRMED(12.39PM)

<EXAMINATION BY DR DWYER

Q. Could you please tell the Court your full name?
A. Yes, RN3.

Q. You've provided a statement to assist her Honour, which is dated 4 April 2025, is that right?
A. Yes.

Q. In it, you explain you are currently a registered nurse at a hospital in Queensland, is that right?
A. Yes.

Q. Which hospital is that?
A. A Hospital in Toowoomba.

Q. What sort of work are you doing there?
A. I work part-time in older person's mental health inpatient facility.

Q. You, prior to that job, were working in a role as a primary health nurse based at The practice, private clinic in Toowoomba, is that right?
A. Yes.

Q. During 2015 to 2024, you worked at that role, and you, in the course of your work there, came to be involved in the treatment of Joel Cauchi at different times that I'll take you to, is that right?
A. Yes. Excuse me, Peggy.

Q. Please.
A. I did have something I wanted to say.

Q. Thank you very much. I'll just pause, and you go ahead.
A. Thank you, Peggy. Your Honour, I wanted to say that this has been a profoundly tragic and sad event, and I would like to express my condolences and sorrow for all the families who lost a loved one, to those who have been injured physically and emotionally, and I also wish to express my condolences to the Cauchi family. Thank you.

HER HONOUR

Q. Thank you, RN3.

DWYER

Q. RN3, before I ask you specifically about your treatment that involved Joel Cauchi, can I come to your background. You obtained a general nursing certificate and registration through hospital-based training?
A. Yes.

Q. That was at Toowoomba Base Hospital, is that right?
A. Yes.

Q. Could you explain when that was?
A. I started nursing after I finished school in 1980.

Q. In 1985 I think you obtained your psychiatric nursing certificate from the hospital where you're now working?
A. Yes, after I finished my general nursing certificate, I decided to go and do training in psychiatry.

Q. Have you then worked with a speciality in psychiatry up until where you're working now?
A. Yes, most of my career.

Q. You worked for a lengthy period of time, nine years, as the primary mental health nurse with the Darling Downs West Moreton Primary Health Network, and that was when you came to work at The practice. You have explained a little bit about the primary nurse care program offered at The practice, and you've provided I think with your statement a flyer about that program. We might just put that on the screen. That summarises the primary mental health nurse care program. The practice won a tender, essentially, to coordinate the mental health nurse care program in Toowoomba and the broader Darling Downs area, is that right?
A. Yes.

Q. You explain a little bit about this in your statement. You explain that in 2015 the Australian Government announced its response to a national mental health commission review of mental health programs and services. The aim was to transform the delivery of mental health care, and a key component of that reform package was the transition of primary mental health programs to networks that ran throughout Queensland, is that right?
A. Yes.

Q. Was this, when you went to work at The practice, was it the first opportunity you had to work within this sort of network?
A. Yes, that's right. Prior to that I'd worked at Queensland Health only.

Q. Had you had any experience of private clinics before this, or had you been working in public sector?
A. I only worked in the public sector.

Q. The role of the mental health nurse in this new primary mental health care model was to provide clinical care and to coordinate clinical care for people with severe mental illnesses, is that right?
A. Yes.

Q. They would coordinate that care alongside general practitioners and private psychiatrists, correct?

A. Yes.

Q. Just pausing there. Do you believe that that model is a good one?
A. Yes, I, I do.

Q. It provides an opportunity, doesn't it, to avoid the silos that might happen outside of a system like that, and to have a system where GPs, nurses and psychiatrists are sharing information?
A. Yes. That's right.

Q. Are there any other allied health professionals that work within that system?
A. No. Our clinic only had mental health nurses and psychiatrists.

Q. At some point in the notes there's reference to a peer support person who was engaged to assist Joel. Was that somebody employed separate to the mental health nurses?
A. I'm not sure how the peer support program operated, so that was under a different funding from the PHN, Primary Health Network, which was tendered by The practice to provide that extra role.

Q. Do you know whether the peer support workers were trained nurses?
A. I believe they were not trained nurses.

Q. Was that peer support element of the program available for the whole nine years that you were with The practice?
A. No. It was - actually, I can't remember when it started, but it - and it didn't last very long. And the idea of peer support were perhaps that other people had had a mental health history themselves.

Q. Can you tell us the years that it did operate?
A. I'm thinking it might've been 2019, but I'm not sure.

Q. We can ask Dr A and we can find out separately, but are you able to offer any reflections on whether or not that was useful for the period that it operated at The practice?
A. Yeah. I think that peer support is, is very valuable. Any extra support that people - vulnerable people can access I think is a good thing. And it helped people to get out of the homes a lot. They often were withdrawn, and so a lot of the people I knew that engaged were taken outside and doing outside activities a lot of the time.

Q. It was a shame, in your view, when it was stopped?
A. I think when any extra support is stopped it's a shame, for people with mental health issues.

Q. I'll come back to that when we look at Joel's condition in particular. You explain in your statement that these Commonwealth funds were made available to The practice when it won the tender. You say:

"The funds were provided to the Darling Downs and West Moreton Primary Health Network and allocated to the successful tender to output the mental health nurse care program. The practice, under principal Principal, submitted a successful tender and was awarded the funding."

Q. Is he a doctor, or are you aware of his credentials?
A. He's not a doctor.

Q. Had The practice been running for a while prior to you working there?
A. Yes. I started there in 2015. I think it had been running some years before that.

Q. Are you aware of the exact year that it won the tender?
A. Not exactly. No.

Q. I'll come now to your role in the primary mental health network. In 2019 you explain in your statement you were working two days a week. When you first started at The practice, were you any more than two days a week?
A. My memory's not a hundred percent on that. I think that I was - maybe started doing four days a week, and I would finish a shift at the hospital and then go and do some afternoon work at The practice some days, and I think I went from like four days to three days, and then I went to two days. And - sorry, there's - the two days wasn't an eight hour day. I was still trying to have the hours up, and so that's why a lot of my days were ten hour days. But I didn't always see patients in that ten hours, but that would give me time to do other administrative activities.

Q. For the nine years that you worked at The practice, did you have another job outside of that?
A. Yes, I did.

Q. Where was that?
A. Queensland Health.

Q. In the hospital setting. Is that right?
A. Yes. Yeah.

Q. Your employer was The practice?
A. Yes.

Q. Were you given a certain number of patients - allocated a certain number of patients?
A. Generally I would be asked for my capacity of how many patients I could see in the time that I worked, so that would vary.

Q. Did your salary, or remuneration, depend on how many patients you had?

A. No.

Q. Did you Medicare bill for those patients?
A. No.

Q. Your responsibility was to attend the clinic and to see the patients who you were required to see, and you saw a number of patients who had different issues. Is that right?
A. That's right. It - the program wasn't - the program was free. There was no cost to the patient, so it, it was separate to Medicare.

Q. As far as you understood it, the patient paid for a component of the psychiatric care, that is the psychiatrist, but not the nursing program?
A. Correct.

Q. Where were you physically located during the two days you worked?
A. In an office in The practice in Street, Toowoomba.

Q. At that office, were there any psychiatrists located?
A. Yes.

Q. Was Dr A also co-located there?
A. Yes.

Q. Did she work at other offices from time to time?
A. Yes.

Q. When you saw a patient you sometimes saw that patient with Dr A and sometimes on your own. Is that correct?
A. Yes.

Q. When you saw a patient with Dr A, was that in person, or would the doctor sometimes Skype in or phone in?
A. No. In person.

Q. Were there any other psychiatrists that worked at the office you were located at?
A. Yes.

Q. Were there regular psychiatrists that you worked with for lengthy periods of time?
A. Yes. There was one psychiatrist that was also there the whole time I was there, Dr B, and there were other psychiatrists that came and went in that - those years that I worked there.

Q. Was there generally two psychiatrists, or more?
A. Generally two.

Q. How many mental health nurses were at the office when you would go in on a day?

A. So depending on the office availability, that would vary. So I think that there were - in the earlier years I think there were three of us in the office, and then I think that just changed to two nurses working out of the office.

Q. You explain that Dr A would be there in person when you met with her and a patient. Were there team meetings to discuss patients?
A. Yes. The team meetings might've been referred to as multi-disciplinary meetings, but there was no allied health. We were only staff of the psychiatrists and the mental health nurses, so they were clinical meetings.

Q. I appreciate you worked there over a nine year period, but did that structure change, or were there generally multi-disciplinary meetings on a regular basis?
A. Yes. The structure did change in when I began there, the clinical meetings had all the doctors that would be on that day, or even another doctor that would come in for that meeting, and all the nurses would be there. And then over time, because we might've been discussing one psychiatrist's patients, the other psychiatrists and the other nurses who weren't case managers also were there for that. Then it just sort of changed down to allocated time on my diary - the computer diary, and it would just be one on one, the treating psychiatrist of that patient and the nurse.

Q. When you first started and there were joint meetings, were they held on a weekly basis?
A. Yes.

Q. Could you see the value in them, even if they didn't involve your patient, in that it's an opportunity for colleagues to assist to have peer support?
A. Definitely.

Q. And it's an opportunity to learn from various issues that are being raised?
A. Yes.

Q. I'll refer to them as multi-disciplinary meetings. Around what timeframe did they stop?
A. I'm not sure, but towards - I'm really not sure, but I think somewhere towards the end of my employment there.

Q. Are you aware why that stopped happening?
A. I think that it was - really no, but maybe it was the doctors' time and money, so the doctors that weren't being discussed were sitting there for that session where they could've been seeing their own patients. So in practicality terms, I think it was seemed to be not worth their while to be there when they're not discussing their own patients.

Q. You could see that it was worth the while?
A. There were times, and it was good to have input, like case studies discussed, you know, with other input.

Q. You explain that in 2019 you worked two days averaging eight to ten hours a day. You had a case load of 41 patients. You're giving a snapshot of

41 patients in April 2019, and at that time, you made 80 professional contacts. Was it part of your role to try and coordinate the care for particular patients you were allocated?
A. Yes. I did try to keep contact with everybody on my case load.

Q. Before we come specifically to Mr Cauchi's treatment, could I just ask that paragraph 21 of your statement come up and we'll just look at (a) to (o). You give examples of the sort of work that you do. It might be too difficult for people to read, but I'll just take some of them. You say that your role as a mental health nurse was not limited to but involved the following:

> "Undertaking various assessments, initial intake assessments, ongoing mental health assessments, risk assessments, medical compliance, review of effectiveness and adverse side effects, assistance for NDIS applications, monthly Clopine clinics to monitor patients in compliance with the protocol, and psychosocial assessments, referrals to the acute care team, et cetera."

It also included referral to domestic violence services. Do we take it from that overview that there were a significant variety of patients who you saw - anybody from people who had experienced domestic violence in a situation, through to clients like Joel, who had treatment-resistant schizophrenia?
A. That's right. Yes.

Q. Did you have any other clients during your time at the Practice who were being managed with Clopine?
A. Yes. I did.

Q. You had had an experience of managing patients on Clozapine, or Clopine, in the public hospital system. Correct?
A. As a member of team of nurses. Yeah.

Q. You, at various times, performed the role of the Clopine mental health nurse for Joel Cauchi. Is that right?
A. Yeah.

Q. Leaving Joel to one side for the moment, what did that involve from a nursing perspective?
A. So that involved maintaining a schedule - writing up a schedule for the psychiatrist to follow when all those patients would come in for their monthly clinics. That involved checking to see when they'd had other treatments like echocardiograms or ECGs and have that recorded so that the doctor could see when it was next due. So that was sort of the administrative side there. There was - if new staff came, it was my responsibility to contact the monitoring system in Melbourne to have staff signed to be able to dispense the Clopine, registering pharmacists if, if required, if asked, or sometimes they did that direct, but, yeah, making sure staff were signed to the protocol system.

It involved having that schedule when the patients had to have their monthly blood test and following up. And sometimes they might be late with getting the

blood test, so I'd be encouraging some of them to make sure they were getting their blood test done. Then a day or two later the results should be in. I'd be opening the computer checking that they were what were called in the green zone, that that was satisfactory; monitoring of the neutrophils and the white cell count, and uploading that onto the data monitoring system; making the note in the clinical file for the psychiatrist to see that they were in the green zone, that it was okay to continue with the therapy.

Q. You knew quite a lot about Clopine and schizophrenia by the time you came to work at The practice. Is that fair?
A. Yeah.

Q. You understood that for patients who were on Clopine, it was absolutely essential that they be seen monthly so that their bloods could be monitored?
A. Yes. They couldn't have - the pharmacist couldn't dispense the next lot of medication if the system didn't have a particular box ticked. If that - so the pharmacist could open the same system and see, "Yeah. They've been seen by the psychiatrist and the bloods are fine", they can then dispense the next lot of medication.

Q. As an experienced mental health nurse, can you tell us why that is so important?
A. The monitoring?

Q. Yes.
A. To make sure that they don't develop neutropenia where they could be susceptible to infections. That made them more predisposed to succumbing to an illness, because they couldn't fight off - they had no defence mechanisms to fight off any illnesses.

Q. What is your understanding as to why a patient would be put on Clopine?
A. Yeah. They had generally been trialled on other medications and probably had been determined treatment-resistant. There, there was evidence that maybe younger people should've been started on some of the new novel antipsychotics at a younger age, and, you know, it was unfortunate that they had to go through a lot of medications and time and space and side effects and things like that, you know, before they could be trialled. The Clozapine was one of the first novel antipsychotics to come onto the market in Australia under the monitoring system.

Q. You knew it to be a drug that was very effective in terms of the treatment of treatment-resistant schizophrenia?
A. In my tertiary hospital role I did see some people with a diagnosis of schizophrenia respond very well to the medication that were able to go through the hospital system to discharge and to the community and have community follow up.

Q. In those circumstances, was it an essential part of the discharge process that there be follow-up in the community?
A. If they - the - discharge still on Clozapine, that they still had to be under the

monitoring system.

Q. I see. Discharged from the public system, but in the community on Clozapine and being followed up?
A. Sorry. Yeah. Discharged from the tertiary hospital to the community. They were followed up by the community, because they still had to have the monthly monitoring.

Q. Can you just estimate, in the public system, how many people you would have seen on that Clozapine, or Clopine, program. Over ten, over 20, that sort of estimate?
A. Over 20.

Q. A significant proportion of those had been discharged from the public system into the community for ongoing monitoring on Clopine?
A. Yes.

Q. Had you ever had a patient prior to Joel who had been completely taken off Clopine, having been started on it?
A. I had seen patients who had had side effects in the tertiary hospital that were taken off - weaned off the Clopine - Clozaril at that stage. So that was done in a hospital setting.

Q. In those circumstances was it replaced with other antipsychotic medication?
A. I believe so. Yes.

Q. Prior to Joel you'd never had an experience of a patient who had treatment-resistant schizophrenia and had been started on Clopine, or Clozavil(as said), whatever it was called, in that setting who'd then been entirely removed from medication?
A. I don't recall. No.

Q. Sorry, I'll just clarify that answer. Your evidence is, isn't it, that you had, to the best of your memory, that had never been done prior?
A. Yes.

DWYER: Your Honour, is that a convenient time to break?

HER HONOUR: Yes. I'm going to take the lunch adjournment now and we'll come back at 2 o'clock.

LUNCHEON ADJOURNMENT

DWYER

Q. I've just been asked to clarify one issue that I asked you about before the break which was in relation to the patients you had had an experience of in the public system who were weaned off Clozapine and trialled on another medication. In those circumstances, were they weaned off Clozapine because

they were experiencing side effects?
A. As being a member of the team of nursing, I can't recall accurately the reasons why they were coming off the Clozapine.

Q. I come now to your care and treatment of Mr Cauchi. I take it that in order to prepare your very detailed statement, you looked at the notes from The practice that were available?
A. Correct.

Q. You explain in your statement that Joel was allocated to your caseload in approximately January 2018, but, in fact, you recall engaging with him earlier on a few occasions between 2015 to 2017 when he was under the primary care of another nurse, but when they were away on leave you might be called in to see him. Is that right?
A. Correct.

Q. On those occasions, how long was, on average, the meeting with Joel as the primary health nurse?
A. 30 minutes would be allocated on our diary and sometimes Joel would leave around 20 minutes.

Q. So, was each patient you have allocated a 30 minute slot with a primary care nurse?
A. No, sometimes I saw other patients longer depending on the therapy or the need that they were seeing me.

Q. But for Joel's particular circumstance, which was between 2015 to 2018, monitoring him while he was on a particular dose of medication and offering nursing support, they were 30 minute allocations?
A. Yes, correct.

Q. And on those occasions - I'll come to when he was allocated your care in the second time slot shortly, but on those occasions, did you understand that Joel was also having monthly meetings with a psychiatrist?
A. Yes.

Q. You understood him to be seeing most regularly the psychiatrist Dr A?
A. Yes.

Q. And that he was her primary treating psychiatrist?
A. Yes.

Q. Is it fair to say, in summary, that during that early period, 2015 to 2018, Joel's mental state was stable?
A. Yes.

Q. In particular, in relation to the Clopine or the Clozapine that he was on, he was attending to his regular blood checks?
A. Yes.

Q. And there was nothing of concern being reported in his bloods?
A. Correct.

Q. You indicate in your statement at paragraph 26, "The care and treatment provided to Joel was in line with the standard care provided to the recipients of the Clopine program until he concluded that program in July 2018"?
A. Correct.

Q. When did Joel come under your care specifically as the primary mental health nurse?
A. The allocation for me to follow Joel up was after the nurse RN2 had finished and his transfer to me.

Q. When he transferred to you, did you have a handover with nurse RN2?
A. Not that I recall.

Q. Would it be typical for you to have a handover when a patient was coming into your care?
A. I think that we would often just have a conversation that I - you know, that someone was being reassigned to, to my care, but because it was - we all saw the same computer clinical notes, that I could read back over the history.

Q. You knew a little bit about Joel, and you could read up on his clinical notes to see where he was at when you took over primary care?
A. Yes.

Q. Is that right?
A. Yes.

Q. So, you came to be seeing him then on a monthly basis, correct?
A. Yes, it was mostly monthly. I do know that there were sometimes where it was longer than that, but mostly it was monthly.

Q. In what circumstances might it be longer than that?
A. Can't actually recall why. I just noticed from rereading the clinical notes that sometimes that there were longer periods of time that wasn't four weekly. And that would - I'm referring to when he was no longer on the Clopine monitoring system, monitoring.

Q. When you first saw Joel between 2015 and 2018, he was being seen by the nurses monthly and by the psychiatrist monthly, correct?
A. Correct, yes.

Q. Then after he stopped the Clopine, he was still being seen monthly by yourself and by the psychiatrist, is that right?
A. Yes.

Q. Why was that?
A. I don't recall having a specific conversation as to why that would be continuing four weekly, other than I think that Dr A would write it in the notes to

be seen by her at such and such a time, to be seen by me, you know, monthly.

Q. It might explain my next question, but in relation to the frequency at which the nurse saw a patient at The practice, could you determine that for yourself, or was that up to the psychiatrist?
A. If the psychiatrist had written at the end of their clinical notes to be seen by me, it would be - the, the appointment would be made by the administrative girls, ladies to do that.

Q. Could you make an appointment with a client for a shorter period of time if you had concerns about them?
A. Only phone calls were generally shorter. I didn't do face to face, less than, you know, the half an hour time slot, or people left a bit earlier if everything had been covered.

Q. Was there a reason for that?
A. For?

Q. Sorry, I'll just give you an example. If somebody came in - let's not use Joel. If somebody came in, they had been the victim of domestic violence, they were particularly upset. You generally saw them on a monthly basis. If you had concerns about them, could you make a follow-up arrangement to see them the next week, rather than a month hence?
A. Yes, yes.

Q. If you'd had particular concerns about Joel but you were due to see him the following month, could you bring that appointment forward?
A. Yes.

Q. With respect to the treatment that you provided, Joel - you set this out at paragraph 27. You say it was:

> "During the appointments, the mental care provided by me varied depending on what was required on that day. It included, but not limited, was not limited to, psychoeducation, mental health recovery focused care, assisting Joel with developing a resume, providing education regarding work-life balance, discussions about Joel's goals and aspirations for the future, and discussions about sleep hygiene".

Correct?
A. Correct.

Q. When you first started seeing Joel on that regular monthly basis around July 2018, what was his mental health like?
A. I found Joel to be consistent with his presentations. Joel would speak slowly. He would often pause before responding to any questions I might ask. He was cooperative, polite. I would be observing him whilst he was sitting there. I would be listening to what he had to say. If he had brought up something in particular that he wanted to discuss, we would explore around

that. The initial appointments had been - you know, he, he had always had his weight done as per the protocol monitoring and his blood pressure, so sometimes he would still want that done.

Q. Had you met Joel's mother or father at any time prior to July 2018?
A. I don't recall ever meeting his father. I spoke with the father on the telephone once, and yes, Ms Cauchi did come to some meetings, some of the appointments. I can only really recall her - perhaps seeing her in my office once, but she was sometimes in with Dr A.

Q. Did you, over the period of time that you worked with Joel Cauchi, form a view of the relationship, or the type of relationship that he had with his mum and dad?
A. Ask me again the question please?

Q. Sure. Perhaps I'll do it slightly differently. You had - I think you spoke to Andrew Cauchi once you said, is that right?
A. Yes.

Q. Is it fair to say you spoke on many more occasions with Michele Cauchi, his mother?
A. Yes.

Q. Did you see her face to face as well?
A. Yes.

Q. Did she sometimes attend a meeting that Joel had with you?
A. Yes.

Q. On how many occasions do you think roughly that happened?
A. I think only a few.

Q. But how many times do you think you would have spoken with her on the phone?
A. A handful of times, I think, not often.

Q. She emailed the clinic at times, is that right?
A. Yes.

Q. Did you form a view about the level of commitment she had to assisting her son to work with his illness?
A. Yes. I found that she was very supportive and concerned, and there all the time involved with his wellbeing.

Q. Given your experience as a mental health nurse in general, what regard did you have to information that was being provided by the family members of a loved one with schizophrenia?
A. What information was being provided to?

Q. I'll ask it a different way. You were a very experienced mental health nurse

by the time you came to work with Joel Cauchi. Is that fair?
A. Yes.

Q. Was it important to take notice of what a family member was saying to you about someone's illness?
A. Yes.

Q. In Joel's case, when you had a mother who you viewed to be concerned and engaged, did you regard her as having high value information to provide to the nurse staff?
A. Yes, I did.

Q. I take it you took careful note of what she was saying to you in terms of how Joel was functioning?
A. Correct.

Q. You would have regarded it as an important information to be passed on to the psychiatrist?
A. Yes.

Q. I'm just going to take you to a couple of notes that you took when - or that were taken when you first took over Joel's care in 2018. By way of example, page 39, and this is particularly, so that everybody else who's listening to the evidence can follow it. You see there, 29 June 2018:

> "Phone call to Ms Cauchi, left a message reminding that Joel will require a pathology request form for next month's final blood test monitoring and paperwork for termination of treatment will need to be faxed at that Clopine clinic appointment."

So, by the time you came to take over Joel's permanent mental health nursing care, it was just at the stage when he had been weaned off Clopine entirely. Is that right?
A. I can't remember.

Q. Do you recall that shortly after you came to work with him permanently, he was ceased on all Clopine?
A. I think the notes reflect here that - in the history section, that Joel had continued with 12.5 milligrams for a further month.

Q. That's right. But let's look, for example, at the top of that page where we see a clinical note from Dr A from 26 July. She says, "Doing very well on no Clopine for two out of 12", meaning two months, correct?
A. That - yes.

Q. So it was around that time that you understood that Joel was stopping Clopine?
A. Yes.

Q. That was the decision of Dr A; that had nothing to do with nursing staff,

correct?
A. That's right.

Q. Given your experience of patients with Clopine, was it in your mind at that stage that there would need to be a high index of suspicion in terms of the risk of relapse?
A. I can't speculate, but I think that it's possible.

Q. Well, I'll just ask you this then. Just draw on your clinical experience and expertise. Did you understand that there is an increased risk of relapse for individuals with treatment-resistant schizophrenia?
A. Coming off Clopine?

Q. I'll come to that in a second, but just in general for persons--
A. I think that a person, a person with a mental health diagnosis of schizophrenia can relapse at any time. There can be breakthrough psychotic symptoms at any time.

Q. So when they're in care, it's important to look out for the signs and symptoms?
A. Yes.

Q. It's part of your training as a mental health nurse to understand what those likely red flags are?
A. Yes.

Q. We will hear expert evidence next week in relation to the treatment of persons with schizophrenia and treatment-resistant schizophrenia. Professor Heffernan, I expect, will express a view that for individuals with treatment-resistant schizophrenia there is an increased risk of relapse, re-admission, and adverse impacts on recovery when Clozapine is ceased. Is that something you agree with?
A. Yes.

Q. Did you know that back in July 2018?
A. Yes.

Q. I won't take you to every single note you make over the year and a half, but I'll take you to October 2018 at page 36 of the notes. There's an example, I suggest to you, of Joel doing well during the course of his treatment. The note there is, "Presented for F2F" - is that face to face?
A. That's right.

Q. "Appointment with CMHN"?
A. Credentialed mental health nurse.

Q. "After seeing Dr A. Wanted to check his weight and physical obs. Obs NAD". Can you tell us what that is?
A. No abnormalities detected.

Q. "And recorded he was continuing going to the gym, he feels well and better off Clozapine". And under "History" it's noted with Dr A later, "Doing well, euthymic, a psychotic". Euthymic is a stable mood, is that right?
A. Yes.

Q. And there were various things he was attending to. He was on Abilify 5 milligrams in the morning. ISQ, can you tell us what acronym?
A. In status quo.

Q. We see there a note for yourself at 3.11pm and a note for Dr A at 2.57pm. How did it generally work around that time in terms of coordinating the different appointments between yourself and Dr A? That is, did you see Joel separately and then together, or just separately?
A. No, I would have seen Joel separately. There were times when Dr A did ask for me to also attend.

Q. On that same page you see an entry from 31 October 2018, and Dr A makes a note, "History, seen with mum and RN3". RN3 is you, is that right?
A. Correct.

Q. "Excelling in function. Doing more than ever. Gym, looking for unit, seeing employment agency for work, social activities, et cetera. Fatigued and frustrated at times. No other problems at all. Mum is happy with progress". So just in general, that obviously indicates that he's doing well at that time. Where it says, "clinical Dr A" and you were present, did you take the notes, or was that the doctor taking the notes?
A. The doctor took the notes.

Q. You say in your statement that Joel around that time was generally positive, in a positive mood with optimism. Can you say was there ever a time when Joel was - when you were confident that he was socially confident, or did he always struggle with those issues?
A. I believe he always struggled with those issues.

Q. You say this at paragraph 38:

> "On occasion I recall he turned his head. This was thought to be muscular action, that is, a tic. It was documented in the medical records in the early illness timeframe that he had experienced episodes of hallucination. When I explored this, he denied voices or experiencing any symptoms".

Did you ever think that the tic might be a manifestation of mental health decline?
A. No, I didn't. I saw it as a tic.

Q. Was it related in any way to the medication?
A. I believe so.

Q. What was it about the medication in your understanding that led to that?

A. The use of the Abilify for the tic. Yeah.

Q. Was there any regular meeting with mum or dad, or regular discussion, or was it only when they made contact with the clinic?
A. Yeah, I can't recall making any - no regular. It was just I think on the background of when mum contacted.

Q. Staying with this timeframe of between July to August in 2018 when Joel had recently been taken off his Clopine but was taking Abilify, he was somebody who had always been happy to come to appointments, is that right?
A. Yes, that's correct.

Q. He was fully engaged with his treatment?
A. Yes.

Q. He was happy to follow direction, as far as you could see?
A. As far as I can recall, yes.

Q. If he had suddenly then not wanted to come to appointments, was that a warning sign, would you see?
A. No, I did not see that as a warning sign.

Q. You noted earlier that you understood at that time that there was a significant risk of relapse. What signs were you looking out for in your regular meetings with him?
A. Changes in - to all the - from all the previous encounters that I'd had with him. So, looking to see if there was changes in his - the way he spoke, how, how he spoke, the content of his speech, the rhythm, tone, volume of things. Observing him, was he, you know, behaviour any different. Listening to see if there was anything out of context, untoward, not related, off on a different tangent or something. So just overall taking in what I'm seeing and hearing.

Q. Had you had an experience of patients who'd previously been psychotic being reluctant to report side effects of medication?
A. To report side effects? No. They seemed to always want to report side effects.

Q. Had you had an experience of patients, where they'd been weaned off medication because of side effects, being reluctant to go back on medication?
A. I can't recall a distinct episode, but I think yes, over my career, yes.

Q. Was it part of your training that you had to be a bit wary that patients might not always report psychotic symptoms because of the fear of going back on medication?
A. Yes.

Q. You explain in your statement at paragraph 45, "Once he was weaned from medication treatment", that is, Clopine and Abilify, "Joel was reluctant to start again, as he did not want to experience negative side effects". You could understand that, correct?

A. Yes.

Q. But you still had to watch out for signs and symptoms of psychosis, correct?
A. Yes.

Q. Because you knew that if Joel did experience psychotic symptoms, it would be far worse for him than experiencing the side effects of medication?
A. Yes.

Q. Did Dr A ever say to you, "These are the things to look out for with Joel"?
A. I have no recollection of that happening.

Q. Did Dr A ever explain to you what the risks of relapse were for Joel?
A. I don't recollect that happening.

Q. By that answer, are you - to the best of your recollection, did she have that conversation, or you're just not able to say?
A. I don't think we had that conversation.

Q. If you had have been told by a doctor like Dr A to specifically look out for signs and symptoms of relapse, would that be in your notes?
A. Yes.

Q. Was it part of your experience that there could be concerns for a patient with treatment-resistant schizophrenia like Joel if their sleeping started to be problematic?
A. Would there be concern that--

Q. Yes.
A. Yes.

Q. What are the concerns you would have?
A. What would be the reason for the sleep disturbance. Surrounding, you know, what was the - with regards to like sleep hygiene, what had been happening previously, what was his activities, screentime. You know, just having a conversation as to why there might be sleep problems.

Q. Can poor sleep be an indication for someone suffering from schizophrenia that there is a risk of relapse? That is, can it be a symptom of relapse on occasion?
A. I think everybody suffers from poor sleep at some time, so it could be, but--

Q. It depends on how serious or how chronic it is, is that right?
A. Yes.

Q. And conversely, can poor sleep contribute to mental health decline--
A. Yes.

Q. --for persons suffering from schizophrenia?

A. Yes, yep.

Q. So, it's something to investigate if it's reported to you, is that right?
A. Yes.

Q. Was it part of your practice when you were reviewing Joel on a monthly basis to read back through any notes that had been taken by Dr A?
A. Yes, yep. My, my beginning of my day, if I had the time, would be to look at all the notes of everybody I was seeing that day.

Q. In September of 2019 there's a note that was taken by Administrative staff. Do you know that person?
A. Yes, I do.

Q. Who is that?
A. Administrative staff at the front of the office.

Q. She records some clinical notes - this is page 29 - and then Joel is seen on that day by Dr B. That's doctor - sorry, can you tell us her first name, which I'm about to--
A. Dr B.

Q. Thank you. Dr B records there "mental state examination", and above that, "history". And under "history" she says, "sleep not as good lately. Had melatonin. Cut it back". She then writes a note on 20 September 2019 to Dr A, which is at page 149 of the notes. That doesn't need to come up, I'll just read it to you. She says:

> "Dear Dr A, thank you for referring Joel to me for review in your absence. I assessed him today. It's been three years since I last saw Joel, and I was pleasantly surprised with his progress. He now lives alone. Finishing certificate IV in TESOL, doing voluntary job, et cetera. He's not on any psychotropic medications. He was not known to smoke, drink or use illicit drugs".

She says, "The only concern is that he has not been sleeping well lately. The onset of disturbance seemingly was in the context of feeling medically unwell, but it has persisted." She then goes on to describe him as euthymic, et cetera. But she's concerned enough to raise that issue in a letter to Dr A when she's seen him when she's been away. Did that come to your attention in September 2019, or thereabouts?
A. I have no specific recall to that at that time. It was only when I would've read the notes at the next time I was seeing him, perhaps, that I would've noted - read her--

Q. I'm not suggesting that that in itself would raise immediate alarm bells, but it's certainly something to add to the mix in terms of assessing how well Joel is going off his medication. Do you agree with that?
A. Yes.

Q. Can I take you then to a notation on 17 October 2019. That's at page 28 of the notes. Do you see a note there, "Seen with RN3 re mum's concern for relapse." This was on the back of the appointment being cancelled by Joel, who was thought to be very unwell and unable to attend?
A. What, what - where are we, sorry?

Q. Page 28, 17 October. Do you see that note?
A. Thank you. Yes.

Q. Just take a moment, if you will, to familiarise yourself with that. "Seen with RN3 re mum's concern for relapse." "Mum" is Michele Cauchi. Correct?
A. Yes. That's right.

Q. "Joel CO cold with deep croaky voice, a bit less sleep and fatigue for two days, but no other signs suggestive of EWSR." What does that acronym stand for?
A. Early warning signs. I'm not sure of the R.

Q. Of relapse, is that--
A. Early warning signs of relapse. Correct. Yeah.

Q. In terms of this note, just pausing there, is this a note taken by Dr A, to the best of your knowledge?
A. Correct.

Q.

> "Feeling good mentally. Studying towards certificate IV in TESOL. Doing modules. Attending gym with good self-care and social activity. No tics. Plan. Counselled. Continue with weekly monitoring by the mental health nurse. Sleep tracker. Follow-up with me in one month."

I'll just ask you a couple of questions about that. Joel was obviously seen here with you and Dr A. Is that correct?
A. Yes.

Q. What were mum's concerns about relapse at that time?
A. I might need to look at a previous entry to answer that, because I have no direct memory of--

DWYER: Could I ask that the nurse be provided with vol 20, tab 793, The practice records.

Q. If you have a look please at page 29 you'll see that there appears to be a note of something. It says "clinical". Is it the case that the records system at The practice involved scanning in any letters or emails that had been received by the clinic?
A. Referring to 23 September?

Q. Yes?

A. Yes. That, that looks like - yeah. That looks like the emails. The first one looks like the email that might've come from Michele Cauchi. I can't see that for sure.

Q. That comes later. The system was to scan in letters or emails. Is that right?
A. I can't remember how the system worked, but, yes. I thought that they were typed directly into Genie, but the - but they look like that they have been scanned in.

Q. In any event, by October 2019 there was information coming from mum that she had concerns about a relapse. Is that right?
A. Yes.

Q. That could've come from a phone call or an email from mum to the clinic?
A. Yes.

Q. That was obviously something that in your mind, as a mental health nurse, needed to be followed up with?
A. Yes.

Q. In addition to the concerns about the poor sleep, that needed to be explored and investigated further. Correct?
A. Yes.

Q. You're familiar with the fact that Medicare has billing items for doctors?
A. I, I don't really know much about Medicare myself, but I do know that. Yes.

Q. I'm not suggesting that you were responsible for billing, but if I could ask you to accept that the billing item on this occasion used by the doctor was for an attendance of more than 45 minutes, but not more than 75 minutes' duration. Was an appointment of more than 45 minutes for Joel unusual? That is, an appointment with Dr A that you were sitting in on?
A. Not - they were not common.

Q. Do you recall that by October 2019, there was a need for longer appointments with Joel because of the concerns being raised?
A. Not aware.

Q. To the best of your memory now, what were mum's concerns for relapse by October 2019?
A. I don't have actually a memory of it, only that - what was in the notes. Yeah. I--

Q. What we see here in this note is that under "History" it says, "Discussion with admin staff, et cetera", and records:

> "Joel's mother rang admin and reported her concern for his mental health and physical health, and she had told Joel to keep the appointment that he cancelled. Mother requested for mental health

nurse to be aware of Joel's current status."

Can you see that?
A. Yes.

Q. Clearly, you were aware of it. If you go up to "The Plan" at the end of "History", it says, "Counselled. Continue with weekly monitoring by the clinical mental health nurse." Do you recall any discussion at that time of a change from monthly to weekly monitoring?
A. I, I have no memory of that. No.

Q. If you have a look at page 28 and go to 23 October. It appears that you did in fact see Joel about a week later?
A. (No verbal reply)

Q. Is that right?
A. (No verbal reply)

Q. Do you see that on 23 October, page 28?
A. I know. I'm just - correct. I'm just looking. It doesn't actually say if it's a phone call or if it's face to face, so I have no memory of which one it was.

Q. Would you accept from me that that appears to be a phone call, because you say at the bottom of it:

"Discussion re peer support with coordinator. Joel's mother reports he has not the skills for independent living, and there is scope for peer support for Joel to increase skills for ADLs and social support. Will discuss this further with Joel at tomorrow's appointment"?

A. That's right. Yeah.

Q. That appears to be a phone call--
A. Phone call.

Q. --from his mum?
A. Yep.

Q. And then you do meet with Joel on 24 October 2019. Correct?
A. Yes.

Q. Just take a moment, if you will, to have a read of that. There's a discussion on peer support?
A. Yes.

Q. I appreciate that it's hard for you to recall now, but would it have been part of your practice back then to raise the concerns that mum had with Joel?
A. Yes.

Q. Would it have been part of your practice to do a mental state examination

with a patient in Joel's position?
A. Yes.

Q. Is there a note there of any mental state examination that was done on that day?
A. No. It's just - it's saying about - the conversation about peer support.

Q. I asked you about peer supports earlier. At that time was there an option for you to refer Joel to somebody to provide peer support separate to you?
A. I have no recollection of how the conversation came up about the referral to peer support, but, yes, we had a discussion on, on his having a referral to the peer support to have that extra level of support for living on his own in his unit.

Q. You did provide that referral. Correct?
A. Yes. Yeah.

Q. Who did you refer Joel to at that time?
A. To the peer support coordinator, which was--

Q. They worked at The practice?
A. Correct.

Q. Do you know whether Joel ever did receive that peer support?
A. Yes.

Q. He did?
A. Yes.

Q. For what period of time?
A. I'm not sure how long it was for, but I don't think it was for very long.

Q. Initially, was it a comfort to you that he might receive that service?
A. Yes.

Q. Had that continued, that might have been one way to keep Joel better engaged with the service. Is that right?
A. Yes.

Q. On 31 October 2019 you saw Joel again. That's at page 27. I beg your pardon. That's another nurse, a RN4, who saw Joel on 31 October and 7 November. Does that suggest that you were away for a period of time?
A. I think that previous entry says that, "On 24 October I introduced Joel to RN4 today, as he couldn't remember who she was, for reviews whilst mental health nurse was on leave."

Q. Do you see over those dates, 31 October, 7 November and - I withdraw that. That he's seen on 14 November. It appears then, doesn't it, that Joel's interventions from a mental health nurse do move from monthly to weekly at that stage, in accordance with what Dr A had asked for?
A. Yes.

Q. That reflects, doesn't it, a concern about the risk of relapse for Joel around that time and the need for closer monitoring?
A. I don't know that for certain, but that was the background reason for it. But it would, would improve more regular contact, more monitoring, more support.

Q. It was a decision that was made by Dr A that we move from monthly to weekly appointments. Is that right?
A. Yes.

Q. It accords with your common understanding of practice that that suggested a need for closer follow-up around that time?
A. Yes. Yeah.

Q. That's exactly what was provided by the nursing staff. Correct?
A. Yes.

Q. I just come to an entry from you then on 20 November 2019 at page 25. You've returned from leave by this stage. Would it have been part of your practice to read through the notes that have been taken in your absence?
A. Yes.

Q. In fairness, I just note that on 14 November 2019, Dr A wrote that she'd "seen Joel with RN4. Insomniac. No psychosis. Accepted a short course of Zopiclone for sleep." That's a drug to help with sleep disorders. Is that right?
A. Yes. That's right.

Q. You would've read that entry as part of your practice?
A. I think I would've. Yes.

Q. I'll come to your clinical note, which appears at the bottom of page 25 on 20 November 2019. This is what you write under "History". Do you see that, RN3?
A. Yes.

Q. "Reports from those known to Joel of changes in behaviour. He is having extreme OCD with" - I think it's supposed to read "showering"--
A. Yes.

Q. --"and washing himself using half a cake of soap during one shower. Writing a lot of notes, plus, plus, plus at home and leaving them about." "A lot of notes, plus, plus, plus", what do we take from that?
A. A lot of notes, plus, plus - a lot.

Q. The "plus, plus, plus" is a common short-term note. Is that right?
A. Yes.

Q. To indicate a lot of?
A. Yes.

Q.

"And leaving them about. Mother read some notes with some content of under satanic control of religious themes, desire for porn with conflict of his religious beliefs and wanting no access to porn sites to prevent temptation. Leaving his phone with his mother at her home overnight so as not to use phone/internet for porn sites. Mother reports that he is walking funny. Change in his gait. He reports he is afraid of getting sick and is wearing layers and layers of clothes to prevent himself getting sick. He has been observed that he bends his head a lot and has odd movements.

Reports that he is very busy but unsure what he's doing with his day. Wanting connection and relationship, has spoken with some girls recently. Mother does not want Joel to know that she's raised her concerns of deteriorating mental health with staff. Possibly hearing voices has been considered".

You go on to note:

"Peer support has cancelled appointments. Only had one meeting and not engaged, making excuses on last two visits to The practice on presentation. He asked for coffee drinks. This was given, but question mark, seen as unusual new behaviour. Joel has rung the office to check on appointment times and given the information, and sometime later, within day or two, he's rung again asking for same information with little recognition of having had this conversation already in recent days.

Phone call to mother, reported that clinical mental health nurse was back from leave. Phone call to Joel, initial reluctance to come into The practice earlier, said he was too busy. Encouraged to present today for frank and honest conversation and agreed to same, asked him to come with mother, agreeable to same".

It appears that by 20 November 2019, there was a significant report of concerns from Joel's mother. Is that right?
A. Yes.

Q. Did this information come to you from a phone call from Joel's mother? Perhaps I'll just assist you with this regard. There's an email received at page 141, if we could have that on the screen. It's an email from Michele Cauchi?
A. Is that the same document that’s been scanned in under that note, under "plan"?

Q. I will just show it to you and then you can tell us, if you will.
A. There's another email scanned in on 12 November and I don’t - I can't see what they are.

Q. I will come to that shortly then.
A. Yeah.

Q. But actually, we'll see if we can go there now because it pre-dates it. So, we'll start with that one. That appears at page 142.
A. It's from Joel.

Q. It's sent to office reception. Is that the email you're referring to?
A. Well, I can't see them, they're, they're tiny, but there's a - so, there's a short one which must be that on 12 November.

Q. Can you see it on your screen?
A. I can see it on the screen, yes.

Q. I'm going to read it because everybody's following the evidence.
A. Yes.

Q.

> "Hi, can we please cover some ideas for a porn free phone and other devices currently using hotspot, on Thursday? I will consider a porn free ISP if the cost is reasonable as well. If seeing a specialist is what you recommend, I will consider that the same. I want a totally porn free internet on my devices, if possible, on all browsers and potential browsers, et cetera".

So, that's an email from Joel to The practice. Is that right?
A. That's right.

Q. Did you read that prior to your resumption of contact with him in November when you come back from leave?
A. I believe I would have.

Q. Does that suggest that at that stage Joel himself was proactive in wanting to stay healthy?
A. He's asking for help.

Q. Yes?
A. Yes.

Q. That's something that you would have obviously given great consideration to?
A. Yes.

Q. Then there's a follow-up email from Michele Cauchi to The practice on 20 November. That's the one I took you to earlier. The attention, or it's marked for the attention of Dr A. Do you see that?
A. Yes.

Q. Would you have been able to see that?
A. Yes.

Q. Was it your practice to read any email that came to Dr A?
A. Yes, it - if it's in the clinical records uploaded, which it was, I would have seen it.

Q. And you see there that Michele Cauchi says to, "Hi, Dr A, I'm contacting you about my son, Joel Cauchi. He isn't doing well since going off Abilify". I withdraw that, I'll start again.

"I'm contacting you about my son, Joel Cauchi. He isn't doing very well since going off Abilify, and I know you thought that it wasn't having any effect, but I have noticed a gradual decline in his condition, judging from notes on paper he has left around the place in the past week. I have a feeling he is now hearing voices, et cetera.

He's very distracted, forgetful, and the OCD is getting out of hand with him going through half a cake of soap in one shower. He found out last week that the place where he volunteers teaching English put someone new on and he'd been hoping to get a job there, so that was a real blow. I would hate to see him have to go back into hospital after 20 years of being stable on medication.

But of course, being off it has made him realise how sedating it was, although I think it was the Clozapine that did that, not the Abilify. Also, he's at a loose end now that he's finished study. He quite possibly won't let on what's going on in his head, but I think you need to know how he is. I would appreciate it if you wouldn't tell him I've contacted you, as I don't want him cutting off communication with me, as I'm the only one who looks after him when he needs it. I would like to see him being able to - be able to live successfully, independently and doing as well as he was a year ago when he first moved out of home. Thank you for your help".

Some of that information makes its way into your file note. Is that right?
A. Yes.

Q. Is it the case that you also had a phone conversation with Michele Cauchi after reading that?
A. I did have a phone conversation with her; it's written in "plan".

Q. Yes. So, the plan is "Telephone conversation with mother re her concerns". You must have taken those concerns very seriously?
A. Yes.

Q. Is that right?
A. Yes.

Q. There are some obvious signs in what is being reported to you by mum of a risk of relapse. Do you agree with that?
A. Yes.

Q. That includes, to state the obvious, the extreme OCD?

A. Yes.

Q. The writing of notes excessively and leaving them about the house, particularly when their content has something about being under satanic control. Do you agree with that?
A. Yep.

Q. The obsession about porn could be a manifestation of his OCD. Do you agree with that?
A. I, I've written this note, but I have no recollection as to where I've got the information from.

Q. I'm asking - well, it seems, doesn't it, that mum sent an email to the clinic about her concerns?
A. But all that information is not in that email.

Q. Yes.
A. Yep.

Q. But if I can just remind you, there's an email there which you read and there's a note that you had a phone call with Michele Cauchi, correct?
A. (No verbal reply)

Q. Sorry, you're nodding. You just need to say yes for the transcript?
A. Yes, sorry, yeah.

Q. You would have been concerned to collect as much information from mum as possible?
A. Yes.

Q. What I'm suggesting to you, relying on your clinical knowledge, is that mum was reporting some serious signs--
A. Yes.

Q. --that indicated possible relapse?
A. Yes.

Q. And they needed to be investigated carefully, didn't they?
A. Yes.

Q. You took them very seriously because they came from mum?
A. Yes.

Q. You knew that mum was well placed to let the doctors and nurses know--
A. Yes.

Q. --how her son was doing?
A. I did, yes.

Q. So, if mum was saying that he was not mentally well and he'd slip

backwards, that information needed to be given priority. Correct?
A. Yes, I would agree, yes.

Q. Included in, I started putting to you some of the signs of possible relapse, including the obsession with satanic - I withdraw that. Extreme OCD, the excessive notes, including content of satanic control. Can I also suggest that her reports that in November he was afraid of getting sick and was wearing layers of clothes to prevent getting sick might have also been suggestive of obsession?
A. Yes. I recall Joel always, at I would say most sessions would report about his physical health. He always seemed to say he had a cold, or he had symptoms of a cold.

Q. Would the fact that he bent his head a lot and had odd movements be of concern possibly?
A. Possibly, but I had no - on presentation, it wasn't terribly untoward, but I noted it that it was happening.

Q. In November, in the email that's sent by mum to Dr A at 8.15, she reports that since going off Abilify she noted a gradual decline in his condition and that included the notes of paper he's left around the place, her feeling that he was hearing voices, he was distracted and forgetful and OCD getting out of hand, going through a cake of soap or half a cake of soap in one shower. They were all symptoms that were suggesting that his behaviour might indicate relapse?
A. Yes, and I think in my mind there was increased libido.

Q. Yes - sorry, please go on.
A. I have no evidence or anything, but it crossed my mind that he had increased libido, that he was masturbating in the shower.

Q. Were you concerned at all with respect to the increased libido?
A. No.

Q. Did that in any way mean that you were less concerned about some of the reports from mum?
A. No.

Q. You saw Joel on 21 November, and your note starts at page 24. I beg your pardon. I put to you a number of symptoms that mum was reporting on 20 November. Could you just listen to these again? I'm just going to start them and add them up. One particular issue that's reported by mum might not cause concern or might just be a flag that you note, but there are a number of things that mum was raising at that time--
A. Yes.

Q. --that were very concerning. Do you agree with that?
A. Yes.

Q. Did that include, most concerningly, the excessive notes about satanic control? Do you agree that that must have - did it cross your mind then that

Joel might be hearing voices?
A. Yes.

Q. If he was hearing voices, that was an obvious indication that he was slipping back into active schizophrenia?
A. As reported by mum but not seen by me.

Q. Sure, but it was a very concerning sign reported by--
A. Seen by mum, yes.

Q. --reported by someone whose opinion you trusted?
A. Yes.

Q. And who was actively engaged in a son's welfare, correct?
A. Yes, correct.

Q. So, what mum said, according to your consultation note on the 20 November, included:

> "Writing a lot of notes, plus, plus, plus at home and leaving them about. Mother read some notes with some content of under satanic control of religious themes, desire for porn with conflict of his religious beliefs and wanting no access to porn sites to prevent temptation. Mother reports he's walking with funny change in his gait."

The funny change in his gait may also have been a symptom of psychosis, is that true?
A. I don't know why he had a funny gait. I never saw him having a funny gait.

Q. No, but if mum's reporting it, it's another symptom to take note of, is that right?
A. It's a change.

Q. Yes, and that change is something that needed to be investigated to see whether it was indicative of a mental decline?
A. Could be, yes.

Q. You saw Joel then on 21 November, and your note appears at page 24. There's shortly after your note, a note which says "clinical Dr A" and a notation with "clinical RN3". So, just going to the timestamps for 21 November, the first note on that day is with you at 8.17am. There's then a consultation note with Dr A at 8.36am, and another note with yourself at 11.19am. Do you recall seeing Joel a number of times on that day?
A. I don't recall seeing Joel a number of times on that day.

Q. Do the notes suggest that you did?
A. The note written at 8.17am is written because I might have been at work late the day before because it says, seen yesterday with mother, after being asked to come in earlier. So, it's a retrospective entry.

Q. So, you wrote that report on 20 November, which I read to you where mum had expressed significant concerns, both in her email and in a follow up phone call?
A. Yeah.

Q. Is that right?
A. Yes.

Q. Then you arranged to see Joel that very day, correct?
A. (No verbal reply)

Q. That seems clear from your note, seen yesterday with mother?
A. And I've written in the plan, Joel, is to return again the next day?

Q. Yes?
A. Yep, yes.

Q. Some of the things that mum reported on that day were Joel - mother concerned of Joel's inability to progress in ADLs. Can you tell us what that acronym is?
A. Yes, activities of daily living, such as, you know, domestic in the house, cooking, cleaning, personal hygiene, yeah, what else, like cleaning the house, just day to day activities.

Q.

> "Joel reports he's very busy, doing resume for future job applications. Mother reports he sits around in his unit most of the days doing little. His unit is very untidy, messy, struggling to cope with independence. Mother reports signs of deterioration. Reports that after cessation of Clopine, Joel was able to drive a car, but this is a struggle".

Do you recall on that occasion being concerned yourself for a possible deterioration of Joel's mental health?
A. On hindsight, yes.

Q. You see there you record in the history "mother concerned of current signs of deterioration"?
A. Yes.

Q. "Return of symptoms of psychoses, OCD? Cleaning in shower? Context of looking at porn and showering excessively, using a lot of caked soap". Mum was clearly concerned about his risk of psychoses and mental health decline, correct?
A. Yes.

Q. And were you also as his mental health nurse at that time, not just in hindsight?

A. Okay, I was concerned at what mum had reported. When I saw Joel, I did not see any obvious signs of returning psychosis or early warning symptoms, apart from I think where I said he was moving his head or bending over.

Q. Were you familiar at that time with the fact that somebody who is becoming increasingly unwell can present differently at different times of the day?
A. Yes.

Q. And you have to have a high index of suspicion that they might be relapsing into active psychoses?
A. Yes.

Q. In mum's email to Dr A on 20 November, she specifically said "He quite possibly won't let on what is going on in his head, but I think you need to know how he is". Were you conscious that Joel might be masking some of his symptoms for the clinic?
A. I don't recall that I had that concern at the time, but I think, yeah, with hindsight, yes.

Q. I'm not suggesting this is all on you. You knew of course that he was seeing Dr A as his treating psychiatrist at that time, correct?
A. Yes.

Q. In fact, on that day there's a note, "Dr A consultation note", with a plan. Did you sit in on the consultation on that day?
A. I don’t believe there was a consultation with Joel on that day. I think that I had come into work. I had written that entry retrospective at 8.17, and I'd say my view on that retrospectively was discussed with Dr A, down the bottom, near the bottom of page 25, and that I'd be reviewing him again today.

Q. I see.
A. When Dr A came to work, I think that we - I would have had a conversation with her, or that there was a conversation or she was aware, and so she had written the script based on information that she had, that she'd come into work and wrote - well, it's not wrote - she had written a script through the computer system at that time.

Q. I see. So just to state the obvious so everyone's clear, as a mental health nurse, you can't write the script, you need to rely on the psychiatrist for that, correct?
A. That's right. It's not in my scope of practice.

Q. There's a plan here, "Abilify tablets, 10 milligram tablets, one morning". And that one mane, meaning morning?
A. Yes.

Q. So Dr A has written Joel a script for Abilify on this day?
A. Correct.

Q. Did you have a conversation with Dr A on that day?

A. I believe I did. My plan on the retrospective entry is "discuss with Dr A".

Q. Dr A considered at that time that Joel needed to go back on Abilify to prevent a relapse of active schizophrenia, is that right?
A. All I can see is that she's written a script, that that would indicate that he was to be given the script and to start the Abilify, restart the Abilify.

Q. Was it your job to explain to Joel that that needed to happen?
A. My job? My job?

Q. Was it part of your role then to explain to Joel that he needed to go back - it was the doctor's view that he needed to go back onto the medication?
A. I had a conversation with Joel that it was recommended that he restart the medications based on conversation from the psychiatrist. When I've written here, "Discussed with Dr A, she's written a script", I think that that script was printed off and probably left in the office, because I never saw the script or touched the script, or I didn't hand that script to Joel. Somehow it was given to Joel.

Q. The plan there says, "Discuss with Dr A and review again today". Did you review Joel again that day?
A. Yes.

Q. Was that face to face or on the phone?
A. It was face to face.

Q. Prior to Joel going off Abilify altogether, he was on 5 milligrams of Abilify. The script that was written by Dr A was for 10 milligrams of Abilify. Did she explain to you why she'd increased the dose?
A. No.

HER HONOUR

Q. Can I just ask, get some clarification. That's take a tablet in the morning and that's 30 tablets, is that five repeats?
A. Yes.

Q. R5?
A. I believe that's right.

DWYER

Q. If you've got page 24 of your notes from 21 November, "Joel was seen face to face on his own today. Discussion on psychoeducation". I'll just pause there. What sort of things would you have discussed as part of the psychoeducation with Joel on that day, given the symptoms that were being reported?
A. I have no direct recollection of the conversation, but I believe it would have been along the lines of what signs and symptoms could have been going on, talking about his psychiatric history or presentation, talking about symptoms.

Q. Joel was obviously happy enough to attend that day and participate in his treatment, correct?
A. Yes.

Q. Did you detect from him on that day any reluctance to start the medication?
A. Yes.

Q. In what way? Can you explain that further?
A. In the plan - I have no recollection of it directly, but in the plan, "Joel will self-monitor the symptoms and self-determine if he will restart medication".

Q. It says, "Joel does not want to restart medication at this time and has taken script. Agreeable to psychoeducation. NVC". What's NVC?
A. It's a type of therapy. It stands for non-violent communication, which later had a name change to compassionate communication. It's a type of therapy.

Q. "And recovery focus therapy. And agreeable that he does not want to deteriorate mentally. Weekly appointments scheduled and agreed to continue". So it's clear, isn't it, that from this time onwards, that is, from the time that the reports of possible decline come in, there is a move from monthly to weekly to try and monitor that, is that right?
A. Yes.

Q. One thing that you note on 21 November is that there's a phone call to a home landline to advise Joel's parents that he had a script for Abilify, but he'd chosen not to have it filled at this time. Do you recall whether you spoke to mum and dad, or just one parent on that day?
A. I do remember that phone call. I spoke to Joel's father.

Q. To the best of your memory, what did you say and what did he say?
A. The best of my memory is that I told him that he was to restart the medication, that he had been given a script.

Q. What did Mr Cauchi senior say?
A. He did not want his son to go on medication.

Q. Did he say why?
A. I don't remember it word for word. It's what I've got written in the notes. That "he was adamant he did not want his son to go on medications as it will kill him. The father spoke that he himself had been traumatised by demons when awake, and hears voices, and he is not on medication".

Q. So that Mr Cauchi senior himself said that he'd been traumatised by demons when awake and hears voice himself and is not on medication himself, correct?
A. That's what he said.

Q. Given your experience as a mental health nurse, do you understand that some persons who have schizophrenia also have a history of schizophrenia by

that a family members suffers it?
A. Yeah.

Q. That is, in fact, when you would take a history from someone suspected as having a mental illness, family history is an important consideration, correct?
A. Yes, it's generally asked and noted.

Q. The environment then that somebody who might become mentally ill is around can have an impact on whether they stay healthy or not, correct?
A. Yes.

Q. Dr A had written a script for Joel intending for him to start Abilify, is that right?
A. That's my correct understanding, yes.

Q. Did you understand that she was wanting you to offer the script to Joel as an option for him to commence?
A. Yes.

Q. Or as a suggestion that that's what he needed to do?
A. I'm not sure of the intent from Dr A if it was to start immediately or whether that was if he had noted early warning signs himself, that he was to start.

Q. I see. Do you recall getting any advice from Dr A as to how urgent it was that Joel start on Abilify?
A. It is, it is in the clinical records there that I'm to encourage Joel to restart the medications.

Q. When you had that conversation with Andrew Cauchi, Joel's father, with no disrespect intended at all to Andrew, were you concerned that Andrew Cauchi himself was unwell?
A. He may have been always unwell and coped at that level. I didn't meet him, so I didn't know, but I think the records indicated that he had a mental health issue. So I wasn't - I was surprised at his comment, which is why I noted it in the clinical record.

Q. Were you concerned that that might adversely impact on Joel in terms of him getting back on the medication that he needed to take?
A. Yes, definitely.

Q. Because there appeared to be a conflict, didn't there, where Michele Cauchi recognised that her son needed to go back on medication?
A. Yes.

Q. And Andrew Cauchi was concerned that going back on medication would not be the right thing for his son?
A. Yes.

Q. I'm not suggesting that both parents didn't have their son's best interests at the front of their mind, but were you concerned about that conflict and the way

that it would impact on Joel's mental health?
A. Yes.

Q. Was that something that you ever discussed with Dr A?
A. I believe I did.

Q. Do you have a memory of it, or are you relying on your general practice?
A. I have a vague memory of passing that information on that what Mr Cauchi had said.

Q. Do you remember anything Dr A said to you about that?
A. Not specifically. I just remember on several occasions was to always encourage Joel to restart the medications if he noticed, especially if he noticed early warning signs.

Q. Was there any consideration at that stage about a family conference with Andrew Cauchi, Michele Cauchi and Joel to get everybody on the same page in terms of educating then about the risk of relapse?
A. Not that I'm aware of.

Q. With the benefit of hindsight, do you think that would have been a good idea to coordinate that type of conference?
A. Yes.

Q. Can you see the difficulty in relying on Joel himself to restart medication or to nominate his own symptoms of relapse when he was so reluctant to start on the medication again?
A. Yes, I did.

Q. On 28 November there's a consultation note that you took, RN3, that an appointment that you had with Joel scheduled on 5 December had been cancelled by the patient going on holidays?
A. I think that it's got my name at the clinical there because there might have been an appointment time scheduled for that time, but that--

Q. I see. So let's go to the 28th then. The history says, "Seen with RN3", and above that it says, "clinical". So, do we take from that that on 28 November, you did see Joel with Dr A?
A. Yes. But I didn't make any notes.

Q. They're made by Dr A. Correct?
A. I think where it says "History", that that's from the administrative staff, Administrative staff. That's the administrative staff member. "Appointment on the fifth at 9.15. Appointment cancelled by patient. Going on holidays. Administrative staff." That's not me.

Q. If you could just have a look underneath that, if you will?
A. Yes.

Q. It says "Clinical 2.40pm. Dr A"?

A. Yes.

Q. "History. Seen with RN3"?
A. Yes.

Q. If you can take it from me that according to the Medicare item this was an attendance by Dr A of more than 45 minutes, but not more than 75 minutes' duration. I think your evidence is that that was an unusual length of time, if that was the time period?
A. Yeah. I have no - they, they were usually about half an hour. I don't remember the specifics of that being 45 minutes.

Q. The note there, "History. Seen with RN3. Mum was contacted by telephone who told Joel to start Abilify for relapse prevention based on his EWSR", early warning signs of relapse?
A. Signs of relapse.

Q. And then the note:

> "Joel presented well today. Feeling good, with good sleep and no fatigue. Going to Caloundra to have a holiday with his male cousin. Not keen to restart Abilify because of the dysphoric feelings of it on the past, but happy to start Rexulti if not going well mentally to prevent relapse of schizophrenia."

What is the drug, Rexulti?
A. It's an antipsychotic medication.

Q. The plan there was developed by Dr A. Is that right?
A. Correct.

Q. Her plan was for Joel to start Rexulti if Joel, himself, determined that he wasn't going well mentally. Is that right?
A. I believe so.

Q. Did you at that stage have concerns that it left too much in the hands of Joel who had these signs of relapse?
A. Yeah. I had encouraged Joel to restart the medications.

Q. Did you have any conversation with Dr A at that stage about the risk that Joel would not restart medication by himself, given that he didn't want the side effects?
A. Not that I recall.

Q. On 4 December we see a note by you, page 23, at the bottom there, "Message received to ring Joel's mother." You then did so. Is that right, RN3?
A. I believe so. Yes.

Q. You see that Michele Cauchi was reporting that:

> "Joel's now gone to Brisbane and wanted to know when his next appointment with the clinic was. That is, the nurse and doctor was. Advised that he'd informed us he was having a two week holiday with his cousin. He'd been given medication from Dr A and agreed to taking medication if he noticed changes in his mental health, which he agreed to. Mother reports that Joel's aunt rang to report he had a medication, possibly Edurant, when he was with her for HIV. Joel left the family and is in Brisbane and mother is feeling very confused."

Having read that note - sorry, I'll just read the end of it. Over the page it says, "Mother remains concerned for Joel, but is pleased he's trying to get out and live his life, but concerned he is very confused." You made a follow-up phone call to the GP. To the best of your memory, refreshing it from the note, what was mum concerned about with respect to Joel's other medication?
A. I believe it was that he was showing signs of confusion, potentially early warning signs.

Q. On the back of all the other concerns that she had had, and in spite of the way that Joel was able to present, did you have concerns that he might be experiencing a relapse?
A. Again, I feel Joel presented well when I saw him. That I had no overt signs and symptoms of psychosis at the time that I saw him.

Q. Is it still your view that, given what was being reported by his mother, he needed close follow-up by The practice?
A. Correct. I did value the weight of the mother's observations and reports.

Q. It was your thought that Joel needed to continue to be seen very regularly by yourself and Dr A?
A. That he still needed monitoring and support and take - yep.

Q. The plan at that time was to advise Joel's mum that he was to present for a face to face appointment on 19 December and earlier if required, or if he returns to Toowoomba earlier?
A. Yes.

Q. It's pretty clear that you wanted to see Joel as soon as possible after that in light of mum's concerns. Is that right?
A. Yes.

Q. In fact, there's another consultation note the very next day on 5 December. The first note on that day is at 11.11am. That's at page 23. "Email received from Joel's mother confirming names of medication that he was seen to be taken" - this was at his aunt's place. That was the anti-HIV infection medication, and Joel's mother was concerned about what that might mean for Joel. Correct?
A. I think that the concern was - yeah - what was that medication? What was it for?

Q. Under "History" there's a note, "Advised Joel's mother that Joel is to start taking the Rexulti medication today. An email had been received from her with a note of the medication." You say, "Advised Joel's mother that Joel is to start taking the Rexulti medication today and to consider his compliance and adherence to doctor's management." The Rexulti was the anti-psychotic medication?
A. Correct.

Q. It appears from this note that Joel's mum had phoned to report her concerns, specifically in relation to the HIV medication, but also that she continued to be concerned he was unwell. She followed that phone call up with an email, noting the exact medications. And the plan was that you were to "advise her that Joel is to start taking the Rexulti medication today and to consider his compliance and adherence to the doctor's management". Is it fair to say that you were intending to be a bit more directive in relation to Joel taking the antipsychotic at that time?
A. I think so. Yes.

Q. The note is:

> "Joel knew he had an appointment for 19 November with the mental health nurse. He had it on a card and it was added to his phone schedule. Joel told his mother he would not be returning home and is booked to return only on 22 December. Advised he is to keep the December 19 appointment and earlier if he returns to Toowoomba earlier."

There's an increasing concern in relation to Joel's mental health at this time. Is that right?
A. Yes.

Q. Did you discuss with Dr A what would happen if Joel didn't come back?
A. No.

Q. If you then go to the next page. There's a further note that you make at 11.48am, RN3. It's a lengthy note from you recording the details of what you next find out, "Phone call received from Joel after his mother rang him to call The practice." I'll just pause there. It's somewhat comforting, isn't it, that Joel was at least prepared to engage with The practice at that time?
A. Yes.

Q.

> "Calling from Brisbane on his holiday re taking HIV medication. States he saw different GP at Platinum Health, Dr Dragone, as he had a dangerous sexual encounter. Saw a sex worker at a licensed brothel, even though they reported to him they were tested. He sought GP advice and was referred to Toowoomba Sexual Health Clinic for preventative HIV medication for one month's supply. He was embarrassed to talk to the mental health nurse and Dr A as it

was a personal experience. Had tests, et cetera, for STIs."

Do you recall, generally, what Joel's presentation was like in that phone call, or are you just able to go on your notes?

A. I, I don't think I had any specific concerns about how he was talking on the telephone, you know, the, the phone call went quite well. There were - there wasn't any, any, that I could hear, that there was anything psychotic or concerning during that conversation.

Q. You advised Joel that his "prescribed management plan is to restart the medication and begin taking the Rexulti". Do you see that?

A. Not yet.

Q. It's the very top of page 23, four lines down?

A. Yes. Yes.

Q. Joel had agreed to make the December 19 appointment with the mental health nurse for a face to face?

A. He, he wanted to make the December 19 appointment from a face to face to a phone call.

Q. I see. And delay the face to face until after 22 December?

A. Yes.

Q. He forgot that The practice would be closed for a Christmas break?

A. Yes.

Q. You advised him that his "prescribed management plan is to restart medication and begin taking the Rexulti"?

A. Yes.

Q. I'll just pause there. It seems from those notes that the plan had changed from just waiting to see whether or not Joel, himself, wanted to take the medication, if he felt unwell, to directing him that he should be taking the medication. Is that right?

A. I believe - yes. Yeah.

Q. Joel said to you that he wanted to discuss that with Dr A because he felt mentally well?

A. Yes.

Q. Under examination that you could conduct on the phone, you say:

> "Reports to be feeling well mentally. Speaking freely about current situation. Embarrassed at talking about seeing sex worker and his concerns of STIs. Speech was clear. Normal rate. Tone. Volume. Thought flowing. Linear. Ambivalence noted about changing his appointments and appointments with peer support bookings. He states there is miscommunication between him and his mother."

Under "Plan" - I won't read it all out - but "Joel remained steadfast that he believed his mental state is good"?
A. Yes.

Q. In your mind, as a mental health nurse trying to assess his mental state, is it fair to say that you put some value on what Joel said himself. Correct?
A. (No verbal reply)

Q. You're nodding. You just have to say yes?
A. Sorry. Yes.

Q. You put some value on what you were hearing, in terms of his speech. Correct?
A. Yes.

Q. But you still had concerns given the reports from mum, who knew him very well?
A. Yes. That's right.

Q. You had experience and training that told you people who relapse into schizophrenic acute behaviour can present well one day and not the next?
A. Yes. That's right.

Q. And also that they can mask their symptoms. Correct?
A. Yes.

Q. The next note in relation to Joel was on 19 December 2019. Joel rang the clinic for the phone appointment that he had arranged. Correct?
A. Yes.

Q. "He was punctual. He was in Brisbane staying in a guesthouse. He was busy with online dating", et cetera. Do you see that?

> "He'd met a lady. He wanted to move to Brisbane because he liked the lifestyle. He was yet to discuss this with his mother. He had been keeping in touch with her. He denied symptoms of psychoses."

You had a discussion with him about safe sex and safety, and keeping awareness and not exposing him to vulnerabilities. Can you tell us, using your notes, what your examination told you, in terms of the phone call that day?
A. That he was feeling good. He was happy. Enjoying it in Brisbane. He was speaking well over the phone. His thoughts were coming across through the conversation at a normal rate. There was nothing untoward I noticed about his thought pattern. The themes of what he was talking about in that conversation was about him enjoying himself in Brisbane. His speech, there was no change in his - the way he spoke. He was understanding what I was saying.

There was no - he had - I've written, "Nil comprehension issues", meaning he was taking on board what I was saying. I didn't detect any perceptual

disturbances, and he - I must have asked him if he was feeling - hearing voices, or was something going on, and he denied the same. And he described his sleep as being fine. There was no issues with his sleep. That he was motivated. That he was happy.

Q. Were you conscious at that time of the inherent limitations in a phone call, rather than a face to face?
A. Most definitely.

Q. It would've been far preferable for you to have seen him face to face at that time. Is that right?
A. It's always best to see face to face.

Q. Was there any option for a Skype contact, or Zoom call, at that time?
A. We'd never done a Skype prior to that, so we weren't set up for a Skype appointment.

Q. This was 19 December 2019. Given what the ongoing concerns were from mum, was there any discussion with Dr A at that time that Joel had not started the Abilify antipsychotic, or the Rexulti?
A. I have no recollection and - of, of that conversation happening.

Q. Back in October, mum had reported that in addition to the OCD and the change in gait, he had written excessive amounts of notes around the house with a satanic content. Did you ever ask to see those notes?
A. No, I didn't.

Q. With the benefit of hindsight, would it have been good to see those notes yourself?
A. Yes.

Q. Did you ever discuss the content of those notes with Joel?
A. No recollection of discussing those notes with Joel.

Q. Do you recall Dr A ever giving you any instructions or raising those notes with you?
A. No, I have no recollection of a conversation.

Q. I just took you to a consultation note from 19 December 2019. The next note is 8 January 2020. Joel had raised with you on 19 December that it was possible that he might move to Brisbane. But you saw him face to face on 8 January. Is that right?
A. It does look--

Q. Page 21.
A. Yes, yeah, "Seen with RN3".

Q. This is a note that had been taken by Dr A, correct?
A. Yes.

Q. The note on that day was that "seen with RN3, totally well and doing fine, euthymic and a-psychotic". Did you take notes of that consultation yourself?
A. No, that was a appointment with Dr A that I sat in.

Q. Were you concerned at that stage with respect to his move to Brisbane, or possible move to Brisbane?
A. I don't recall having concerns about him moving to Brisbane. It was just at, at, at that stage was a holiday and that it was a discussion.

Q. Given that the reports had come in from mum around October that was of such great concern, was there any discussion with you and Dr A about contacting mum to see what her perception was around this time?
A. No recollection of a conversation.

Q. In hindsight, would that have been a helpful thing to do, do you think?
A. I can't speculate what might or might not have. I guess in clinical reference it could have been, but.

Q. The plan was continue, or "history", Dr A wrote "continue no meds". Do you recall the discussion with Joel around medication on 8 January?
A. No, I don't have any recollection of what happened in that session, in that appointment.

Q. At that time there was - it's under "plan" again and appreciating that this is written by Dr A, it's written "Agreed to monthly Skype appointments with me and monthly Skypes or phone calls with RN3". Do you see that?
A. Yes.

Q.

> "We had a period after the concerns raised by mum when it moved from monthly to weekly consultations with Joel. But by this time, in January, on the back of what Joel himself was reporting with no collateral information from mum or dad, Dr A agreed to put him back to monthly reports by Skype."

Do you see that?
A. Yeah, I see that.

Q. Did you have concerns about that at the time that there would not be sufficient monitoring?
A. I don't recall having concerns at the time as he was presenting as well.

Q. Do you have any reflection on that looking back? I appreciate that it was Dr A's determination as to how frequently the appointment should take place. Is that right?
A. That's right, yes.

Q. Do you have any reflection on that now yourself in terms of the complexity of this patient and whether that was sufficient?

A. Very difficult to again speculate on what could have been. Hindsight's a very valuable thing. Looking at the notes, it can - it does look, you know, that there could have been other things done or more concern or more follow up.

Q. There was a complexity to this picture, wasn't there, because mum was reporting these very serious concerns and Joel was presenting in a different way, correct?
A. Correct.

Q. When you reflect on it now, do you think that more should have been done to follow up mum's concerns, given how important she was in his treatment?
A. Yes.

Q. On 30 January, so that's the next month, there's a note from you, RN3, it says:

> "Phone call to Joel, as he requested, trying to find out information if Clozapine has damaged his body's temperature. 'With my body, I'm hot. I feel hotter than I used to, or if I'm cold, I'm colder than others. I feel hotter or colder than I used to'. He was questioning if there was a damage to his temperature centre in his brain and requesting further support and information from us about that".

You discuss that with Dr A, you can see in the plan. Firstly, did you at that stage think that that might be evidence of some form of psychosis or paranoia by Joel?
A. I don't recall that I did because he always did talk about his physical flu like symptoms, cold like symptoms comes up a lot in his presentations and, and in the clinical notes, and I think I just listened to his concern that day. I do have some memory about that conversation, and I thought it was actually a valid question, as Clozapine does have effects in the thermoregulation, the body's temperature.

Q. Even though he was not on the Clozapine at that time?
A. Well, I just still thought it was a valid question.

Q. So, appreciating Joel's not a doctor and he might have thought at that time the fact that I was on Clozapine previously, has it damaged me?
A. Yes.

Q. That's what you took him to mean?
A. Yes.

Q. Is that right?
A. Yeah.

Q. And did Dr A raise with you anything differently?
A. Not that I recall, no.

Q. That was 30 January - excuse me for one moment. At that time Joel was

raising or asking for ways to get assistance with housing in Brisbane. Correct?
A. Yes.

Q. It was clear, at that stage, that he was looking to move?
A. He had discussed that, yes.

Q. Was there any discussion that you had at that time with Dr A about how to manage any move?
A. I don't recall there was.

Q. You would have thought at that time that regardless of how Joel was presenting over the telephone, he needed to be followed up and managed and monitored?
A. Yes.

Q. On 12 February 2020, there's a consultation note. He presented for face to face because he was still living in Toowoomba at that stage and had not yet found a place to live in Brisbane?
A. Yes.

Q. It's clear then that although Joel stayed in Toowoomba, his mission to move to Brisbane was still on foot?
A. It was his plan.

Q. And again, was there any discussion either with the mental health staff or any allied care about, or Dr A, about transitioning him if he did move?
A. No.

Q. Had you ever had another patient at The practice who had transitioned to outside the jurisdiction?
A. I had one that I recall.

Q. Do you recall what condition that person was suffering from?
A. They'd been bullied in the workplace to a point of severe distress and anxiety and depression.

Q. Were they still suffering from some of those symptoms when they moved out of the jurisdiction?
A. They had done a - they had recovered well with therapy.

Q. Was there a need to transfer them to another service or not?
A. It was - the focus there was - the answer, no. No, not to another service, but to have a new GP where they were going to.

Q. Is it fair to say that you had not had - prior to Joel, you hadn't had another patient who had previously been on the Clopine program who was moving out of jurisdiction?
A. That’s right, I didn’t, yep.

Q. So, you'd never had any experience previously of a patient who needed to

have follow-up, who then moved out of the jurisdiction?
A. That's right.

Q. On 14 February, there's a note from RN2. Do we take it then that you were away for a period of time, otherwise Joel would have seen you?
A. I was on leave from 17 February to 1 April the - following year. In the same year, April.

Q. When was the last time that you saw Joel face to face?
A. 12 February 2020.

Q. Did you have any phone call with him after that time?
A. I don't - I - no.

Q. Did you have an expectation on 12 February that you would see Joel again?
A. Yes.

Q. When did you expect to see him again after 12 February?
A. He had an appointment booked with me for 2 April 2020.

Q. You did not expect that he would have moved to Brisbane in that time. Is that right?
A. That's right.

Q. When you came back to work, did you review the notes that had been taken with respect to Joel in your absence?
A. Yes.

Q. Do you see there then that on 14 February, RN2 receives a phone call from Michele. It's just two days after you had spoken to him, and Michele called to express her concerns about Joel's functioning at home and his probable moved to Brisbane. She talked about his poor self-care. She said that he was getting annoyed, that he gets irritable and had sworn recently. Just pausing there, if you had received a phone call from Michele at that time to say that her perception was that Joel had poor selfcare and was getting irritable and had sworn recently. Would you have had concerns that they may be symptoms of a decline in mental health?
A. I still would have supported Ms Cauchi on her views on what she noticed as breakthrough symptoms or, or changes in his behaviour.

Q. Would that have been assigned to you that Joel needed to be seen again face to face as soon as possible?
A. Yes.

Q. When you came back and you read the notes, you will have seen notes from Dr A. Is that right?
A. Yes.

Q. There's a notation from you on 17 March if you can just have a - or it

appears to be on, if you have a look at page 19?
A. No, I was not at work on 17 March. I think this is where the Genie system isn't accurate. I would - I get - I am guessing that he had an appointment booked in with me on 17 March whilst I was on leave and that remains in the Genie system, even if it, it was a colour coded diary system for nurses or doctors, different appointments and then if that appointment was cancelled, the names stayed there but the, it, it would say that it was cancelled.

So, I couldn't have written anything that day because I was actually not at work, I was on leave at that time, and these are notes by administrative staff that appear where it says "Clinical 10.53am". I, I don't actually understand the Genie computer system, but I do know that I wasn't at work on that day.

Q. You were at work though on 2 April, is that right?
A. I returned to work on 1 April.

Q. On 2 April you had expected to see Joel, is that right or you had an appointment booked--
A. He, he had an appointment booked for 2 April, yes.

Q. Were you expecting to see him face to face?
A. So, I'm - the appointment could not have been face to face because at that time that's when COVID-19 had made major ramifications to how everything functioned throughout the world. And I had - I was coming back to work, I don't recall how the conversation came back but I was told to work from home from 1 April which was my first day back at work, and so whether there had been pre - conversation, me preparing to come back from work and what was the situation. I have no records or recall on - but I must have spoken to someone that I was going to be working from home and also the computer system had to be accessible, remote dial-in, remote access from my home. So, all my appointments from then on were face to - sorry, were not face to face, they were phone calls and Skype.

Q. Did you have a set up at home at that time in April 2020 which included making Skype calls to patients?
A. For patients that I had already had Skype appointments with, they were already set up in the system, yes.

Q. Did you have a system of Skype calls set up with Joel prior to that time?
A. No, I did not because we had never had a Skype.

Q. Could you set up other patients that you had with Skype once COVID-19 hit?
A. Could have, yes, yep.

Q. You came back on the 1 April, you were expecting to see Joel on the 2 April. What happened in relation to that appointment?
A. I think I would have read the clinical file. I tried to read the clinical files prior to seeing all of my patients that were booked in. And I can't recall if I had been told that Joel had been discharged whilst I was on leave or I read it. I have no

memory of how I found out. I may have had a conversation with admin staff during the setting up of working from home, but I have no notation or recollection of how I knew that he had been discharged on 19 March, according to the GP letter. And - sorry, I lost my train of thought.

Q. It's fine. If you read the notes in preparation for seeing Joel, do you think that you will have read the note from RN2 that Michele had called to express her concerns about Joel functioning at home and his issues with irritability and swearing and mess?
A. Yeah, I believe I would have read back to when I had last had engagement with Joel.

Q. That would have given you some concern about his mental health functions at that time?
A. Probably, yes.

Q. Then you would also in accordance with your practice have read the note from Dr A to say that she had seen him on Skype and he was well groomed with good hygiene and no tics and mentally good at that time, correct?
A. Yes.

Q. In spite of what was written by Dr A, would you have wanted to see Joel yourself by Skype or over the phone to continue monitoring him?
A. I think that's hypothetical because he'd been discharged.

Q. Sorry, put the hypothetical to one side. I'm asking you about your, relying on your clinical knowledge. He was a patient you'd had something to do with for a considerable period of time. He was a patient who'd been on Clopine and was then had been diagnosed with treatment resistant schizophrenia and had been managed well on medication and mum had raised concerns. He was somebody who required ongoing follow up, wasn't he?
A. Yes.

Q. So you would have wanted to continue to see that patient had you had the capacity to?
A. I was surprised that he was discharged.

Q. Did you raise that at all with Dr A?
A. No recollection of raising that.

Q. At that time you had not had a previous experience of a patient who needed ongoing follow up who'd moved out of the jurisdiction, but Joel was a patient who needed ongoing follow up, wasn't he?
A. Yes.

Q. That was psychiatric follow up that he required, correct?
A. Yes.

Q. You understood that a referral letter had been written to the general practitioner, correct?

A. I read that on file.

Q. I'll just bring that up. That's at page 136 of the notes. It was a letter written by Dr A to Richard Grundy. Did you understand that Dr Grundy was a GP who was in Toowoomba?
A. Yes.

Q. When you read that letter - I appreciate you didn't write it - but did you have any concerns about it?
A. I can't recall specifically, but I think I did.

Q. Why do you say that?
A. Because there appeared to be no planned follow up, no ongoing follow up organised.

Q. When you read it now, are you also concerned that there's no indication in there for the GP that Joel's mother had raised those very significant concerns about a possible decline in mental health?
A. Yes.

Q. Do you read that now and have some concern that the referral is to the GP in Toowoomba when in fact Joel had moved to Brisbane?
A. Yes.

Q. Was there any discussion that you had around that time with Dr A about those concerns?
A. No, I don’t believe I had any conversations at that time, after that time.

Q. Were you aware of a network like the Practice, a primary mental health network completed with a psychiatrist that Joel could have been referred to in Brisbane?
A. No, I didn’t know of another PHN funded mental health nurse care program, but I did know of another nurse who worked in a GP practice and I think it was under that model, but I think it was a different set up. But I didn’t know much about it.

Q. Is it fair to say that there was no investigation that you're aware of at The practice as to a similar set up that Joel could have been referred to in Brisbane?
A. Yeah, I had no knowledge of one, no.

Q. I'm going to ask you then now, nurse, for your reflections about Joel's care. It appears that for a considerable period of time at The practice Joel received good clinical care where he was being medicated on antipsychotic medication and regularly followed up by a psychiatrist and mental health nurses, is that fair?
A. Yes, yeah. I thought that the mental health nurse care program was an excellent opportunity for people with mental health issues of a severe nature to have free support and monitoring.

Q. There was a system in place where Michele Cauchi could convey the information that she needed to by way of email or telephone, correct?
A. Yes.

Q. And face to face consults as well on occasion?
A. That she joined with Joel?

Q. Yes.
A. Yes, yes.

Q. I see. So, you're not aware of any separate consults that were had with Michele Cauchi, but she could attend with Joel?
A. She could attend with Joel, yes.

Q. So, there was a flow of information that was possible from Michele Cauchi to the clinic, correct?
A. Yes.

Q. And then when she started reporting her concerns from October 2019, they were recorded in the notes, correct?
A. Yes.

Q. There was a period of time where they were taken into account, and there was a suggestion that Joel go back on his antipsychotic medication and have more regular follow-up, correct?
A. Yes.

Q. But from the time that Joel moved to Brisbane, he was effectively lost to the mental health follow up, do you agree with that?
A. Yes.

Q. You must have thought about this case very deeply and often since you found out about the tragic events of 13 April?
A. Yes.

Q. You were in court earlier when your colleague RN2, was asked about her reaction when she found out that Joel was the one who had caused these terrible deaths? And I'm sorry to upset you nurse, but do you feel able to tell us what your response was?
A. Yes. So, on the day my phone gave me a notification and I just sort of saw a headline and went, "Oh, that's too traumatic", and I just wiped it off my phone. I didn't want to know about it on the actual day. And then I think it was the next day that RN2 rang me, and I was outside gardening. And then she told me, and I just was quite shocked, and I was outside and I had to find my steps, the steps to my laundry to sit down. And--

Q. What - sorry, please go on.
A. Yeah, and I think I just sat there while she was on the phone to me.

Q. Was that the general reaction - I withdraw that. Did you speak with other

staff at The practice about it?
A. At that time, no. But my thoughts went to all the people who knew Joel. The Joel we knew was not the person who did what happened on 13 April, and so we were all very shocked that what happened happened and that the person that we had spent time with could do that.

Q. Is it your view that if Joel had remained medicated and mentally well, he would not have been capable of committing this terrible travesty?
A. I guess so, yes. I think so, yes.

Q. You understand that the coroner has power to make recommendations to try and prevent deaths. Do you agree that looking back on Joel's transfer to Brisbane, more should have been done to ensure that there was follow up psychiatric care wherever he went?
A. It's very, very hard. You know, people do get lost follow up, you know, from time to time. With hindsight, things could have been done differently, with reflection.

Joel was wanting to get on with his life that had been in a hiatus for some time. He was looking to use his TESOL qualifications. This was a man who had come off medication, still managed to get high distinctions in his studies. He learnt I think about six languages that he could speak. He could do that, but he didn't have ability to manage his activities of daily living or to know how to speak to women or to socially speak to most people. All those things had been stunted through his illness. And I could see that he wanted that autonomy to have that freedom to live his life, but the illness was always going to be there that would have an impact on him.

And I don't know how you can make somebody who continually presents well and was seen by other doctors after he was discharged from The practice as I can see from the clinical notes for requests from collateral from other doctors that Joel had sought to see, and he still presented well. There was still no evidence to those medical people.

Q. But when he was presenting well to those medical people, they were one off presentations, and you know that people with schizophrenia can mask their symptoms?
A. Yes, yes.

MATHUR: There's just an objection because the presentations weren't one off to all of the clinicians. For example, Dr Ruge, there were 12 consultations. Just in terms of the accuracy of that proposition.

HER HONOUR: Yes.

DWYER

Q. In terms of the psychiatric presentations, to the two psychiatrists, they were one-off, do you understand that?
A. From, from the clinical notes?

Q. Yes.
A. Is all I know.

Q. So, you don't believe that it was sufficient for Joel in terms of follow-up to have a one-off consultation with a psychiatrist from time to time, do you?
A. Not sufficient.

Q. You understood when he left The practice that he would require regular follow-up?
A. Yes.

Q. From a psychiatrist?
A. Yes.

Q. You agree that he effectively became lost to the system after he left?
A. Yes, I do

Q. You understand that Joel had what is known as treatment-resistant schizophrenia?
A. I don’t recall reading in the clinical notes of treatment-resistant schizophrenia.

Q. You realise that he had been put on Clopine because he had not responded--
A. Yes.

Q. --to the first line treatment for schizophrenia?
A. Yes.

Q. So, he had a severe form of the illness, correct?
A. I did not ever see his clinical records prior to him coming to The practice.

Q. For most of the period of time that you were involved with Joel, he was treated with Clopine, correct?
A. Yes.

Q. You understood that to be a form of medication, antipsychotic medication, which is only used after other medication is trialled?
A. Yes.

Q. Because of the serious risk of side effects?
A. Yes.

Q. You understand that people suffering from schizophrenia, or that form of schizophrenia, who have been trialled on Clopine for a period of time will be at risk of relapse? That's your earlier evidence?
A. Yes.

Q. That's a reason why you need close follow up, correct?

A. Yes.

Q. For Joel, having suffered that condition, in circumstances where his mother from October 2019 was reporting serious signs of possible relapse, it was particularly important to ensure that he had follow up, do you agree with that?
A. Yes.

Q. So, I want to ask you from your expertise, what more do you think could have been done to explore better psychiatric follow up for Joel in Brisbane and ensure from the time Joel said he wanted to leave that there would be a safety net for him in Brisbane?
A. So, there could have been phone calls to the primary health network to ask what they knew of what was available in Brisbane. There might have been, you know, word of mouth to ask if anybody knew of any other service available in Brisbane. I'd like to think that if I wasn't on leave that I, on reflection or with hindsight, that I might have continued to do that exploratory work. But that's speculative.

Q. You're relying on your general practice though in terms of your concern for patients and the need for follow up, you'd like to think that you would have identified another service where there was a psychiatrist and mental health nurse working together?
A. Some sort of mental health follow up if it was in the, like the public community.

Q. In those circumstances, I take it you would write a letter to that service from your side of the equation, from the mental health nurse perspective, is that right?
A. Yeah. There would've been maybe phone calls initially to find out who, and what, and where, and, and then formalising that with a letter.

Q. Do you agree that best practice would require a handover to a mental health nurse, from your perspective, and then Dr A would do a handover to a psychiatrist, from her perspective?
A. I'm not sure. The - once the psychiatrist discharges the patient they're discharged from the mental health nurse care program as well.

Q. Would that prevent a discharge letter being written by the mental health nurse?

ROBB: Your Honour, if I could just - I'm just not sure that we've identified at any point a receiving service for such a letter.

DWYER: I'll withdraw that.

ROBB: We've identified it would be a desirable, but not that it's possible.

HER HONOUR: Yes.

DWYER

Q. You said that you'd like to think that if you were on deck and not on leave at the time that Joel was discharged, you would've tried to identify a service which had a psychiatrist and a mental health nurse working together. Is that right?
A. Some sort of mental health service. I don't know that it would've been a program similar to The practice, or it would've been a public system, which - whether they would accept him - that they could take on new patients. Like it's hypothetical, or it's speculative.

Q. It's speculative because is it the case that you still don't know whether or not that exists in Brisbane at this time?
A. Yes.

Q. Have you made any inquiries since as to whether or not such a system does exist in Brisbane?
A. No.

Q. There are clearly psychiatrists in Brisbane. Correct?
A. Yes.

Q. And there are clearly mental health nurses in Brisbane. Correct?
A. (No verbal reply)

Q. And GPs, of course?
A. Yes. Yes.

Q. If this situation presented again, is it the case that the onus would be on the psychiatrist to do a handover of the patient?
A. There should be better continuity of care steps.

Q. We'll hear from Dr A tomorrow, but we know that when Joel was discharged he was discharged into the care of the general practitioner in Toowoomba, rather than any service in Brisbane?
A. Yes.

Q. Can we ask you for your expertise in saying what would be best case scenario if the system was set up to provide for continuity of care?
A. I don't know. I think - like Joel had to agree to being referred to someone else. He was under the Mental Health Act. We, we did not have patients under the Mental Health Act, but I would've encouraged, you know, he was encouraged by the admin staff to notify The practice of his new GP. Reading the clinical notes, I don't see that that happened.

Q. Can you see the difficulty of leaving that up to the patient who may well be becoming unwell?
A. I think it should be collaborative, that if someone is discharging and relocating that there would be steps made to work out the best support and, and follow-up that could be arranged.

Q. Do you agree that there could've been a follow-up call from staff at The practice to Joel--
A. Yes.

Q. --to find out who his GP was in Brisbane, and to advise him of the services available in Brisbane?
A. If the - if he hadn't been closed on the system, so - but because he was discharged by the psychiatrist and he was discharged off the nursing program. But if there could've been opportunity to work towards, "Well who's going to follow you up when you relocate in Brisbane", that could've been definitely conversations.

Q. Thank you nurse. Those are my questions.

HER HONOUR: I note the time. We might have to stop here. I imagine there'd be some questions that might take some time. Unfortunately, we'll have to go over till tomorrow. We'll adjourn till 10 o'clock.

DWYER: Yes, Your Honour. Would you excuse me for one moment?

HER HONOUR: Yes. Sure. I'll just take five minutes and just see how much time might be required.

SHORT ADJOURNMENT

HER HONOUR: Ms Chrysanthou?

<EXAMINATION BY MS CHRYSANTHOU

Q. Thank you for staying back to finish your questioning. My name is Sue Chrysanthou, and I think you've already heard that I act for some of the families. You've already been asked quite a lot of questions about your interactions with Joel in November 2019. Thinking back and having reviewed the notes, do you agree that he had a pre-occupation in that period, October, November, December, January 2019/2020 with his sexual function?
A. He had an interest in his - having relations with women, sexual relations. Yes.

Q. That was new, wasn't it? That hadn't been something he discussed with you a lot prior to mid-2019?
A. That's right.

Q. You understand, don't you, that one of the side effects of the anti-psychotic drugs that he had been taking for many years was potential impact on libido?
A. That's right.

Q. And sexual function?
A. Yeah.

Q. And by coming off the drugs this was a part of his life that he had

discovered. Isn't that right?
A. Yes.

Q. One of the reasons he didn't want to go back on the anti-psychotic drugs was because he didn't want to lose out on that new part of his life. Isn't that correct?
A. That was one part of it.

Q. To your knowledge?
A. Yep.

Q. Were you concerned, knowing that, that he was hiding his symptoms from you because of his pre-occupation with continuing that new part of his life?
A. I wasn't aware that he was hiding any symptoms from me. I just saw that - his presentation as I saw it.

Q. You agree, don't you, his presentation, in your presence was very different to what his mother was reporting. Wasn't it?
A. Yes.

Q. Did you suspect, given the drastic difference between what his mother was reporting to you and his presentation to you, that he was hiding his symptoms?
A. No.

Q. Did you think his mother was deluded as to her statements to you as to what was happening at home?
A. No.

Q. Why did you not consider that he was misleading you as to his symptoms?
A. I valued what the mother's input had to say as she was someone who'd seen him when he was unwell and she had care and concern and closely supported her son. On his presentations with myself and my colleagues, he presented well. There was no overt, psychotic signs and symptoms. So my reaction to him restarting his medications was based on his mother's concerns.

Q. How did you justify, in your mind, his presentation to you compared to, for example, the satanic notes his mother had reported to you she'd found around the house?
A. How do I justify?

Q. Yes. How did those two different pieces of information, how did they make sense to you?
A. I've worked with a lot of patients who do a lot of writing that have permanent illness - symptoms, but that's kind of like things that are going on in their head, but they're not actually outwardly expressing those in their day to day behaviour. They're still able to manage day to day activities.

Q. Prior to mid-2019 you had not had similar reports as those we've heard about all day from Mrs Cauchi, had you?
A. That's right.

Q. Prior to mid-2019 Joel had not told you of any hallucinations that he was having, had he?
A. That's right.

Q. He had not told you of any voices that he was hearing?
A. Denied voices.

Q. He had not expressed any desire for violence, had he?
A. He had not.

Q. And he had not expressed, I think you've agreed, any pre-occupation with his sex life?
A. I wouldn't use the words pre-occupation with his sex life.

Q. I'm putting to you that that's what he was exhibiting to you by November 2019, a pre-occupation?
A. It was just one part of his whole lifestyle.

Q. Did he tell you about his concern that he had contracted STIs?
A. He was embarrassed to tell us initially, and then when he did, he was - said he was embarrassed to talk about that with us - with Dr A and myself.

Q. On the day that you saw him with the doctor, which was on 28 November, did he tell you that on that same day he had gone to a clinic in order to store his semen?
A. No.

Q. He didn't tell you that at all? That he was concerned that he was going to become infertile?
A. I have no recollection of that.

Q. If he had reported to you something like that, would that have been something that would concern you?
A. Is that a hypothetical?

Q. Yes?
A. Did it happen?

Q. Yes?
A. I have no recollection of it.

Q. The same day he saw you, on 28 November, that same day he sought his semen because he had a concern that he was going to become infertile and that was necessary?
A. Where's this written?

Q. It's in the fertility clinic documents, and based on a referral from his GP who reassured him that he had no condition which would cause him to become infertile at that time?

A. So that's the first time I've heard that information.

Q. Yes. I'm not suggesting you've otherwise heard it. I've asked you if you've heard it and you've said no. I then asked you if you had been told that whether that would have been of concern to you?
A. Possibly.

Q. I know you didn't write the notes on 17 March that you've been asked about. If they could just be shown quickly at tab 793 on page 19. They appear to be an administrative history of communications with Joel. You read these, didn't you, when you reviewed the file when you came back from leave?
A. Yes.

Q. It says "Actioned by the Receptionist." Does that mean that the Receptionist is the person who wrote all these notes?
A. Correct.

Q. Was she just someone at the front desk at the clinic?
A. Correct, she was administrative staff.

Q. Did you notice on the 17th of the third that she recorded that he didn't have a new GP in Brisbane, but he would advise the office if he did?
A. Sorry, I missed that last bit.

Q. Did you notice that first record on 17 March that there would be--
A. I would have read it, yes.

Q. To your knowledge, did anyone in the office take any steps to follow that up?
A. I'm not aware of that.

Q. Is it your evidence, and I just want to make sure I understood it, that there was no follow up because he was officially recorded as discharge from the clinic?
A. That's right.

Q. To your knowledge, were there any steps at all taken, prior to 17 March, to make any inquiries at all as to a new GP or a new psychiatrist for him in Brisbane?
A. I was on leave, so it's only what's written in the clinical notes.

Q. So, to your knowledge, nothing. No inquiries at all?
A. That's right.

Q. In relation to that discharge letter that you saw on 19 March, and you saw it at the time, I think you said, but you didn't raise any concerns. Do you agree that any subsequent provision of notes to the two psychiatrists that later sought Joel's notes should have included the interactions between Joel and the clinic in October and November and December 2019 and in January and February 2020?

A. I don't see that as part of my scope of practice my role. He had been discharged, so that was the end of his - what I had been involved in.

Q. If you were a psychiatric nurse, first meeting with Joel in November 2023, would it have been relevant to you to know the reporting of Joel's behaviour shortly after he was taken off antipsychotic medication, having been on it for 15 years?
A. 2023, and he was discharged in 2020?

Q. Yes?
A. I'm not aware that I would be - the records were, the clinical file would be closed. I wouldn't be seeing anything and hadn't seen anything until I had access to the notes again.

Q. But I'm asking you, if you were seeing Joel for the first time as a new patient in 2023 as a psychiatric nurse, would having the full record of his interactions with the clinic, particularly after he came off the antipsychotic medication, have been helpful or relevant to you in treating him as a new patient?
A. Would be helpful.

Q. To your knowledge, insofar as your review of the records is concerned, the only things that were sent to the new psychiatrist, the only files that were transferred were a handful of letters that were sent to the GP. Is that your understanding?
A. That's what I can see from the clinical records.

Q. The full clinical records were not provided to the new psychiatrist?
A. Correct, yeah.

Q. Isn't that right?
A. Yes.

CHRYSANTHOU: No further questions.

HER HONOUR: Any questions?

SPEAKER: No questions, your Honour.

SPEAKER: No, thank you.

SPEAKER: No, your Honour.

MATHUR: No, your Honour, thank you.

SPEAKER: No, your Honour.

LYNCH: No, your Honour.

HER HONOUR: Anyone in court 2?

CALLAN: No questions, your Honour.

JORDAN: No questions, your Honour.

CASSELDEN: No questions, your Honour.

JORDAN: No questions, your Honour.

HER HONOUR: Thank you. Yes, Ms Robb.

ROBB: Very briefly just one question.

<EXAMINATION BY MS ROBB

Q. You were asked some questions about hypothetically what you might have done in a perfect world, had you been at work at the time that Mr Cauchi was discharged and I think you gave some evidence to the effect that you could have done some of your own leg work and maybe made some calls and used your own networks to find out if there might have been a service that might have been able to provide some sort of analogist to him elsewhere.
A. Yes.

Q. Am I to take it from that that there was no established pathway by which a nurse could refer a seriously ill patient with a diagnosis of a major mental illness to another nurse at a different catchment?
A. Yes.

HER HONOUR: Thank you, Ms Robb. Anything arising?

SULLIVAN: No, your Honour.

HER HONOUR

Q. Thank you very much, RN3. It's been a long time giving evidence, so I appreciate your patience.
A. Thank you.

NO EXAMINATION BY MR FERNANDEZ, MR ROFF, DR FRECKELTON, MR CHIU, MS CALLAN, MR JORDAN, MR CASSELDEN, MS CLARKE, MR GNECH, MS MATHUR, MR PEN, MR WILSON AND MR LYNCH

<THE WITNESS WITHDREW

DWYER: Sorry, your Honour. That completes the witnesses for today, your Honour. We'll start again at 10am tomorrow. We're sitting late tomorrow until 4.30pm.

HER HONOUR: Thank you, we'll adjourn.

LTS:DAT

ADJOURNED PART HEARD TO TUESDAY 13 MAY 2025