LTS:DAT

IN THE NEW SOUTH WALES STATE CORONER'S COURT

STATE CORONER O'SULLIVAN

TUESDAY 13 MAY 2025

2024/00139002 - BONDI JUNCTION INQUEST

NON-PUBLICATION ORDERS MADE

PART HEARD

AUDIO VISUAL LINK COMMENCED AT 10.06AM

HER HONOUR: Good morning. Dr Dwyer?

DWYER: Your Honour, just before I call the next witness, I note that yesterday, there was evidence given by RN2 of the existence at the practice of a hard copy grey book which recorded the weekly team meetings. That book should be retained by the practice in accordance with the obligations of record keeping. Inquiries have been made with the current practice manager. We're grateful to those who appear for Dr A for making those inquiries. It doesn't appear that that book can be located. A formal subpoena has been issued in relation to those books, and of course some questions can be asked about them today.

HER HONOUR: Yes. Thank you.

DWYER: Your Honour, I call Dr A. Dr A has prepared two statements to assist the Court. One is dated 7 June 2024, and there's a supplementary, 12 March 2025. They appear in vol 19, tab 790 and 791.

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<DR A, SWORN (10.07AM)

HER HONOUR: Just a reminder to the media that there is a non-publication order over the doctor's name.

WITNESS: Your Honour--

HER HONOUR

Q. Have a seat, thank you.
A. I am--

Q. Is there something you'd like to say?
A. I am Dr A, and I am here today as a former treating psychiatrist of Joel Cauchi, the attacker responsive for the death of Pikria Darchia, Ashlee Good, Dawn Singleton, Faraz Tahir, Jade Young, Cheng Yixuan, and the ten other people injured in the terrible attack on April 13, 2024, in Bondi, Sydney. I understand the gravity of these proceedings and will do my best to provide an accurate and truthful information to assist the Court.

I would like to say to the victims, their families, Joel Cauchi's parents, friends, and everybody, that I offer my sincere apologies to you, that this tragedy has happened. I wish to acknowledge the profound pain, grief and lasting trauma that has, and will be, endured by everyone impacted in this devastating attack. I am aware that no words will ease the profound pain, suffering and grief felt by myself and everyone involved.

As Joel's previous psychiatrist, I am sharing the pain. It has devastated me personally, and an enormous effect on my life and health. No psychiatrist would wish for themselves this trauma. We all have the strong desire to understand how this even could have happened. As a psychiatrist with decades of experience in treating patients with mental health condition, I fully support investigating the reasons that led to this terrible act of violence. There are no simple words, answers. Schizophrenia is a chronic and severe mental disorder, and symptoms can change over time.

Q. Thank you. Now there'll be some questions from senior counsel assisting for you.

DWYER: Your Honour, the doctor's third statement is found at tab 791A.

<EXAMINATION BY DR DWYER

Q. Dr A, no doubt, as Joel's treating psychiatrist for around nine years, you are also keen to learn whether or not there were any opportunities lost to have prevented this terrible atrocity. Do you agree?
A. Eight years, and I'm keen. I'm helping with my truth.

Q. I'm going to ask you some questions in this order. Firstly, your background and training. Secondly, the setup of the practice now and previously. Thirdly,

your treatment of Joel over those eight years or so. Fourth, your discharge of Joel when he moved to Brisbane. Fifth, the discussions that you had with any general practitioners, or other doctors, who treated Joel afterwards. And then finally, your reflections about anything that you think can be learnt from a review of the circumstances of Joel's treatment.
A. Thank you.

Q. If you need a break at any stage, will you please let the Court know?
A. I will.

Q. Can I start then with your background. Where were you born?
A. I'm born in, in Europe - Hungary, and--

Q. You got your medical degree, I think, from Semmelweis University in Hungary?
A. University in Budapest.

Q. You did then your fellowship in psychiatry in Australia in 2003. Is that correct?
A. Three. That is when I finished my training. I was a physician before in Hungary.

Q. You were a physician, did you say, in Hungary?
A. Physician. General medicine.

Q. You have kindly attached your curriculum vitae to your first statement. I won't go through it all--
A. Thank you.

Q. --but in short measure, you worked in New Zealand when you left Hungary. Is that right?
A. Yes.

Q. You went to New Zealand in 1991, and am I right--
A. 1991 December. Yeah. Yeah.

Q. Am I right that you specialised in psychiatry from around 1994?
A. Yes. Started the training, yep. 1995, and finished in - become a consultant psychiatrist in 2003.

Q. When did you move to Australia from New Zealand?
A. 2006, from Auckland to Toowoomba.

Q. When you first moved to Australia you worked for the Darling Downs District Mental Health Service for about a year. Is that right?
A. I was the clinical director.

Q. That's the public mental health--
A. Of acute, acute mental health - acute community mental - acute community services. Yeah. In--

Q. That's the public mental health--
A. Public mental health system.

Q. Did you do that job as the Director of the Darling Downs District Mental Health Service for about a year?
A. Yes. Acute mental health. I wasn't - nothing to do with Baillie Henderson.

Q. I'm sorry, I missed that--
A. Baillie Henderson is the extended rehab. Nothing to do with that.

Q. Baillie Henderson, which is the name of a hospital in Toowoomba. Is that right?
A. Yes. Yeah. It's the, it's the old asylum, which become extended rehab.

Q. In the Darling Downs Acute Mental Health Service, you would obviously have come to treat people having an acute episode of psychoses?
A. Many.

Q. Many of those persons were found to be suffering from schizophrenia. Is that right?
A. Yeah.

Q. No doubt it was a significant part of your training to become a consultant psychiatrist to understand the best treatment platforms for people with schizophrenia. Correct?
A. Of course, and still.

Q. I'll come back to the treatment for persons suffering from schizophrenia and the variations that can take shortly. But to finish off on your experience, you worked at St Andrew's Private Hospital from 2007 to 2011. Is that right?
A. Yes.

Q. Where is St Andrew's Private Hospital?
A. St Andrew's Private Hospital is a general hospital in Toowoomba, and they have a 20-bed psychiatric unit, acute psychiatric unit, where people can be voluntary private patients.

Q. What was your role there?
A. I was a VMO, visiting medical officer. So basically, worked during the day, and afternoon, I went up to the ward and saw my patients and go home.

Q. In 2011 you set up the practice, is that right?
A. The practice, which is a standalone private clinic, which is in the CBD that we started after the floods in January.

Q. Your husband Mr A has a role there, is that right?
A. Yes.

Q. What's his role?

A. He is a director. He, he is the - he, he renovated the place. He is the - he, he, he does the financial side and a little bit of supervising the practice manager, who is the front of the house. And also delivers the - at that time it was, it was a federal government incentive, it's called the Credentialed Mental Health Nurse Incentive, and it was taken over by the PHN in 2016, and we no longer needed credentialed mental health nurses. We had a year of peer support in 2019/20, which we lost, and now the PHN now totally disembarking, dismantling that, and, and talking about the living hub which is going to take place, and maybe we won't have nurses working with me.

And the nurses were working with me because in that case, in Toowoomba, always been, until 2020 July, area of need for psychiatrists. We didn't need - we didn't have enough psychiatrists. So, by having nurses, I could have seen more patients in the private practice, because they were extremely, extremely skilled nurses. We saw yesterday the two best. RN2 is a mostly graduate, cognitive therapies, DVT therapies. RN3 has vast experience as a nurse and, and worked since, since 18 as a nurse, and he had - she had special skills in, in other part of the talk therapies, iRest meditation, mindfulness. Lovely skilled - skill base we had with the nurses. So, they are more medical people than psychologist. They can monitor--

Q. I'll come back to the setup of the practice.
A. Yeah, yeah.

Q. If you just excuse me for a second, Doctor, I've got to go through some of the rest of your history.
A. And I answer that, yes.

Q. But you've told us something important about the setup of the practice, and the way it changed because of government funding. So, I want to come back to that shortly. You set up the practice in 2011 - sorry 2000 - yes, 2011. Your CV indicates that you also worked at the Caloundra Private Clinic from 2013 to March 2020?
A. Yes.

Q. Is that right?
A. Yes. I, I made sure that my week was, was broken up with some other places, because - to get away during the weekend to the coast. So Sunday, Monday, Tuesday I was working as a VMO at the Caloundra Private Clinic, which is Ramsay, and basically visited patients. I had another psychiatrist who was part-time, and we, we beautifully shared the same patient load. We agreed who is the primary psychiatrist, and we, we managed patients without any complaint together.

Q. So Sunday, Monday, Tuesday you were at the Caloundra Private Clinic from 2013 to March 2020?
A. Yes.

Q. And when were you at the practice?
A. Okay. Monday - Sunday, Monday, Tuesday I was in Caloundra, and

Wednesday, Thursday, Friday, Saturday and Sunday morning in, in Toowoomba.

Q. Do you mean you worked seven days a week through that period of time?
A. Basically. Saturday - I mean seven day a week in terms of not just. I saw outpatients during weekdays, but inpatient during weekends too.

Q. You didn't have one day off during that period, is that right?
A. No. But it was - I mean, seeing inpatients, it's just a breeze, you know. It is, it is - to, to me is not work.

Q. Where were you seeing the inpatients?
A. In St Andrew's Private Hospital after I finished my outpatient clinic, and Sunday afternoon when I arrived in Caloundra I went and saw my patients, and Monday, Tuesday I saw them.

Q. So if you had patients at the practice who needed to go to hospital for a period of time to become inpatients, which hospital would you send them to?
A. I always respected their preference, because we don't--

Q. No, no, just answer my question, Doctor, if you will?
A. Yes.

Q. Which hospital did you have an option to send them to?
A. Both hospital.

Q. Which hospitals?
A. St Andrew's, the west ward or south ward, or Caloundra Private Clinic.

Q. So there was St Andrew's and there was Caloundra Private Clinic?
A. Mm-hmm.

Q. And you had visiting rights, did you, in both of those hospitals?
A. Yes.

Q. Was that from 2013 right through to 2020?
A. Yes.

Q. Is that the same situation now?
A. No.

Q. Do you have visiting rights in any of those private hospitals?
A. No. No, since May last year, I stopped doing inpatients. Just doing outpatients.

Q. Since May 2024--
A. Yes.

Q. --you stopped doing inpatients?
A. 2024, yes, last year, yes.

Q. Was there a reason why you stopped doing inpatients?
A. Yes.

Q. Why was that?
A. [redacted]

LYNCH: Your Honour, I hesitate to interrupt, but I'm not clear as to the relevance of this part of the evidence, bearing in mind the timing, and I wonder if my friend could identify how it's relevant.

DWYER: It was actually an answer given by this witness.

HER HONOUR: I think it was the question probably.

DWYER: The question was "Do you have visiting rights". I'm attempting to identify the workload and responsibilities of the witness over the relevant period of time.

HER HONOUR: I think she's said that she's no longer doing inpatients.

DWYER: Okay.

HER HONOUR: It sounds like it's going to be a long answer.

DWYER: Sure. I'll ask it differently.

Q. You indicated that you could send patients to a hospital, a private hospital. You had the option of St Andrew's or Caloundra, correct?
A. Yes.

[redacted]

Q. That's a private clinic?
A. Yes.

[redacted]

Q. All right. Was it your plan then that patients could be sent to that clinic as inpatients?
A. Yes.

[redacted]

Q. Was it just an inpatient clinic facility?
A. It was just an inpatient facility. Downstairs they had psychologists working as well.

Q. So, it was different to the practice?
A. Yes, totally different.

Q. It was for acute - or patients with acute illnesses, is that right?
A. Yes, it was a 27-bed new modern building.

[redacted]

Q. If Joel had needed an inpatient bed at any time when you were treating him prior to 2020, you could have arranged for him to go to St Andrew's Private Hospital--
A. No.

Q. --or Caloundra?
A. No. Because he never had private health.

Q. I see.
A. So only those people who had private health could go to private hospitals. If Joel would have needed any inpatient admission, he would have gone back to the Toowoomba Base Hospital.

Q. I see.
A. Mental health acute care.

Q. Did you have a visiting hospital right at the public hospital system?
A. No, no. I did have short locums, like when they needed me for a week or two or something like that. But, but never had long term credentialing after that.

Q. If Joel had needed to have inpatient care for a period of time, either on a voluntary basis or because he was scheduled, you would have referred him back to the public system and he would have been seen by a different psychiatrist, is that right?
A. Yes, definitely.

Q. Can I come back to the practice that you were telling us about. It was set up in 2011. Was it set up by yourself and your partner Mr A because of a government initiative that was being offered at the time?

A. No, there was no government initiative. It was that I was, I was renting a room in, in the St Andrew's Private Hospital, and it was small. So it was just a small room. And I - we found a nice place, an art deco place. My husband renovated it, and I moved in, in there. And we had applied, tender, for the credentialed mental health program, which it, it was really handy, so we worked with nurses so I could see more patient, and that was purely that. And the patient could have had medication management, talk therapy in one place, a one-stop shop.

Q. You talk about a credentialed mental health nurse?
A. Yes.

Q. And at a different point in time there was no longer a requirement for a credentialed mental health nurse?
A. No, no. PHN.

Q. What's the difference?
A. Okay. The credentialed mental health nurse is like a provider who have Medicare provider number. They have, they have to meet criteria. They are regulated more strongly than average nurse. They had to - every year they had to do CPD points to qualify. So they, they were really the top, the top, the cream of nursing. And, and so that when I'm, I'm talking about credentialed mental health nursing, they are extremely skilled people, nurses. And, like, I would say that I regarded them that they were my eyes and my ears. So what they said, I always knew that I could trust. So their, their assessments were spot on.

Q. Sure. I asked you about the difference between credentialed nurses and non-credentialed nurses. I think you explained earlier that at some stage the situation changed so that you could employ non-credentialed nurses, is that right?
A. Yes, so those nurses who were credentialed, they no longer continued the credentialing process, because that was not needed and it was an extra work. Not that they - they had to, they had to provide all the paperwork, it's more red tape like anything else. They did not become less skilled.

Q. When did that change come in?
A. 2016 when, when the PHN came in. And since then it was kind of diluted, diluted, diluted with, with the adding of the peer support work, which I - which we tried for a year, and RN2 was the, was the head of that.

Q. That peer support was from, I think you said 2019 to 2020?
A. Yes, one year we did it. And then we lost the tender to the clubhouse. And currently they are everywhere. They are - there are now peer support workers everywhere, but under different - like one of the biggest one is Richmond Fellowship, the other one is Wellways. They are - they have their peer support kind of Certificate III, IV in mental health. They have their own training.

Q. We heard from RN3 yesterday, and she explained that the mental health

nurse care program was provided by the practice when the practice tendered for that program and won the tender. I just want to understand how the payment setup was. You tendered for the mental health program. Is that right?
A. Not me.

Q. Run by the nurses?
A. My husband. I wasn't involved. So, he, he did it in order to help my job.

Q. Sure, that's fine. Just listen to my questions because we've got to get through the day, and there's other people who want to ask questions after me.
A. Okay.

Q. I understand that you want to tell the Coroner about the program and its effectiveness, and I'm going to give you that opportunity in a second. But you won the tender. Effectively - well, your husband tendered for it, then you worked there as a psychiatrist, and there were mental health nurses who were employed by the practice?
A. Yes.

Q. Correct?
A. Yes.

Q. So, the practice as a business paid the nurses, is that right?
A. The practice is separate from me. Yes, the PHN pays for the nurses, and the delivery of the program is by my husband and practice manager. And, and I think what is right now, they - until - the credential mental health program was more like a case management, so needed much supervision, and I did give the supervision, that's why we had the meetings. But as soon as the, the, the PHN took over, the PHN required the nurses to work out in GP's offices. So, they were more into the community. Not to, not to be owned by me, or not to have the majority patient referred to them by me, they were more kind of community purpose, and right now, what we are tendering now, that would be totally, totally community-focused, even placed in the community in a living hub.

Q. When Joel was being seen at the practice, he would come into the practice and be seen by the nurses there, correct?
A. Yes. They were credentialed initially, and in 2016, they were -noncredentialled PHN, PHN, PHN-funded.

Q. But they still saw Joel in the clinic?
A. Yes.

Q. Or in the practice?
A. They were, they were so-called Clozapine clinic. I had a Clozapine clinic, which was, which was my idea to pay it back to the society, and I'm - I have a very warm spot for people with schizophrenia and the treatment-resistant one, and I wanted to give them the opportunity to come to a private clinic, different atmosphere, different treatment, but the same quality, or even better quality. So, we did try that.

DWYER: Could I have on the screen please, tab 793.

Q. I'm just going to show you an appointment schedule for patients at the practice. By way of example, this is going to - sorry, page 2 of those records. I'm going to ask you about the setup of the records first. Do you see there some examples from 2015? Up the top of the page it says, "[RN2] 30 minutes at 2.30, [Dr A] at 3pm"?
A. Yeah. So, this is what they did. Every month they had to come and see the nurse for taking their observation. The nurse was responsible to put in the white blood cells and the neutrophil count to the Clopine connect. They had to do the metabolic monitoring. So, weight, heart rate, blood pressure, waist circumference, temperature, and during that time they had some chats and, and they return it up, and then I came.

Q. I'm just asking you about the records, but I'll go back a step. You had a number of patients through the practice--
A. Yeah.

Q. --who were on the Clopine protocol, correct?
A. At that time, I had one, two - I took over three Clozapine patient from the mental health Clozapine clinic, including two chronic schizophrenia patient, and, and one - they were just came, you know, I didn't choose, they were the three and, and we, we did three.

Q. When you say "we did three"--
A. Yeah.

Q. --do you mean from what period of - so Joel came in 2012.
A. Yes.

Q. I'm about to take you to his records.
A. Yes, yes.

Q. He was with you until early 2020.
A. Yeah, yeah.

Q. Over that period of time, did you have three patients with chronic schizophrenia?
A. Yes, from, from the public system, and I started one patient who was private patient in St Andrew's Hospital. I started one patient on, on Clozapine and she's still on Clozapine.

Q. In relation to each of the patients that you had who were on Clozapine, was it your setup that they would see the nurse once a month?
A. Yeah.

Q. And you once a month--
A. Yeah.

Q. --as well?
A. Yes.

Q. Were there any other doctors at the practice who were regularly seeing the Clozapine patients?
A. No, no. Just me, because it wasn't required, they were not interested. I had a special interest. But when I went away for holidays, then I - because I went away holidays quite frequently, so I always asked them to look after or, or see my patient with clear handovers.

Q. Sorry, I missed that last--
A. Handovers.

Q. There would be a handover?
A. Handed over, handover. Not like spontaneously.

Q. I'm going to take you to some of the entries made by other psychiatrists, but in terms of the frequency, it was always once a month for you--
A. Yeah.

Q. --for patients who were on Clozapine. Is that right?
A. Yeah, even though, even though later on the government said three monthly doctors, but I really wanted to see them monthly. And I saw them monthly, so it was, it was routine. And, and I, I have to tell you, two people who were chronic and I felt that I couldn't make a difference to their, to their treatment, and the PHN started to kind of dilute. Then I felt that I didn't have enough nurse to support the Clozapine program, and I referred the two patients back to the, to the hospital. But by that time, Joel was off the Clozapine, so, it - they - I made this difference when, when the PHN has started to change.

Q. Sorry, you said - I just want to understand that evidence - from 2012 to 2020, when Joel was your patient--
A. Yeah.

Q. --how many other patients did you have on Clozapine?
A. Four--

Q. Four?
A. --I said, but, but by 2000--

Q. So there was five - sorry, just wait for a moment. There was five including Joel. Is that right?
A. No.

Q. Four including Joel?
A. Four including Joel.

Q. Was it your practice to see each of those patients--
A. Monthly.

Q. --once a month?
A. Yeah.

Q. You said at some stage, the government changed the arrangement, in terms of the recommendations?
A. They, they become a bit lax. So nurses every month, metabolic monitoring every month, but stable patient could see their doctor just once a month. I, I saw them once - or three, three monthly. I saw them monthly because, because I, I wanted to know how they are doing. So, so by the time that Joel finished his Clozapine, then after that, I decided to give the other two chronic patients who were symptomatic, even on Clozapine, I referred them back to the Clozapine clinic, and they didn't have any problem.

Q. In relation to Joel, you saw him once a month at a minimum. Is that right?
A. Yes.

Q. And that was so that you could take an active role in his monitoring?
A. Yes.

Q. Not just the mental health nurses?
A. Yes. I just - I wanted to know, yes. I wanted to have a relationship with him, rapport, talk, and find out how can I help. And I think nobody has asked me this question, why did I keep seeing him monthly after he stopped the medication? The reason, and I saw it - he would ask me: because he was going through..(not transcribable)..transitions and was going through kind of transition from one city to other. So, I wanted to see through that, that he would, he would, he would complete those very, very stressful transitions in his life, and stabilise.

Q. You wanted to make sure he would complete those very stressful transitions in his life?
A. Yes. And stabilise in a new place. And that was the plan, and Joel knew that, and the parents also knew that, that, that, that once he, he, he, he transitioned to another place where he wanted to go, then, then I would, I would finish and I would refer him to, to whatever place he needed to go, you know. But by that time, because it was all, all, all planned that he would, he would have an address, he would have a place to live, and he would have a new GP. And then I could facilitate his transfer.

Q. I'll come to that shortly. In relation to these records, do you see that they indicate a 30 minute time slot--
A. Yes.

Q. --for yourself and for whatever nurse?
A. Yep.

Q. In terms of the meetings, they were arranged, at least on a monthly basis, for a period, booked in for a period of 30 minutes?
A. Yeah.

Q. Is that right?
A. It's always took me more than 30 minutes. That was just the time allocated. Usually it was on a Thursday or, I don't know, Wednesday afternoon, so there was - I didn't have any more patients on that day. So, it took them as much as it took. Sometimes this patient came with parents, sometimes nurse, sometimes - you know. It was more like a free - psychiatrist likes to talk with their patients. So, it was more like a free talk, and I'm assessing their mental state by talking freely, unstructured, rather than say, "Do you hear voices", and other things, you know. It was, it was part of it but it's more like a spontaneous kind of chat.

Q. I'm going to come to some of the specific entries, of course, but whereas the nurses were paid by the practice, you would enter a Medicare item number in terms of--
A. Yes, yes and, and none of the, none of the Clozapine patients was billed privately. They were all bulk billed.

Q. Right. So, we know for example, if you use a particular item number, it's supposed to indicate 30 minutes?
A. Yeah, yeah.

Q. If it's another item number, it's more than 30 but less than 45?
A. Yeah.

Q. If it's more than 45, there's a different item number. That helps us to understand how long--
A. Yes.

Q. --the time was--
A. Yes.

Q. --that you saw Joel--
A. Yes.

Q. --for individual items. Is that right?
A. And that was always done by admin staff based on when did we start, when did we stop, and sometimes, you know, spontaneous speech when go on and on and, and it took me to a long time. And, and I just saying everybody that it's so much easier to diagnose a psychosis because it's there than diagnosis that somebody's not psychotic, you know. It's a bit--

Q. What do you mean by that, sorry?
A. Because, because if somebody psychotic, so you would see it in the beginning, you know. You, you, you have positive symptoms, psychotic. But when people not psychotic, you have to talk a little bit more to challenge them to, to, to, to go from different angles, whether they are, they are sane and not psychotic.

Q. Do you mean by that that if somebody is obvious - there are some patients

who are obviously psychotic?
A. Yes, yes.

Q. And there are other patients who might be experiencing the symptoms--
A. Yeah, yes.

Q. --of schizophrenia, but it takes a little longer to tease that out. Sorry, you need to listen to my questions.
A. Yes, yes.

Q. Is that right?
A. Yes. I always spend more time with Joel because I wanted to make sure that he's not hiding something or not concealing something.

Q. I'll come to that shortly when we come to the relevant entries. In relation to working with persons who are experiencing schizophrenia or are living with schizophrenia, do you agree that it is best to have a multi-disciplinary team that includes a nurse, a GP and a psychiatrist?
A. Very correct. So - and peer support workers and social workers and all the others.

Q. And a psychologist if they require one?
A. Psychologist if they would want to.

Q. For you as the treating psychiatrist, you're in charge of the medication regime, correct?
A. And also I acted as a psychologist because I, I acted most of the time, we talked about strategies to deal with certain symptoms, cognitive symptoms, negative symptoms, because he didn't have any positive symptoms.

Q. In relation to that team framework for dealing with Joel, I take it that you would have paid careful attention to what the mental health nurses were explaining in their notes or telling you directly?
A. Correct. And all the incoming information like mother's letter. So even my staff, always, my admin staff, they, they know Joel very well and they really liked him, and they always told me that "Mum is - mum has phoned". It's the first thing what I did. Yes, returned a phone call, finding out what's happening.

Q. I'll come now to Joel's referral. That's at tab 790, page 342. So, on the screen in front of you, you will see particular letters.
A. Yeah. That was the first letter. No, no, that was a - the referral letter from Dr Grundy.

Q. Yes. Referring Joel to you--
A. Yes, yes.

Q. --on his discharge from the public sector. Is that right?
A. Yes.

Q. You see there a note that he's referring you a patient who is 28 years of

age, and his condition is described as "schizophrenia, OCD, obsessive compulsive disorder"?
A. Yeah.

Q. They were two separate conditions. Is that right?
A. Yeah.

Q. At the time that he came to you, you understood his particular medication regime, which included Abilify and Clozapine. Correct?
A. Yeah.

Q. He was on a large dose of Clozapine at that time?
A. (No verbal reply)

Q. Can you see that there?
A. I think 550, 550 milligrams. Yeah.

Q. Because he was required to take 100 milligrams at night, 200 milligrams twice daily. Sorry, what does that mean, "100 milligrams of the one nocte" - that's night - "MDU"?
A. No. He always taken all his Clozapine at night, and Abilify was always in the morning. So he took this one, this way.

Q. What was the dose of Clozapine that he was on when he came to you first?
A. 550 milligrams.

Q. Did that appear to you to be a high dose?
A. Average dose. It always - Clozapine is - I think, what we know of it, Clozapine, that we have blood levels and it's always dosed to the blood levels, especially in treatment-resistant schizophrenia. So some people take 800 milligram to match the..(not transcribable)..blood levels. Some people have 200. Some people 100. So dose doesn't mean much. It's more like how much is the blood level.

Q. You wrote a letter back to Dr Grundy, which is 6 March it appears, at page 88. If that can come on the screen now. By this time you've received a letter from mum?
A. Yeah. That was, that was 6 March. I didn't receive any correspondence from the Base Hospital, so I had a big interview with mum and, and Joel ..(not transcribable)..and my assessment was not based on the hospital discharge summary which came many, many weeks later. But it was after a what we call - we call it comprehensive psychiatric assessment, okay. So, comprehensive.

Q. His first Clopine coordinator, the credentialed mental health nurse, was RN1?
A. Yes.

Q. You wrote back to Dr Grundy that he's a "28 year old single man, et cetera, presents for ongoing private mental health care for schizophrenia following

recent discharge from the mental health service"?
A. Yes.

Q. "He's had 12 years of illness and had been on Clozapine for ten years or so"?
A. Yeah. I think it was - it was all relayed to me, the patient and the mother.

Q. It was immediately obvious to you, wasn't it, that Joel's mother had been very engaged in his treatment over a long period of time - a decade?
A. Yes. He(as said) was a fantastic carer.

Q. Your diagnosis of Joel, based on that history and your understanding of that ten years, was "chronic, paranoid and disorganised schizophrenia, in control on Clopine"--
A. Yeah.

Q. --"OCD, obsessive compulsive disorder". Correct?
A. And I erred on the side of the safety with my first diagnosis. First - in my first working diagnosis, I always err a bit more seriously than what it is, because I didn't have the letter from the hospital. I, I thought he could have, could have concealed positive symptoms, because at first assessment you don't know. I definitely knew that he had negative symptoms and cognitive symptoms. So schizophrenia has positive, negative cognitive symptoms, and, and I thought he, he was in control, means that the Clozapine was controlling the symptoms. However, I know that he had ongoing negative and cognitive symptoms of schizophrenia.

Q. Positive, negative and cognitive symptoms?
A. Yes.

Q. What do you mean by positive symptoms?
A. Delusions, hallucinations of all kinds, catatonic symptoms, and disorganised speech and behaviour.

Q. What do you mean by negative symptoms?
A. The negative symptoms are basically five symptoms. The two which can be observed, it's affective flattening, or blunted affect, and alogia, which is people don't speak, poverty of speech. The other three is more like experiential anhedonia, which is the lack of positive feelings, pleasure. Asociality, but not because of paranoia. It's social - apathetic--

Q. Lack of joy, and then the second one was?
A. Asociality, which is passive apathetic withdrawal from social contact.

Q. I'm sorry Doctor, could you say that more slowly?
A. Passive apathetic social withdrawal. It's not the - because they are paranoid. Because they just - and amotivation, or avolition, so people just not feeling motivated. That is a negative symptoms.

Q. Passive apathetic social withdrawal, you said?

A. Yeah.

Q. And then the third category was cognitive?
A. Cognitive. Yeah.

Q. That one's probably a bit clearer, but could you explain it?
A. That was the most - Joel explained it with processing speed, that his processing speed was obviously both objectively and subjectively impaired. Took, he said, two hours instead of one hour, which usually take two hours, take one hour. One hour is took him two hours. I knew that he was very intelligent, because he just finished the Bachelor of Art in German, or something, over many, many years - ten years. And he was extremely ambitious academically. And I think she - he had some issues with memory, verbal and, and, and visual, and he also had some executive dysfunction, which is organisation. So it was a bunch of pockets of, of, of cognitive symptoms, which were - which could be primary or secondary, and I thought they were secondary due to the high dose of sedating drug, Clozapine.

Q. Explain to us the difference between primary or secondary?
A. Yeah. The secondary is, is, is there is a cause for it. And most, most commonly in, in negative or, or cognitive symptoms is the positive symptoms. You know, if you have hallucinating or having delusion, that, that gives you secondary negative and cognitive symptoms. But, secondary means is due to the drug side effects, or depression, or whatever is going on.

Q. For people living with schizophrenia, there's a wide variety in terms of how ill people become. Is that right?
A. Yeah.

Q. There are some people in the community who will experience schizophrenia and respond to first line medication and be symptom-free. Is that right?
A. Yeah.

Q. And there are other persons who are treatment-resistant and will need a period of inpatient care and ongoing medication for the rest of their lives, some people. Correct?
A. Yes.

Q. Is the aim always, in assisting a patient with schizophrenia, that you look at whether there are positive symptoms, negative symptoms and cognitive symptoms; the aim is to reduce all those symptoms, if possible?
A. Yes.

Q. You want someone symptom-free, if possible. Correct?
A. Yes. Yes.

Q. If you're trying to determine whether or not somebody is experiencing the effects of their illness, you are assessing them for positive symptoms, negative symptoms, or cognitive symptoms. Correct?

A. Yes. Exactly.

Q. When Joel first came to you in 2012 you understood that he had developed psychotic symptoms when he was 17 years old?
A. Exactly.

Q. That he'd had a period of hallucinations at that time?
A. Yes. Delusion. Hallucination of all modality..(not transcribable).. terrible disorganisation disorder, you know. He couldn't put those things together. He had, he had no, no self-care, and he had to be hospitalised. No aggression, just frustration, and he had to be hospitalised because he had what we call paranoia and disorganised, which is called hebephrenia. So he had both. A mixed, mixed type of schizophrenia.

Q. You understood that it was his parents who had had him admitted to the Mental Health Unit for a period of time?
A. Yes. Because they told me.

Q. And trialled on antipsychotics?
A. Yes.

Q. You understood that his psychosis did not resolve with risperidone or olanzapine, he had to be readmitted to the--
A. He, he had olanzapine first and then risperidone second, and he was still suffering from symptoms, and then he was - his second time he was admitted for trial of Clozapine. So it was a - it's a elective admission when he was - in 2002 when he was admitted for Clozapine. And, and it's always best to happen in the hospital because they are - it's a, it's a, it's a highly specialised drug, so it has high risk of side effect. So could, could have myocarditis in the first few weeks, and, and it can wipe out the bone marrow, and--

Q. Because of the high risk of side effects, Clozapine is the last choice, isn't it, for somebody suffering from schizophrenia - a serious illness, and experiencing schizophrenia as a very serious illness?
A. Yes.

Q. You would trial other antipsychotics before you moved to Clozapine because of the risk of side effects?
A. Yes.

Q. Correct? Is that right, Doctor?
A. Perfect. In 2001/2002, actually there was a policy in Queensland Health called “risperidone first”, but I think it wasn't embraced by everybody. So he was trialled on olanzapine and then risperidone. So that was, that was just policy at that time. So nobody was trialled on Clozapine first. So it always comes third time in the algorithm.

Q. The Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines for the Management of Schizophrenia are in our brief of evidence. I can take you to them if you wish me to, but it defines

treatment-resistant as this: "Treatment resistance is usually defined as continued positive symptoms after trials of at least two different antipsychotics at moderate doses for a reasonable period, usually six weeks." Joel is properly described as having treatment-resistant schizophrenia, isn't he?
A. Definitely.

Q. You understood that, of course, when he came to you in 2012?
A. Yeah.

Q. That is, you understood he had experienced a very severe form of the illness?
A. Yes.

Q. And that he had ambitions to live a happy, healthy life. Correct?
A. Mm.

Q. And that he was a very clever man who had done well at university?
A. Yes.

Q. And that he was well supported by two parents who cared for him very much?
A. Yes.

Q. And who also had ambitions for him to live a happy, safe life. Correct?
A. Yes.

Q. In your letter, which is at page 88, back to Dr Grundy, you put your diagnosis there of "chronic paranoid and disorganised schizophrenia in control on Clopine"?
A. But don't forget it was a working diagnosis at that time based on, on what I - what my suspicion that--

Q. You don't deny, though, that Joel had chronic schizophrenia?
A. No. Because I thought at the moment - at that time, I didn't have any, any, any background history. I thought the best to err on the most severe form that he might have had some positive symptoms until I, I rule it out, so--

Q. Sure. But do you accept that Joel did suffer, in 2020--
A. Yeah.

Q. --from chronic schizophrenia?
A. That was my first impression. It was later on, later on revised that it was first episode schizophrenia, after got the letters and first--

Q. When did you revise that diagnosis?
A. Soon after when I got the letters from, from the discharging mental health team, and I went through that he had, he had symptoms quite, quite long. I mean, a few years after the Clozapine, and they had to go up in Clozapine to the maximum dose in order to get the symptom control. By the time - from the notes, from 2008, he didn't have any positive symptoms. And so I didn't have

to - I was very, very reassured that this first episode psychosis which has, which has remitted on Clozapine. And then they, they gave him a little bit of Abilify in the morning for OCD, and then he was free of positive symptoms.

Q. Could I ask you to have a look, please, at page 328 of the brief of evidence, which appears to have the discharge summary that you might be referring to?
A. Yes.

HER HONOUR: What tab?

WITNESS: That was after I saw him first time.

DWYER: It's the same tab, 790.

WITNESS: Sorry..(not transcribable)..

HER HONOUR

Q. It's on the screen now.
A. I see it. So the--

DWYER

Q. Is this what you're referring to as informing you as to a changed diagnosis?
A. Yes. Yes, it was first episode psychosis. He wasn't a multi-episode psychosis or wasn't--

Q. Sorry, where do you see "first episode psychosis"?
A. He just had one episode.

Q. Under "Summary of care", which appears at page 327 - have you got that there?
A. Okay, where is it?

HER HONOUR

Q. On the screen, Doctor.
A. Okay.

DWYER

Q. Can you see that on the screen?
A. Yeah. "Long episodes". It was, "first began to experience - became distressed..(not transcribable)..Joel has treated with olanzapine", yeah, Clozapine.

Q. Do you see "Summary of care" reads, "Identified risks and outcomes of care. Joel has been treated with olanzapine and risperidone in the past"?
A. Yes.

Q. "With poor response to these treatments. He has been stable since being commenced on Clozapine"?
A. Yeah.

Q. "He has now been treated with Clozapine for around ten years"?
A. Yeah.

Q. It goes on to read, "It appears that Joel may continue to experience some positive symptoms with fluctuating severity, however, Joel denies any positive symptoms"?
A. Yes.

Q. "If symptoms are present, they do not interfere with his functioning. There was a brief period exacerbation of symptoms around 2008 coinciding with a transition from Clozaril to Clozapine at equal dose"?
A. Yes.

Q. "Clopine at equal dose. This was managed by an increase in his dose of Clozapine and additional aripiprazole"?
A. Yes, that was very helpful, yeah.

Q.
> "Negative symptoms remain a feature of his illness. Joel spends much time at home and finds socialising difficult. Despite this, he's recently completed a Bachelor of Arts degree with distinctions and received an award for his achievements."

A. Mm.

Q. It goes on to talk about his side effect profile?
A. Yes.

Q. "With the completion of his bachelor degree, he sought a gradual reduction of Clozapine to combat tiredness."
A. Mm.

Q.
> "He had considered doing this earlier but decided to wait until he'd completed his degree in case he had a relapse of symptoms. A small reduction in dose to 550 milligrams at night was made in December 2011 from his previous dose of 600 milligrams."

A. Mm-hmm. There was not relapse of symptoms.

Q. That suggests, doesn't it - sorry. That suggests, doesn't it, that it's a chronic form of schizophrenia--
A. He had considered--
Q. --that the hospital is telling you about?
A. --in case he had a relapse of symptoms. So, he didn't have a relapse of

symptoms since 2008.

Q. Sorry, "He was still experiencing negative symptoms--
A. Yes.

Q. --as a feature of his illness", do you see that?
A. Yes, yes.

Q. And he'd been managed on a significant dose of Clozapine or Clopine?
A. Yes. And this is what my task, to, to find out it is secondary or primary negative symptoms. So after that, after giving that, it just confirmed that he had a long episode of first episode psychosis, and then he was symptom-free from 2008, and he had ongoing negative and cognitive symptoms.

Q. Sorry, Doctor, how is he symptom-free in circumstances where he's being managed with a high dose of Clozapine and he's still experiencing negative symptoms?
A. Yeah. Okay, I tell you something.

Q. Doesn't that suggest that he actually suffers chronic schizophrenia which is being well managed by the treatment regime that the public system had put in place?
A. "In case". That is the question which need to be uncovered, whether these symptoms are primary or secondary. So the only way to, to distinguish, if you find an optimum dose of, of medication where the secondary negative symptoms would subside and you would see what it is there. And that was my task.

Q. Okay. So that's what you did after you--
A. Yes.

Q. --received Joel?
A. Yes.

Q. But you tried to determine whether or not in fact--
A. Yes.

Q. --he had had first episode psychoses that had been managed for a decade--
A. With high dose of medication.

Q. --or whether it was chronic schizophrenia--
A. Yes.

Q. --that had been managed for a decade with high dose medication?
A. Yes, exactly.

Q. That's what you were going to do by titrating down his dose of Clozapine--
A. Yes.

Q. --is that right? Sorry, Doctor, just listen.
A. Yes.

Q. Is that right?
A. I was already - when I - when he arrived, the mental health team already decreased his medication from 600 to 550 a few months before.

Q. Yes.
A. So, it gave me a little bit of - usually when, when the mental health system transfers a patient to private practice, they don't, don't alter the medication. But because they did and he arrived and he felt better, and that was the reason why they did, because he was so, so troubled by the side effect. He had actually quite high dose above 1,000 microgram per millilitre Clozapine, which could put him into the seizure side effect category. So, they have reduced that dose and--

Q. Where are you getting the 1,000 milligrams?
A. It was in the notes.

Q. At what time was he on the 1,000 milligrams?
A. Before they, before they cut it down.

LYNCH: Sorry, your Honour, I think she was saying the serum Clozapine was--

WITNESS: Serum Clozapine was that.

DWYER

Q. I see.
A. So that was, was the reason why he felt so drowsy, was full of negative symptoms, and, yeah, and cognitive symptoms.

Q. You said that on the discharge, you changed your diagnosis. You had a working diagnosis--
A. Yeah.

Q. --which I'd referred you to earlier?
A. Chronic. And then I changed it to first episode schizophrenia with secondary--

Q. When did you do that?
A. After, after I got the letter.

Q. After you got the letter that I just took you to from the hospital?
A. Yes, and I talked, I talked with him, and I was listening to him.

Q. Sorry, Doctor, I just need you to focus on my questions.
A. Yeah.

Q. You changed the diagnosis. But what was set out in that discharge summary was a long history of being managed on Clozapine, and the diagnosis on the next page was paranoid schizophrenia. Do you see that?
A. Yes. And they didn't even put down the, the disorganised one, which was the primary features. So, these, these diagnoses are very good indicator that this person had a, a treatment-resistant schizophrenia. Whether it was a long episode or first episode schizophrenia, that was my job to, to--

Q. Sure. But there was nothing in the hospital discharge that suggested first episode psychoses, was there?
A. But nothing also about multi-episode, and was nothing about - I mean even, even the positive symptoms, they were so vague in that letter that they didn't even say what was it, you know. It was, it was, it was suspicious that he might have had positive symptoms.

Q. So, is this the summary of your evidence: you initially assessed Joel with his mother, having received a letter from Joel's mother?
A. Yeah.

Q. You then had a working diagnosis?
A. Yeah.

Q. Which was chronic schizophrenia?
A. Yeah.

Q. You then received a discharge summary from the hospital which suggested--
A. Yeah.

Q. --paranoid schizophrenia, and you thought to yourself, "I'm not sure whether this is chronic--
A. Yes.

Q. --or first episode--
A. Yes.

Q. --and I'm going to find out by titrating the dose down"?
A. No. I, I was going to, I was going to find out by serial assessments, developing rapport, having multidisciplinary assessments, and finding out really what's going on. And then, and then I wasn't, I wasn't keen to touch the Clozapine until I know how much was the level.

Q. When you determined that this was first episode psychoses, did you discuss that with any of his treating doctors in the public health system?
A. No, I never had any discussion with the public system. Once they discharged, they discharge. The only thing what I did, then Dr Stephens came back to the town, I had a second opinion from her.

Q. I'll take you to that shortly. I want to go back to the letter that you sent to Dr Grundy, which is on 6 March 2012 at page 88. You refer there to some

vulnerabilities that Joel had, and you note, "Father is over religious with revelations".
A. Mm.

Q. "Intelligent child, adolescent turmoil with conduct disorder and MJ abuse". What's "MJ abuse"?
A. Marijuana. Marijuana.

Q. Thank you. "Which could have been the prodrome of his schizophrenia at age 16"?
A. Yes.

Q. "OCD due to Clozapine, especially avoidant with lots of strengths".
A. "Socially avoidant".

Q. Sorry, "Socially avoidant with lots of strengths. Fortunately, there have been no safety issues to date"?
A. Yes.

Q. The fact that - again I mean no disrespect to Joel's father - but that he was over religious with revelations, where did that information come from?
A. This is from them. From, from the, from the family.

Q. You refer to that under a subheading of "Vulnerabilities?
A. Yes.

Q. Did you consider that that was a risk factor for Joel?
A. Well, definitely genetic.

Q. I see. Definitely that the schizophrenia was genetic?
A. Genetic, yes. We couldn't talk about it. I actually speak with Joel about her - his father, and he was quite understanding. He said that "We just - we love him and we accept him as he is". So, he didn't have any, any negative thoughts, feelings about the father. And the father was not - and when I saw the father, it was obviously, obviously, obviously symptomatic. But it just showed that without medication he was, he was actually accepted and had a role in the family and was respected. And I always asked him, "Do you share the ideas of your father?" and he said, "No".

Q. You subsequently met Joel's dad, and it appeared to you that he was obviously symptomatic--
A. Yes.

Q. --for the condition of schizophrenia, correct?
A. Yes.

Q. But he clearly wasn't causing any--
A. No.

Q. Well, I withdraw that. There's no evidence that he was a harm to himself or

others?
A. No.

Q. He was loved by the family--
A. Yes.

Q. --and he loved Joel, correct?
A. Definitely. And even though his ideas about anti-medication did not influence Joel, because Joel was not anti-medication. Wasn't - it was the mother who - and Joel who embraced the idea of, of schizophrenia needs medication. Attitude was positive.

Q. Sure. You identified dad's condition as a vulnerability--
A. Yes.

Q. --that the condition of schizophrenia can be hereditary, is that right?
A. Definitely.

Q. That suggests, doesn't it, that it was more likely that Joel's condition was chronic and going to need--
A. No.

Q. --ongoing management?
A. It was just, it was just genetic. It was just genetic. 50% is genetic in schizophrenia.

Q. It suggested, didn't it, that it wasn't a condition that had been triggered by an environmental factor--
A. Could be.

Q. --like marijuana?
A. It could be that.

Q. It was in fact more likely, I suggest to you, to be a hereditary condition that needed ongoing management?
A. It was, it was a very severe end of schizophrenia, and I thought that the marijuana was a trigger rather than marijuana-induced schizophrenia.

Q. You, in your letter to Dr Grundy, indicated that you would continue the Clopine medication and also that there would be social supports for Joel--
A. Yes.

Q. --and ongoing monitoring, correct?
A. And I think my nurses definitely addressed the psychosocial support, more psychosocial support that he ever got before. You know, they - he, he actually very well engaged with RN1, social skills training. I ask him whether he wants to see Dr McQueen, who become private psychologist, but he said he, he saw him enough so he didn't want to have more treatment. So basically, he had monthly treatment with me and, and monthly therapy with RN1.

Q. RN1 you're referring to there?
A. Yes.

DWYER: Can I ask that p 335 come up on the screen?

Q. There are some handwritten notes, as well as some electronic notes. When you first saw Joel - is that your handwriting?
A. Definitely, this is what I used to do.

Q. Did you move to electronic notes at some period in time, or were your notes typed up?
A. I, I, I started - that was always what I did, and then I scanned it in and I did the letter to the GP on - based on this.

Q. I will just take you to your very first new patient assessment that you completed. It's at page 334.
A. Yeah. That is not for the GP, that's for me, you know.

DWYER: Can you just scroll down from that please.

Q. "Presenting problems very well on Clopine". Do you see that?
A. Yep.

Q. "Find studying challenging but doing not too bad et cetera". That's your handwriting?
A. Yeah, yes. And he said he was very well - and mother - on Clopine for ten years. This is what they said. That is what they, they, they firsthand experience.

Q. You said, "The OCD is pretty good, but mainly cleanliness, washing, teeth cleaning for 30 minutes, et cetera"?
A. Yeah, yeah.

Q. And if we scroll down, you note the current medications?
A. 55.

Q. The personal history is listed there and then there's a mental state examination?
A. Yes.

Q. I'll come to the mental state examination. "Seen with mother Michelle. Joe(as said) was able to shake hands" - sorry, perhaps you could just read your entry there?
A. Okay. So, it was not OCD variable, terribly bad. "Very shy anxious young man, dressed casually, fleeting eye contact, downcast mainly", which is not uncommon, first appointment.

Q. Sorry, just read your notes, if you will.
A. Yeah. "Euthymic".

LTS:DAT

HER HONOUR: Did you want the doctor to read them to herself?

DWYER: No, out loud if she may, thank you, your Honour.

WITNESS: Yeah.

"Euthymic, restricted affect, telegraphic speech".

And what does it mean, that he did not elaborate, just kept to the minimum cut, cut to the bone answers. And accepted that mother was talking for him.

"Guarded about his psychotic experiences and traumas in the past."

So, what means, that he said that he didn't want to talk about it, yeah. Not even the psychotic experiences.

"Open about his poor organisation skills, mental slowness, which he compensates for with extra double time. No positive symptoms of psychosis, no safety issues. Fair insight to illness and he knew that he had an illness".

DWYER

Q. There's two things there I wanted to point out. His mother talked a lot for him, correct?
A. Yes.

Q. He had a euthymic but restricted affect?
A. Yes.

Q. Euthymic is a stable mood, is that right?
A. Yes, he never complained of depression.

Q. He was guarded about his psychotic experiences?
A. Yes, yes.

Q. So is it fair to say, although there were no positive signs--
A. No.

Q. --of psychosis, there were signs of negative symptoms there?
A. Yes, definitely. And the guarded means that he did not volunteer, he didn't want to talk about it. He, he, he was kind of sealed it. Sealed it over.

Q. He was - I'm sorry, I missed that?
A. Sealed it over.

Q. Sealed it over?
A. So, it was in the past.

Q. That suggested, didn't it, that he might not be open - well, what did that suggest to you, the fact that he was--
A. I think just the first, first assessment, that rapport has to be developed. Because he came with the mother. The mother was talking about this awful psychotic relapse he had, or a, a first episode and he was just sitting there quietly and didn't, didn't add much, and didn't want to volunteer more.

Q. Joel himself thought that he had not been unwell for a long time. Is that right?
A. Yeah, ten years he said he was good.

Q. But in spite of that, there were negative symptoms--
A. Yeah.

Q. --that you were recognising?
A. Yeah.

Q. Did that suggest to you that Joel may not be able to recognise for himself?
A. No, he was perfectly intelligent, and recognised that he was - and he attributed it that he was, he was overmedicated.

Q. At the practice, Joel saw a mental health nurse as well as you as a psychiatrist. You started to say earlier your initial plan was to refer him to a psychologist as part of a multidisciplinary team. Is that right?
A. Wanted. I wanted to refer him back to Dr, Dr Paul McQueen, who started private practice at that time, but Joel declined it, and not just to me, to, to RN1, and he said he just want to get on with his studies and whatever he does, and he had enough psychotherapy with the psychologist, and I had to accept it.

Q. Sure. I take it that when you saw Joel once a month, part of your process was to read the notes that had been taken by the mental health nurses?
A. Always.

Q. Did you sometimes also meet with Joel and the nurse alongside?
A. Yeah, of course, of course. We have to. So, it was more a common practice that when the nurse saw, we had to catch up. The nurse brought, brought the patient in, handed over, and we talked before sometimes, and after. After a debriefing. "So how did you - what did you find? What do you think?" And the weekly - at that time, initially we had weekly meetings with the mental health nurses, and monthly we discussed what we should do. We, we discussed a lot about Joel. How should we go with the management.

Q. Just a couple of things in that. I'm going to ask you about three phases of your engagement with Joel. The first one is 2012 to 2015, the next phase is 2015 to 2018, and then there's the final phase 2018 through to his time in discharge in 2020.
A. Yeah.

Q. So, starting with 2012 to 2015.
A. Yeah.

Q. Joel saw you and the mental health nurse--
A. Yeah.

Q. --very regularly. You said there were initially weekly meetings. Did they continue for that three year period?
A. Weekly meetings with nurses, yes, but not with the - we didn't discuss Joel every time, you know. Just once a month.

Q. What was the purpose of the weekly meetings?
A. It's about to hand over, like, those patients who I didn't see for three months, they said, "Okay, this is the problem". So, they, they highlighted. So, I have to do - maybe see this person earlier, because they were doing their own therapy, and if it didn't go over, so I knew. So, that's what the good things about them, that, that I knew my patients' journeys.

Q. Were all of the psychiatrists who worked at the practice involved in those weekly meetings?
A. Initially, yes.

Q. Did you see that as beneficial, because there was an opportunity to learn about each other's patients and to share ideas?
A. It was, it was, it was definitely beneficial.

Q. Why did they stop?
A. Because of the PHN. The - they - the nurses, nurses were asked to do more patients from GPs, and they were not under my supervision, you know. And, and, and we just gradually dropped it - not, not totally dropped it, but became, became more like we did - they did - there was no admin taking the minutes, every nurse was responsible to - when they discussed the patient, responsible to put it on, on the Genie, on the software, that it was discussed in the meeting. And then that is what happened. So, it was not centrally monitored. It was every nurse who brought the patient case went away and wrote it up that we discussed it in the meeting.

Q. Well, we heard yesterday - you sat in, I think, in another courtroom to listen to the evidence of RN2 and RN3. Is that right?
A. Yeah.

Q. You will have heard RN2 refer to a book that was used to take minutes of weekly meetings?
A. Yeah, yeah.

Q. She talked about a hard cover book that was grey. Are you familiar with that book?
A. I don't know what kind of book was that. That's - [redacted] was the, the admin was doing that, that - who was discussed..(not transcribable)..was discussed, and--

Q. That's the admin manager [redacted], is that right?

A. Yeah, yes.

Q. So you saw her write minutes in a book?
A. Yeah, she was - she - but, but it still, it wasn't transferred to the patient notes.

Q. Where was that book located?
A. I think as, as he - she - because I asked my receptionist to contact [redacted], and [redacted] said it was, it was in a locked cupboard behind the, behind the admin and there is none. When [redacted] left after ten years, I had four or five different admin, and that book disappeared. But we didn't lose any information because, because the nurses were documenting the meetings.

Q. Did you ever go back and read yourself the hard copy notes that were taken?
A. Never, never, because it was always--

Q. What was the purpose of them?
A. Just because, because a minuting, minuting of the meetings.

Q. The purpose of the minutes of the meetings, though, is to keep a record of--
A. Yeah, who was discussed and--

Q. Do you agree that those records should have been kept by the practice?
A. Yes, should be, but that's the problem. Handovers, like nursing handovers in the ward, they don't keep a copy. That's the problem, that they, they hand it over, they print it out every day, but then disappears somewhere. Nobody - that is--

Q. Did you have a protocol at the practice --
Q. No.

Q. --for how they should be kept?
A. No, it was just kept in - it was, it was the - it was his - her idea - her, her, her responsibility to keep it, because I don't know, it was - I don't even know who did she keep it for. It's just because of the practice.

Q. Is there still a weekly meeting that takes place?
A. No. No, no, not at, not at all. The nurses are independently mainly managing their patients. If, if there is somebody new they send me a bubble, so let me know, or if it is more urgent, they catch me in the corridor or come to me and we will talk and then we, we modify the--

Q. You just said that it was [redacted]'s responsibility, but it's your responsibility in terms of running the practice to ensure that all records are kept properly?
A. Yep.

Q. Do you agree with that?
A. Yes, yes, yes.

Q. I don't want to make too much of it, but you agree, don't you, that it's an oversight that that book was not retained at the practice?
A. I don't know - it's - where is it. I don't know. That's the problem, that we had six more receptionists and - since, since [redacted] left, and it, it just disappeared, and we didn't do it anymore.

Q. Between 2012 and 2015, Joel was living with his parents, is that right?
A. Between 2000 - between birth and 2018, October.

Q. I'm dealing with this phase of 2012 and 2015.
A. Yeah, yeah.

Q. You would have thought that it was a stabilising factor for Joel to be living with his parents?
A. Yes.

Q. They were accessible to you to have a discussion at any time if you wanted to check how Joel was going?
A. Usually the good things about mother, that she always was proactive. So, I don't - didn't have to ask her, she was always proactive.

Q. You didn't have an arrangement for a regular meeting with Joel's mother or father?
A. Yes, we did. And we did it with every time when something changed.

Q. How would you arrange that meeting?
A. Simply just tell - Joel, Joel wanted to decrease the medication. I said "Okay. Let's review how you're doing at home and what is your - what is the significant others' thoughts about it". So, then the next time the mother came and we sat down and said "Okay, Joel wants to decrease the medication, how has she(as said) been?" And there's always - I wouldn't have done any decrease if all parties disagree, or ever - somebody disagree, if somebody--

Q. I might come to that when we have a look at what happened at the end of 2019?
A. Yeah.

Q. But between 2012 and 2015, you made the decision to slowly reduce the dose of Joel's Clozapine from the initial 600 or 550 milligrams to ultimately weaning him entirely off?
A. No, no, it was optimisation. The first, first stage was optimisation.

Q. What do you mean by optimisation?
A. Finding the dose which controls - which, which prevents the, the recurrence of the positive symptoms and, and, and does decrease the secondary negative and cognitive symptoms. So, so I would find some - a dose optimally, as it doesn't have side effects but still controls the, the insurance policy that he doesn't relapse, you know. Controls the recurring - okay.

So if you, if you, if you decrease the medication, when he was a chronic schizophrenic - sorry, person with chronic disorganised schizophrenia, and you start decreasing the medication, in terms of Clozapine, 400 microgram per millilitre, then you would expect - if it's seen, it is, it is a treatment, it - the person still has treatment-resistant schizophrenia, you would, you would see the recurrence of the positive symptoms, okay. If you go down 200 microgram per millilitre, then you would expect the non-treatment-resistant schizophrenic positive symptoms coming back, you know. But if you go below 200 and, and nothing comes back, that it means that it's basically remission.

Q. What are you basing that on? Are there guidelines that you are following?
A. Yes. It is based on - and that is the issue, isn't it, because it's called the, it's called the neuroleptic threshold. A neuroleptic threshold is more apply for first and second, second generation antipsychotic, like first generation Haloperidol 60-80% of dopamine blockade. Olanzapine, risperidone is more 50 to 70% of dopamine D2 receptor blockade. In terms of Clozapine is a 20-40%.

Q. Are you referring to any guidelines in that?
A. Yes. It is, it is, it is into - no, not - because it's not guidelines. It is basically neuroscience and, and chemical science.

Q. Are there guidelines of the RANZCOG(as said), the Royal Australian and New Zealand College of Psychiatrists, or are you relying on your clinical practice, or what are you determining--
A. No, no, no. It is the science behind the neuroleptic threshold. The science behind that you don't need higher doses of medication than the neuroleptic threshold in order to, to achieve remission.

Q. Are you able to refer to any peer-reviewed articles or anything that would assist us to understand the neuroleptic threshold that you were talking about?
A. I think it's, it's taught in, in the basic psychiatric training and, and if, if you - if you want, if you want to know the - who are the experts in the world, is Silvana Galderisi, Andrea de Bartolomeis, and..(not transcribable).. They are well-known people who, who talk about - and, and this is, this is possibly also pharmaceuticals, because that is how they, they, they classify second, first generation antipsychotics, and, and a two medication, which is Clozapine and, and, and..(not transcribable)..who, who don't follow this, because--

Q. Just before the break, I want to take you to a secondary opinion that was sought in 2015 by another psychiatrist, Nicky Stephens. Are you familiar with that person?
A. Yes, yes. She does - she, she started him on, on Clozapine in 2002 December, or something.

Q. How was it that a second opinion came to be sought from her?
A. Because she went away and she came back into the town as a private psychiatrist. So she was part of my peer review people and, and I, I was - I welcomed and said, "Okay. Would you, would you agree to see my patient who I am managing for a second opinion", and he(as said) said yes.

Q. So you arranged for that second opinion from Dr Stephens?
A. Of course. But I asked the GP to refer, because of the item numbers.

DWYER: Can I just have page 86 up on the screen.

Q. That's the referral letter from Dr Grundy that forms part of your records at the practice. Is that right?
A. Yeah.

Q. You took notice, did you, of that letter that had come back from Nicky Stephens?
A. Definitely. And, and we are - I think we, we also had some personal communication about that too.

Q. Towards the bottom of that first page at 86, last paragraph:

> "In consultation with his regular psychiatrist, Dr A, Joel has been very slowly reducing the dose of Clozapine from 600 milligrams down to his current dose of 275 milligrams at night with no signs of relapse"?

A. Yes.

Q. He goes on to say:

> "I have discussed with Joel and his mother today the potential risks and benefits of stopping Clozapine medication. The risk of relapse, of positive symptoms, and also potential exacerbation of negative symptoms, and the attendant impairment of functioning and disruption to his ongoing study and lifestyle."

Did you understand yourself at that time that there were risks--
A. Yes.

Q. --to Joel of stopping Clozapine?
A. And they were also. It wasn't a, a secret.

Q. You discussed them with Joel and his mother, did you?
A. Definitely. And with the mother. And I have severally, before, before this, this was asked, and after that.

Q. This letter goes on to say:

> "On balance, Joel reported he wished to proceed with the trial of a further slow reduction in the dose of Clozapine at a pace of 25 milligrams less every three to six months with ongoing monitoring of his mental state."

That was something that you had proposed, and that he was wanting to trial.

Is that right?
A. I didn't propose it. I, I just said I wouldn't go slower - wouldn't go quicker. So I, I wouldn't have, wouldn't have done quicker, because after every, every decrease I would have to wait whether the positive symptoms comes back, whether the negative symptoms get worse, and the cognitive symptoms get worse, but it didn't happen.

Q. The letter goes on:

> "He agreed" - that's Joel - "that if there was any recurrence of early warning signs of psychosis then the reduction would have to be abandoned and a return to a slightly higher dose of Clozapine would most likely be the recommendation."

You agreed with that?
A. That is - that is a - that is a normal recommendation. Yes. I agree.

Q. "Joel was aware of the importance of continued abstinence from illicit drugs and excessive alcohol, and also carefully managing his levels of stress during this testing period of medication reduction"?
A. Yeah.

Q. You understood at that time that there would have to be very careful review of Joel to make sure that any negative symptoms were recognised--
A. And positive--

Q. --any positive symptoms were recognised, and if that they returned, there would likely be a return to Clozapine. Correct?
A. Yes. During the Clozapine withdrawal. Yes.

Q. And that Joel had agreed to that?
A. Very much. Yes.

Q. And then it goes on to read:

> "His mother was agreeable to support him through this time, and in view of Joel's limited recollection of his positive psychotic symptoms, the family are most likely to be the people to recognise any early symptoms of relapse"?

A. Yes.

Q. You agreed with that?
A. Yes. And, and I think by that time he was more talkative about his positive symptoms, so he knew what was the positive symptoms he was looking for.

Q. You had never seen Joel acutely unwell, had you?
A. No. And, and I have to tell you, during my eight years of treatment, he never showed any signs of positive symptoms, never showed sign any relapse, and never showed sign any issues with safety, and never been fascinated or

preoccupied with any weapons.

Q. The question I asked you was you had not seen--
A. No.

Q. --Joel acutely unwell?
A. No.

Q. But his mum had seen him acutely--
A. Yeah.

Q. You understood that?
A. Yes. And in two thousand--

Q. Sorry, Doctor, just listen to my question.
A. Yeah.

Q. You agreed with Dr Stephens--
A. Yeah.

Q. --when the doctor wrote that "due to Joel's limited recollection of his positive psychotic symptoms, the family are most likely to be the people to recognise any early signs of relapse"?
A. And I fully honoured that.

DWYER: Is that a convenient time to break?

HER HONOUR: Yes. We'll take the morning adjournment. We'll come back at 10 past 12.

SHORT ADJOURNMENT

DWYER

Q. Can I just take you back to the 2015 second opinion that was obtained from Dr Nicky Stephens. Is Dr Stephens a female or male doctor?
A. Female.

Q. Did Dr Stephens treat Joel while Joel was in the public health system?
A. Yes.

Q. In fact, did Dr Stephens have the opportunity to see Joel when he was unwell?
A. Yes.

Q. She was a good person to provide a second opinion--
A. Perfect.

Q. At the time that you sought the second opinion from Dr Stephens did you have in mind that the goal at that time was ultimately to cease Joel's

medication with Clozapine?
A. At the time, not. At the time I wanted to find optimum dose, which prevents the relapse of the positive symptoms and minimise or, or, or stops the secondary negative symptoms and cognitive symptoms.

Q. You understood by that stage, of course, that Joel had experienced treatment-resistant schizophrenia?
A. More than enough. I understood.

Q. What were you seeking the second opinion about? Was it in relation to the slow reduction of Clozapine to try and find the optimal dose?
A. Every time when I had opportunity for second opinion and I'm doing something which is a bit iffy, or not, not in - actually, I wouldn't say that. Because every doctor wants to find optimum dose. It's part of the guideline. But I thought I would ask second opinion because she came back to the town and it was perfect timing to, to, to see, to show to somebody and get some opinion of what to do.

Q. You understood, didn't you, that there were risks for Joel in reducing the Clozapine dose and you wanted a second opinion--
A. Yeah.

Q. --when you were going to make that decision to continue to reduce?
A. Risks of relapse and, and, and, and what was he like when he was unwell, and how did it compare to that person, because he - she would say that okay, she's masking, or something, or, or doing something which is - which is, you know, kind of doctor who had daily contact many years with him - not daily contact - daily contact when he was on the ward, and follow-up, he would - she would have some knowledge.

Q. Sure. Can I just have that letter back on the page? It's page 234. She says to Dr Grundy, "Thank you for referring Joel for a second opinion regarding his Clozapine medication and his treatment of schizophrenia." She notes some of the history that:

> "He first developed psychotic symptoms when he was aged 17 in the context of using marijuana. Joel's memory of his symptoms at that time appeared quite patchy, but he could recall mostly tactile hallucinations of being touched on his back and believing that this was a spiritual experience. However, his psychotic symptoms did not resolve with risperidone or olanzapine medications and he was readmitted to the mental health unit to be established on a Clozapine medication."

So far that's a recitation of his history and acknowledgment that he had suffered treatment-resistant schizophrenia. Correct?
A. Yep.

Q. She goes on to say that:

"He'd done well on quite high doses of Clozapine and his positive symptoms resolved completely. He told me he had no further relapse of positive psychotic symptoms in the intervening 14 years. He has remained compliant with Clozapine throughout this time and has not used illicit drugs or alcohol. Abilify was added to his treatment several years ago when the Clozapine brand was changed. Although there were no signs of positive symptom relapse, the family felt Joel became more withdrawn at this time.

He's functioned well in terms of completing a university degree part-time in language, though he remains reliant on his very supportive mother to organise him, provide social interactions, and he continues to live at home. He's been able to tolerate Clozapine quite well with no problems with neutropenia. No significant weight gain or metabolic syndrome. His echocardiograms have been normal. However, he has suffered with OCD symptoms and anxiety about cleanliness, none of which particularly affect him now.

In consultation with his regular psychiatrist, Dr A, Joel has been very slowly reducing the dose of Clozapine from 600 milligrams down to his current dose of 275 milligrams at night with no sign of relapse. I've discussed with Joel and his mother today the potential risks and benefits of stopping Clozapine medication."

I'll just pause there. Did you at that stage think that there was a possibility that you would titrate the dose so far down that you would stop Clozapine altogether?
A. Not at all. Not at all.

Q. It goes on to read, "The risk of relapse of positive symptoms and also potential exacerbation of negative symptoms and the attendant impairment in functioning and disruption to his ongoing study and lifestyle." I'll pause there. Were they the types of risks that you also discussed with Joel in terms of a reduction in Clozapine?
A. Of course.

Q. Goes on to write, "The benefits of a trial off Clozapine would be to reduce the ongoing risks of potential side effects, such as neutropenia, cardiac side effects and metabolic syndrome." I'll pause there. Does that not refresh your memory? Are you sure that there was not any discussion of a trial off Clozapine?
A. No. At that time we didn't.

Q. What she writes is:

"The benefits of a trial off Clozapine would be to reduce the ongoing risk of potential side effects, such as neutropenia, cardiac side effects and metabolic syndrome, and to determine whether his illness is manageable on a less complex antipsychotic medication such as aripiprazole for the longer term"?

A. Yeah.

Q. Is it fair to say, it was never discussed with Dr Stephens that Joel might be completely unmedicated at some time?
A. I didn't.

Q. Because in your mind at that time Joel would have to at least be medicated with some type of antipsychotic for the rest of his life. Is that right?
A. This is what I was thinking. Yeah.

Q. Is that because at that stage you recognised that he had chronic schizophrenia that would be likely to need management with some form of antipsychotic medication for the rest of his life?
A. Exactly.

Q. That's because you understood that treatment-resistant schizophrenia is a chronic relapsing remitting brain disorder and usually requires lifelong care and treatment, which includes antipsychotic medication?
A. Yes.

Q. I think you said before the break, you agreed with her assessment that because Joel had limited recollection of the period when he had had positive symptoms, the family were most likely to be the persons who could recognise early signs of relapse?
A. When he was getting better he was able to talk with me about the positive symptoms. And I'm just looking at the notes that by the time when I - when, when she saw him, the Clozapine was very low, 160 microgram per litre - actually, 6 June--

Q. What are you reading from there?
A. My notes.

Q. Your notes, as in your medication notes and the tab--
A. It will be here. It will be here. Like, like we took Clozapine serum - Clozapine level - series of Clozapine levels and - okay, I don't want to talk too much, but at the time her Clozapine - his Clozapine level was very low.

HER HONOUR

Q. A serum--
A. Serum Clozapine level was very low, 160 microgram per litre, which would - showed me that if he had - if he still had the first episode schizophrenia, treatment-resistant schizophrenia, he should have shown a relapse. He should have shown - if it wasn't remitted underneath, he should have shown symptoms of positive symptoms. And if he had not treatment-resistant schizophrenia, 160 microgram per litre, he should have shown positive symptoms. So to me it showed that he, he was actually on a subtherapeutic dose of Clozapine and he was still not showing positive symptoms which mean that he was in full remission.

DWYER

Q. He was not just on Clozapine, was he, he was on another form of antipsychotic medication?
A. Yes. But it was 5 milligram and it is, itself - you need to have at least 15 milligram of Abilify to get the neuroleptic threshold and he didn't have that.

Q. I asked you before about whether or not you were following any formal guidelines in relation to the reduction of--
A. Yes. It was a scientific--

Q. Sorry Doctor, please just wait for my question. Whether you were following any formal guidelines from the Royal Australian College of Psychiatrists about the reduction of Clozapine, or the weaning off medication, and you said you weren't. You were relying on your clinical knowledge. Is that right?
A. Yes. No. It was, it was a joint discussion. It was a shared decision-making. If I would have followed the guidelines it would have said after full remission of a first episode psychosis, after full remission 12 months, you can start withdrawing the medication. And there is no guidelines of how quickly, usually half, half a year. So we have been, we have been engaging during this time when I was withdrawing the medication and getting to know him. And I was more and more firmed up in my belief that he fully recovered from his first episode psychosis.

Q. I just asked you a question previously--
A. Sorry that I may give more than what you ask.

Q. I just asked you a question about what he was suffering from and you agreed just a moment ago that he was suffering from chronic treatment-resistant schizophrenia. Do you accept that?
A. I think we disagree on it. I think in my mind he was - he, he was suffering a long episode of first episode treatment-resistant schizophrenia. In my mind he was first episode. He wasn't multiple episode. He was first episode treatment-resistant schizophrenia. With ongoing negative and cognitive symptoms--

Q. Did you ever write a note anywhere revising your initial diagnosis?
A. I think it must have been in, in my notes because that is how I treated him. He never had multi-episode schizophrenia.

Q. Perhaps over the lunch break you could have a look at your notes and see if you can find anywhere where you write a note about a revision that he's not suffering from chronic schizophrenia or paranoid schizophrenia, that he had suffered from first episode psychosis now in remission?
A. First episode chronic - first episode of paranoid and disorganised treatment-resistant schizophrenia.

Q. That's a chronic condition. Do you agree with that?
A. It wasn't episode; was chronic, because it lasted for long time. But I was,

I was very happy to see Dr, Dr Stephens' notes that at that time, 2015, she agreed that he didn't have positive symptoms for more than 14 years, he said, so it's - you know, sometimes, sometimes the clinicians who see him misdiagnosed him with positive symptoms. But I don't know. It is, it is to me, he could have had breakthrough positive symptoms. But anyway, to me, it was a first episode treatment-resistant schizophrenia long episode.

Q. Did you think that there was any risk of relapse when--
A. Definitely. But I have to tell you, in - when I started my training it was 25% of first episode schizophrenia patients will never relapse. Right now the latest literature shows in very selected cases 14% of the first episode schizophrenic patient would never experience a relapse. So in my mind I was hoping that he was going to belong to this 14%.

Q. But what he had was treatment-resistant schizophrenia--
A. Yeah.

Q. --where he had been placed on a medication regime involving Clopine for over a decade. Do you agree?
A. Yes.

Q. That suggests, doesn't it, a serious severe form of the illness?
A. Yes. A serious first episode treatment-resistant schizophrenia. Yeah.

Q. Do you mean a first episode psychosis that lasted a decade?
A. Yeah. It - no, not - it didn't last a decade. It did not last a decade. Even Dr Stephens said that the positive symptoms stopped in 2015, 14 years ago. So that was it. So let's, let's just move on because it is - it is first episode in my mind.

Q. You sought a second opinion from Dr Stephens in 2015--
A. Yeah.

Q. --and can I suggest to you that that was a sign of you being diligent and careful--
A. Yeah. I was diligent and careful.

Q. --when you were going to reduce his Clozapine further?
A. Yes.

Q. You knew that there was a risk involved and you wanted a second opinion--
A. Yeah.

Q. --about whether or not that was appropriate. Correct?
A. And by that time he had such a low level that he should have shown signs of relapse if he was underneath, not--

Q. Your evidence so far is that you were not contemplating removing him from--

A. Not at the moment because I still believed that he needed - at that time, he needed ongoing treatment.

Q. Why? If you thought this was a first episode psychosis that had fully resolved, why did you think he would need ongoing treatment?
A. Because of the insurance policy to stay well and to protect him for further relapse, especially in terms of studying and trying to establish a life independently from the parents, and to reduce their psychosocial disability and be able to - look, there's no evidence that Clozapine does treat negative symptoms and cognitive symptoms. The only evidence is the positive symptoms. But--

Q. What's written in this letter from Dr Stephens at page 235, first paragraph, last line:

> "The benefits of a trial off Clozapine would be to reduce the ongoing risks of potential side effects and to determine whether his illness is manageable on a less complex antipsychotic medication such as Aripiprazole for the longer term."

So it was never--

HER HONOUR: Sorry. Could we just go back. It's confusing because we're in the wrong spot.

DWYER: Sorry. That's page--

HER HONOUR: Go up to the first paragraph.

DWYER: --235.

HER HONOUR: I don't know that the doctor's trying to read what's on the screen--

DWYER: I see.

HER HONOUR: --but first paragraph.

DWYER

Q. Just have a read of that last sentence then, if you don't mind?
A. Last sentence--

Q. Just to yourself, if you don't mind.
A. "Was agreeable to support..(not transcribable).." Yeah. That's okay. Yeah.

Q. Dr Stephens was trying to consider the benefits of a trial off Clozapine and whether or not he could be off Clozapine and to determine whether his illness was manageable on a less complex antipsychotic medication such as

aripiprazole for the longer term?
A. Correct.

Q. There was never a discussion, or you were not seeking a second opinion as to whether or Joel could be removed completely from antipsychotic medication?
A. No.

Q. You agree that what's contemplated there is whether or not he can be taken off Clozapine and kept on a longer term basis on aripiprazole, or another medication with less side effects?
A. No, actually, I just wanted a second opinion, and I got it.

Q. I'm going to take you shortly to a period of time where Joel is removed altogether from the Clozapine in 2018?
A. Yeah.

Q. Was there any second opinion that you ever sought at that time from another--
A. No. It was not necessary--

Q. Sorry. Just listen to my question, please. Was there ever a second opinion that you sought from a doctor at that time when you removed Joel from Clozapine altogether?
A. No. It was not necessary because, because the guidelines says that after the first episode of psychosis if somebody is symptom free for a year you can take him - take the medication off, or if there is a second guideline, but is not in our Australian guidelines, if somebody had treatment-resistant schizophrenia or Clozapine and symptom-free for five years you can consider, in selected cases, to take them off the, the, the antipsychotic and, and I was listening to the patient as the medication is part of the psychiatric care. The psychiatric care also means ongoing monitoring, ongoing therapy, psychosocial rehabilitation and, and basically a conjoined decision of how to manage the biological aspect of the illness.

DWYER: Could I have on the screen, please, p 240?

Q. This is a letter that you sent to Dr Grundy on 6 May 2015?
A. Optimum dose.

Q. No, just wait for the question, please. I'll just ask you to familiarise yourself with it.
A. I did.

Q. That's a letter you sent on 6 May 2015. I'll ask you if it refreshes your memory. You note there to Dr Grundy that:

> "Joel was started on Clozapine for his first episode of schizophrenia at age 17, after not responding to olanzapine and then risperidone, by Dr Nicky Stephens in 2002 while he was an inpatient at the

mental health unit. With the advent of Nicky coming to the private practice, I've approached her to give a second opinion regarding Clopine. What would be his optimum dose, could we switch him to another medication, for example, optimum dose of Abilify. Note this was reduced for Clopine induced OCD. I do believe Joel needs an antipsychotic for long term relapse prevention".

That was your view in May 2015 when you asked for the second opinion from Nicky Stephens, wasn't it?
A. Yes.

Q. Does that refresh your memory now?
A. Yes.

Q. That you actually did think at that time that Joel had chronic schizophrenia with a risk of relapse?
A. No, I said - it actually confirms the opposite. First episode schizophrenia, it says.

Q. But you do, you write there specifically, "I do believe Joel needs an antipsychotic for long-term relapse prevention"?
A. Exactly. Long-term relapse prevention. It is, I don't see any, I don't see any problem in here.

Q. Is there anywhere that you write in there that Joel does not have chronic schizophrenia, that it was first episode schizophrenia only?
A. It's first episode schizophrenia, and I--

Q. All right. I'll move on.
A. Yes, good, thank you.

Q. Is it the case that you at no time after 2015 when you decided to stop - well, I withdraw that. I'll go back a step. Clearly in May 2015 you did not intend for Joel to cease medication altogether, correct?
A. At that time not.

Q. You decided in mid-2018 that he could cease--
A. Yes.

Q. -- Clozapine altogether, correct?
A. And the reason because I couldn't see any schizophrenic process, which is--

Q. Okay, and in--
A. --the negative and positive symptoms.

Q. Just wait for the next question. In July 2019 or thereabouts, you decided he could cease any form of antipsychotic medication?
A. In 2018 May, end of May, we, we stopped, we stopped the Clozapine, and it was in - after I was very confident that he recovered from the first episode

schizophrenia and there was no schizophrenic process, negative or cognitive symptoms. And his personality has got better.

Q. Dr A, I'm going to give you every opportunity to say what you want to say about why you ceased the medication.
A. That's fine.

Q. And Mr Lynch will also be able to ask you questions when we've finished to make sure that you've had every opportunity.
A. Okay.

Q. But just so we get through your evidence, would you mind just focusing on what I ask you?
A. Yes.

LYNCH: Your Honour, I think in that answer it was responsive until my friend interrupted the answer, with respect.

WITNESS: Thank you.

HER HONOUR: If you could ask the question again, Dr Dwyer.

DWYER: The question I had just asked was Dr A deciding in 2019 to cease Abilify, and I think that was in response to her decision about Clopine.

Q. The medication for Joel was ceased altogether in 2019, you having made a decision in mid-2018 to cease Clozapine?
A. Mm.

Q. Am I right that you did not seek a second opinion when it came to the decision to cease Clozapine or to cease Abilify? That is all the--
A. No, I did not seek second opinion.

HER HONOUR

Q. Sorry, what was your answer?
A. I didn't seek second opinion to stop that or the others. And it wasn't necessary.

DWYER

Q. Why do you say it was not necessary when you had sought a second opinion from Dr Nicky Stephens about reducing Clopine and possibly changing to a different antipsychotic in 2015?
A. Simply because of his clinical state, and his - evidence that he hasn't relapsed and is evidence that the negative and cognitive symptoms has reduced. He's actually kind of got better, and his personality has shown positive growth and his functioning improved.

Q. I'll come back to that time period shortly, but in brief, you continued to

monitor Joel--
A. Yes.

Q. --from 2015 on a monthly basis, correct?
A. It was part of my job to do that.

Q. And the mental health nurses continued--
A. Yes.

Q. --to monitor Joel as well? And there was evidence that he was doing well--
A. Yes.

Q. --on the gradual reduction of Clozapine, correct?
A. Yes.

Q. So, for example, page 63, 21 October 2015, there is a note there that Joel was seen alone with his supportive father?
A. Mm-hmm.

Q. And he reported feeling mentally and physically well?
A. Mm.

Q. "Studying was going well. He had noticed improvement since decreasing Clozapine. Helps with memory. Feels more like used to when he became unwell. He feels more like he used to before he became unwell", that's page 63 and 64. Page 61 there's a note from 10 February 2016 - I'm just giving some examples here - you note that:

> "Joel was becoming more animated, talkative, and getting in touch with his emotions in a good way. He was appreciating the opportunity to feel this way with reducing the dose of Clopine. There were no negative effects so far. Spoke about the goal of becoming a Chinese language interpreter then marrying a nice girl, buying a house and working, and to work and live well."

So Joel obviously had significant ambitions at this stage, do you agree?
A. Mm.

Q. And he was reporting that he was physically and mentally better on the reduction of Clopine?
A. Yes.

Q. Then page - I'll just take you to by the end of the year, 16 November 2016 - page 56. He was seen with his mum, and he'd completed a Diploma of Arts in Chinese with a high distinction. And you continued to titrate the dose down after that, correct?
A. Mm-hmm.

Q. I'm going to suggest to you that was careful monitoring of Joel by yourself and the mental health nurses--

A. Yes.

Q. --do you agree? And you were very keen to make sure that given the reduction in dose you were going to watch Joel very carefully and take note of any changes, correct?
A. Yes.

Q. I'm going to jump forward then, because he continued to do well through 2017. Let's take 19 October 2017, page 46 of the notes. Joel's doing well. The organic screen was negative, except for a slightly lower serum calcium and sodium levels. He'd recovered from flu, et cetera. There's a note there, "Parents and he have decided to wait with the next cut in his Clopine dose until after Christmas". Do you recall now why his parents decided to wait?
A. Because of Christmas. Because they wanted to do the Christmas. Same as the last minute when we did - because they went on holiday. They were very thoughtful.

Q. So it's another example of you working with the parents?
A. Yes.

Q. Taking into account what they had to say about his Clopine dose, and monitoring him carefully, correct?
A. Correct.

Q. Page 44 is 24 January 2018. "Seen with mum. Mentally excellent but physically tired, fatigued", et cetera. And at that stage Joel was planning to continue with Clopine 25 milligrams at night, Abilify 5 milligrams in the morning. And he was asked to see Dr Grundy, his GP, about feeling physically fatigued?
A. Yes. Fainting.

Q. Sorry?
A. Fainting.

Q. He had fainting spells. Page 42, I'm just going to take you through the trajectory now. 5 April 2018.

> "Best I've seen him. Developed new interest in IT on top of continuing with Chinese. Energy is normal. He's happy with lots of spontaneous brief smiles, apsychotic and euthymic. Finding it difficult to terminate Clopine. Wants to do it slower, going down from 25 to 12.5 milligrams at night for a month, then maybe 6.25 milligrams at night for a month, then stop. Agreed with his plan. Follow up in a month".

So Joel there was very much involved--
A. Driving.

Q. --in determining his own plan for Clopine, is that right?
A. Driving, yes.

Q. Do you recall why he wanted to slow down?
A. I think it's because of this holiday coming up, and, and he was very cautious. He didn't want to relapse. He was frightened of relapse, but he also wanted to know. But at that time I wasn't really worried, because his Clozapine level was basically none.

Q. He was still on the Abilify, correct?
A. Yes. It was just, when you go down that, that slowly, that you can have withdrawal symptoms.

Q. You were conscious at that stage that he would need ongoing monitoring, even when he was completely off the Clopine?
A. I wanted to keep him in psychiatric care for the rest of his life.

Q. That's why you continued to see him on a monthly basis, correct?
A. Even though after stopping the meds, because he needed psychosocial help and monitoring.

Q. That was going to come from yourself--
A. Yes.

Q. --and from the mental health nurses, correct?
A. Yes. We didn't know anything about wanting to leave, you know, at that time.

Q. I'm sorry, I couldn't hear you, doctor?
A. We didn't know anything about he wanted to leave the town.

Q. At page 40 there's a note from 31 May 2018, and he was reported as perfectly well, no more physical symptoms, going hiking, et cetera, and he was ready to stop the Clopine at night and grateful to be given that opportunity?
A. And did not do the 6.25.

Q. You were committed to regular follow up after that time?
A. Yes.

Q. You were conscious of the risk of relapse, correct?
A. Always.

Q. Did you discuss that risk of relapse with his mum and dad?
A. Always.

Q. Is there a note about the discussion of the risks of relapse?
A. I did not read - I did not read it myself, so we always discussed early warning signs. So the nurse and I, every time talked about early warning signs of relapse and early intervention.

Q. Do you agree that if you talked about that there should be a note in here about the risks of relapse?
A. No, I thought it was redundant. And it's my fault that I didn't do it every

time.

Q. What risks of relapse, what did you ask Joel to look out for?
A. Always the positive symptoms.

Q. Which were?
A. I mean it's in his risks of, a management plan. That if he doesn't sleep for 24 or 28 hours in a row, if he feels that his thoughts becomes muddled or confused, or if he feels that he is having hallucinations and having preoccupations with, with an idea which he cannot let go.

Q. Given Joel did not have much memory of the positive symptoms, did you also discuss those issues with his mum and dad?
A. Yes.

Q. I'll just pause there.
A. Yes.

Q. I'll take them separately. Did you discuss those risk factors--
A. All of these.

Q. Sorry, I'll just pause.
A. Mum--

Q. Sorry, Doctor.
A. Yes.

Q. Did you discuss those risk factors with his mum?
A. Yes.

Q. Did you tell her specifically to look out for those symptoms?
A. Yes.

Q. Do you agree it would have been better if you had specifically recorded that in the notes, that you discussed that with mum?
A. In hindsight, yes.

Q. What about with dad? You knew that one of the vulnerabilities was that his dad suffered from schizophrenia.
A. Yes.

Q. And had positive symptoms. Did you discuss with dad, or no?
A. With, with - I did not discuss it with his father, who did maybe come with him once. But he was, he was obviously, he was obviously not well, but I did not discuss anything like - he was, he was happy with the medication discontinuation and what he wanted what the son wanted, but we did not really involve the father closely. The mother was closely involved.

Q. Can you tell us who RN4 is?
A. Yes. RN4 was one of the credentialed nurses who kept up with the

credentialing even though it didn't need. And she was one of the nurses who, who sometimes when RN3 or, or RN2 wasn't there, RN4 was there and, and stepped in.

Q. You said earlier that you would read the nursing notes when you came to see Joel?
A. Yes, always.

Q. I'm just going to show you a nursing note that was taken by RN4. It's at page 40 from 28 June. It's the month after the decision to stop the Clopine.
A. Mm-hmm.

Q. Do you see there the history, if you just scroll up, please, to 28 June. This is the Clopine clinic?
A. Mm-hmm.

Q. And the notation in relation to Joel is:

> "Waiting for referral letter from GP, came with father, Andrew, who dominated the interview with his grandiose religious delusions, claiming he has Daniel's delegated wisdom and knowledge from God, hearing the voice of God and demons, et cetera, but not psychotic. Glad to see son well, and he's happy that Joel is off his meds. Joel is doing well on no Clopine a month, no symptoms of mental illness".

You would have read that when you came back?
A. Yep. And I even asked Joel about the father, and he was such a lovely man who said, he was smile a little bit, and he said, "Yes, I know my father thinks that". And I asked "Whether you share anything of this belief with your father", and he said both mum and he didn't share it. But he was kind of appropriately answered this to me and put down his head and he little bit smiled, because he knew that, that it wasn't appropriate and maybe, maybe it wasn't a good thing to bring his father with him. He knew this father was psychotic.

Q. I'll just take you to that note. That's page 38 from 26 July 2018. At that time, Joel had been on no Clopine for two months. He subjectively was continuously improving mentally, according to your assessment, he was apsychotic, euthymic with good functioning. Very happy to come off Clopine, doing tutoring. And there's a note there "Spoke about his father's chronic psychosis and assured me that he and his mum are not sharing his eccentricities and delusions, but love him for his goodness"?
A. Yes.

Q. "Continue with Abilify and follow up monthly"?
A. Correct.

Q. It's pretty clear, isn't it, that Joel's father was very loving of Joel, no doubt still is, and his mother was very loving of Joel?

A. Of course.

Q. Both very loving and attentive to Joel?
A. Yes.

Q. But in terms of having a therapeutic alliance, that was going to be with mum, because dad was still suffering from delusions. Dad wanted Joel unmedicated?
A. Correct.

Q. Mum was happy for Joel to be medicated if it was required?
A. Yep.

Q. And mum could notice where he was delusional?
A. Yes, yes.

Q. Correct?
A. Yes.

Q. Did you know that Joel's mum had a nursing background?
A. No.

Q. In any event, you paid careful attention to what she said to you in relation to Joel's functioning, is that right?
A. Always, always checked it out with her before and after. Before we did something and after.

Q. You always checked it out with her, but you were also conscious, weren't you, that she was going to be well placed going forward to report what Joel's mental state was?
A. Yes.

Q. By November 2018, Joel came to be living independently. Is that right?
A. That was a very critical move in his life. It was, it was, to me, a success, an optimum outcome that he was able to start living alone, and I, I don't want to tell too much, but before, we prepared Joel for that. In the beginning he couldn't even do a tea for, for himself. But by that time he was able to make two minute soup, and those kinds of things, what the nurses were practicing with him and mum at home. So, he was able to look after himself to the point that we were all reassured that he would be able to move into accommodation.

Q. That was a very significant achievement for Joel and his parents and for your clinic to have got him to a point where he could live independently. Do you agree?
A. It was a milestone.

Q. But he really needed to have ongoing monitoring?
A. Yes.

Q. Because it was going to be a risk factor that he was living out of home. Do

you agree with that?
A. It's a stress. It's a stress, a stress, what we needed to manage.

Q. It was a stress?
A. Mm-hmm.

Q. So, one of the things that might be relevant to a relapse is stress that he came under. Do you agree?
A. Yes. Stress is always the relapse. I mean, most of the time with schizophrenia, stress causes the early warning signs and early warning signs if it doesn't respond to intervention that it would end up in relapse.

Q. On 31 October, this is at page 36, you see Joel with RN3. RN3, he was excelling in functioning, doing more than ever, going to the gym, looking for a unit, seeking employment agency for work, et cetera. The plan was to switch Abilify 5 milligrams in the morning to the evening, and he was congratulated on his progress. You obviously still wanted him closely monitored, monthly after that, by yourself and the nurses?
A. Yes, forever.

Q. Forever, you say?
A. I think not, not monthly, but I never wanted - I always wanted to kept him in psychiatric care or care or on a mental health care.

Q. That was because of the risk of relapses, that right?
A. And because of his very serious diagnosis of schizophrenia, they need, they need ongoing monitoring by, by a doctor.

Q. I'll come to skip to 15 May 2019, page 32. The note there from yourself is "doing really well, nervous, facial and UL tics noted". What's the UL stand for?
A. Upper limb.

Q. "Upper limb tics noted. Life long, about to meet a girl from online dating, keen to stop Abilify. Plan, arrange meeting with mum to discuss stopping Abilify in one month". Did you have any concerns about the risk of stopping all medication at that stage?
A. Always the risk of stopping medication was, was a risk. However, we were, we were now five years of, of full remission of, of schizophrenia at that time and we were dealing with the psychosocial rehabilitation at that time. So, it was, it was not against any guidelines.

Q. The plan was to continue with timely follow-up after that--
A. And I followed him up. I gave him the, I gave him the lead to choose what he wants to do. But always assured him that I will be there. I will never let him go down. I will, I will always keep him in mental health care.

Q. I'm going to come now to the period where there were signs of Joel's deterioration in 2019. Can I ask that you have a look at page 29. Joel was seen by Dr B--
A. Yep.

Q. --when you were on leave and in the history, she notes that the sleep is not as good lately, had melatonin, cut it back. She then wrote a follow up letter which is at page 149. "Thank you for referring Joel to me for review in your absence. I assessed him today". That was a letter to you to inform you of her specific concern. "The only concern is that he's not been sleeping well lately. The onset of disturbance seemingly was in the context of feeling medically unwell but it has persisted". Did that give you any concern as a possible sign that you needed to look out for?
A. Well, there's - the sleep is one of the most important signs.

Q. Did you discuss that with Joel as a risk factor in terms of his relapse?
A. I didn't see him on that month but when I saw him next time I think he, he was seen by, it was what month, was it--

Q. This was September?
A. September, did, after this, what nurse did he see. Did he see RN4 or who did he see after that?

Q. RN3, he saw her?
A. Okay, so RN3 might have discussed it with him, and I think at one stage I did with - I did take it on, I don't know when, maybe October with RN4, RN4, that nurse I talked to.

Q. I'll just take you to a note in October. Joel was due to have an appointment on 15 October 2019 and the appointment was cancelled by the practice and rescheduled. I withdraw that. A consultation note from 15 October suggests that Joel had an appointment on 24 October, but it was rescheduled to an earlier date of 17 October. Was that because of your concern about the sleeping?
A. I don't think so. No, no, no.

Q. I'll just take you to 17 October then, page 28?
A. Mm-hmm.

Q. You saw Joel on this occasion with RN3. "Seen with RN3 re mum's concern for relapse"?
A. October, okay.

Q. "Joel had a cold. He had a deep croaky voice, a bit less sleep and fatigue for two days. No other signs suggestive of an early--
A. Warning.

Q. --warning relapse". Is that right?
A. Yes.

Q. He was feeling good mentally?
A. Yeah.

Q. Mum's concerns and that lack of sleep were enough for you to want Joel to

be monitored more closely at this time?
A. Yes.

Q. Is that right?
A. Exactly. And the mum wasn't living with him, so he - she, she knew it from Joel for some reason and I don't know how but I always gave credit to the mother's concerns, and I don't know what was behind it. That was thought about the medical problems, yeah, but he, he - when people have a flu or symptoms, the sleep goes out.

Q. Under the history in that note, it says that Joel's mum had rung admin and reported her concern for his mental health and physical health, and she told Joel to keep the appointment that he had cancelled?
A. Yeah, correct.

Q. You then saw Joel--
A. Mm-hmm.

Q. --with RN3, and you discussed the concern for relapse, correct?
A. We did go through all the symptoms signs and he, he did not have any other signs just the insomnia.

Q. But was it in your mind, at that stage, that there was a possibility that Joel might mask the signs of relapse because he did not want to go on to back on to medication?
A. Okay. That was a good question. So, by the time I know, knew Joel very well and those little few sentences that I wrote actually was based on a quite thorough assessment, and I discussed it. I know that, I don't know, should I say that? Because since then I had access to all the collateral information what they sent me, the court. And I, I don't know whether I should say that but there's something major things happened in life which he concealed in that, in that, in that appointment.

Q. I'll just get you to explain that a bit further if you don't mind. So, on this appointment of 17 October--
A. At that time, I did not know about those, those stress, what he was going through. I just knew about that he wasn't sleeping well and that was all attributed to the, to the flu and cold at that time. He did not tell me anything about other stress.

Q. This was an attendance of more than 45 minutes--
A. Yes.

Q. --but not more than 75 minutes?
A. Yes.

Q. We know that from, that's what the Medicare billing suggests. So, over that 45 minutes, you saw him in relation to his mum's concern for relapse?
A. Yep.

Q. That's what you've written in the notes?
A. Yeah.

Q. What did mum report as to her concerns?
A. I think it was, it was, it was RN3 who took them, who took them, I am not - I think it's, it's the admin - relapse, that, that he wasn't sleeping and he looks stressed. That is what, what was that.

Q. You were obviously looking out for signs in him--
A. Yeah.

Q. --of the early warning symptoms for relapse. Correct?
A. Yes.

Q. And mum was obviously concerned that there might be an early--
A. But it was more like a general one. It wasn't specific because we didn't know any specific. It was just not, not himself.

Q. What were you going to say?
A. Having called, having called and, and can you, can you remind me of what did mother said to the admin? Because I always, I've always knew what the mother says.

HER HONOUR: I think it's if you go up the page.

DWYER

Q. The same page you were just on, page 28, has two histories recorded.

HER HONOUR: It might have been in the letter.

WITNESS: ..(Not transcribable)..

DWYER: It's a different date.

Q. So this is 17 October?
A. Yeah.

Q. "Consultation notes." There's a history with Dr A and there's a clinical consultation note at 11.12am from RN3. Do you see that?
A. Yeah. About possible relapse.

Q. Sorry, I missed that?
A. Mum was concerned about the possible relapse.

Q. "Mum rings." Do you see the clinical note taken at 11.12am by RN3 says:

> "History. Discussion with admin staff. Joel had cancelled reporting being unwell. Joel rang back and requested to continue with appointment. 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. Mother requested mental health nurse to be aware of Joel's current status."

We don't have a record of anything else that mum said to admin, but what she did say clearly was that she had concerns for his mental health and his physical health. On the back of that - that's a note that appears to be taken with RN3. You then see Joel the same day with his mum. Correct?
A. On 17 October I didn't see his mother.

Q. It says, "Seen with RN3"--
A. "Regarding mum's concerns about possible relapse."

Q. I see.
A. And it was - it was a physical and mental. Usually when people have, have a cold they mentally demoralise as well. So I, I - we actually did not know what happened at, at this stage in his life which was happening. But it was all somatised at the moment, physically.

Q. What do you mean by "somatised physically"?
A. Exactly. That he was having a cold, malaise and didn't want to come, and that was the issue, and didn't sleep well. That was--

Q. You thought that might be due to his physical experience of the cold?
A. Yes.

Q. What I'm going to suggest to you is that when mum rang up and expressed her concerns the practice very diligently followed Joel up--
A. Yes. Always. Always. Always. Promptly. So when I come in the morning the admin staff says, "Mum called." So the first thing what I said, "Okay, RN3, go and talk with - review the patient." That's it. I did that because I had no appointments, like that. So that was good, good to have nurses because they, they have flexibility.

Q. It was your view, wasn't it, that Joel should be closely monitored after that time?
A. Yes. Of course.

Q. There was a subsequent meeting then. From 17 October he was seen; just one week later on 24 October. It was your view, wasn't it, that the monitoring should switch at that stage--
A. Yep.

Q. --from monthly to weekly for a period of time?
A. Yep. Because, because, because, because of the - because of the stress and to monitor whether he, he will have early warning signs of relapse or not. And he was unmedicated. That's why.

Q. You must have been sufficiently concerned--
A. Yeah. I was.

Q. --by the fact that mum was raising--
A. Always.

Q. --possible mental health and physical health issues. Correct?
A. Yes.

Q. You referred earlier to an event that you didn't know whether to talk about, but something was happening around that time that you didn't know about?
A. Yeah.

Q. What was that?
A. I, I read the court stuff, that at the time he - and I did not know that he had a girlfriend with a normal three dimensional relationship. At that time he ended this relationship with that girlfriend of five months and he didn't have - we didn't even know that he had that girlfriend. I don't know whether it is relevant or not, but I think it is a bit relevant, I think.

Q. That would've been a significant stressor?
A. Yes. And I did not know. And we did not know about that girlfriend.

Q. I took you earlier to the fact that you then move from this period from monthly follow-up to weekly follow-up for a period of time. Correct?
A. Yes.

Q. I'm going to take you to that after the break, but it's 5 past 1?
A. Okay. One, one thing also. On the September when, when I know from my..(not transcribable).. In September when she saw Dr B about the cold, 4 September, he had an appointment with Jo Barkla, another psychiatrist. So he was well kind of looked after with psychiatrists at that time. So - and, and I just didn't even know that she(as said) saw Jo Barkla as well. So I just mention that. So this is how this..(not transcribable)..from this Court is helping me to understand better what's happened.

Q. I don't think anybody's going to suggest that Joel was not carefully followed up and seen regularly--
A. Yeah.

Q. --until the period of time when he was discharged from the practice?
A. Okay.

Q. After the break I'm going to take you to a period of time--
A. Thank you.

Q. --where Joel was no longer followed up.
A. Yes.

Q. To finish on that point that you raised, on 21 September 2017 there's a note at page 47?
A. I see it. 21 September.

Q. Joel was still on Clopine at this stage. You've got a note there, "Doing really well. Lost a kilo due to exercise. Apsychotic, euthymic, not over-anxious. Believes he's getting better mental state. Energy levels and QOL." What's QOL?
A. Quality of life.

Q. "With decreased Clopine. Obs stable. Normal temperature. Forget to do the group B test in August for yearly Clopine monitoring plan. Continue Clopine 50 milligrams at night and Abilify 5 milligrams in the morning. Referral to Dr Barkla re body balance"?

A. Yeah.

Q. Body balance was not a medication, was it? It was a--
A. No. This is a nutraceutical, and I did not do the referral. It was always the GP did, because the GP referral lasts for one year and my referral I just leave and have three, three months.

Q. He was referred to Dr Barkla in relation to something that was quite different to a review of the medication regime. Do you agree?
A. Yeah. I think he was - she was doing the body balance and what - did I refer to Barkla at that time?

Q. The notes there suggest "referral to Dr Barkla re body balance"?
A. Okay. Three months. For three months referral. So that was 17 September, but the continuing referral was done by the GP.

Q. Was it your view that body balance was an appropriate alternative to a medication regime?
A. I couldn't make any decision on it. He, he started the body balance way before he came to me. Dr Golik and then Dr Barkla.

Q. Did you think that Dr Barkla was an alternative psychiatrist?
A. No. He's a very good psychiatrist who, who, who became interested in nutritional and, and this nutraceutical type of--

Q. But he was not part of the plan for regular follow-up for Joel, was he?
A. Dr Barkla was - everybody who prescribes some he needs to follow up, so Dr Barkla followed it up.

Q. Dr Barkla was specifically in relation to body balance?
A. Yes.

Q. She was not there to monitor--
A. But he always - I, I saw her, her letters and he was also monitoring his mental health too. And he was - she was aware, aware that he stopped the medication. He was totally aware of, of the mental health issues.

Q. But it was not Dr Barkla's responsibility to continue to monitor Joel's mental health, was it? It was yours?
A. No. But he - but, but she did as a, as a, as a psychiatrist and psycho - nutraceutical prescriber.

Q. Do you take responsibility for the decision-making in relation to removing Joel from his Clopine and Abilify? Was that your decision?
A. It was my decision and his decision, not Dr Barkla. Dr Barkla was just in - but is a very, very good psychiatrist.

DWYER: Thank you, your Honour. Is that a convenient time?

HER HONOUR: We'll take the adjournment. We'll resume at 10 past 2.

LUNCHEON ADJOURNMENT

HER HONOUR: Yes, Dr Dwyer?

DWYER

Q. Just before the break I'd come to the point where Joel's mother had started expressing concerns that he was at risk of relapse. Do you recall that?
A. Yep.

Q. I put to you the issues of sleeping in September that Dr B had raised, and then in October you will recall that Michele Cauchi called the practice and expressed her concern for his mental and physical health at that time. She had concerns that he had relapsed. That's the presentation I put to you before the break on 17 October?
A. Yeah.

Q. At 2.38 that day you recorded a note that you'd seen Mr Cauchi with RN3 regarding his mum's concerns for relapse and at that time you recorded that there was a bit less sleep and fatigue for two days, but no other signs or symptoms suggestive of the early relapse with schizophrenic symptoms?
A. Yeah. Correct.

Q. You arranged, however, for him to be seen weekly for a period of time by the nurses, rather than monthly, for increased monitoring. Correct?
A. Yep.

Q. On 23 October 2019 there's a note from RN3 that recorded that Joel's mum reported that he did not have the skills for independent living and there was scope for peer support to increase his skills. You will have read that?
A. Yeah. And he was referred next day to peer support.

Q. He was referred to a peer support worker who worked at that stage at the practice--
A. Yeah.

Q. --on 24 October, the very next day?
A. (No verbal reply)

Q. On 7 November Mr Cauchi saw RN4 at the practice. He reported that:

> "He was sleeping well and that he'd met with a peer support worker the previous day, and they intended to work on things, including building relationships and overcoming sexual concerns, but he was unwilling to elaborate, other than confirming he was experiencing sexual dysfunction and he found it uncomfortable to talk to a female about it."

There was a note that he might wish to discuss those concerns with his GP. You will have read that note?
A. Yes.

Q. And been comforted that Mr Cauchi had seen the peer support worker as planned. Correct?
A. Yes.

Q. On 12 November 2019 Joel emailed the practice reception. Would you have read the emails that Joel wrote to the reception, or to the practice?
A. Yes. And also instructed the nurse to, to have an appointment with him about that concern.

Q. It sounds like you were anticipating the questions that I'm going to ask you. If you could - that's fine - but just focus on what I'm about to say.
A. Yes.

Q. Joel emailed the reception saying this:

> "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, Xbox, et cetera. Thanks, Joel."

It was clear that Joel himself had concerns about his excessive use of porn. Would you agree?
A. Yes. And that was the first time I knew about it.

Q. Did you have concerns that that might be a symptom of OCD?
A. No.

Q. Did you have concerns that that would be very difficult for Joel, given the religiosity in the household--
A. Yes.

Q. --and the apparent conflict?

A. Yes. OCD is different from compulsive involvement in porn viewing, or pornography. OCD is ego alien and, and is negative things, while those kinds of behavioural addictions are basically chasing the positive pleasure.

Q. Did you have any concern at all in relation to what Joel was writing, that he wanted to speak about having his access to porn restricted?
A. I think it was - it showed how good insight he had, and he showed how open he was with us.

Q. He himself wanted to restrict his own access to porn?
A. That was beautiful. Yeah.

Q. Which suggested that - I mean there's plenty of people in the community that look at pornography. But for Joel it was problematic, and that's what he was telling the practice. Do you agree?
A. Yeah. And the first - yes. And that is the first time I got to know that.

Q. You were concerned, weren't you, that for Joel, that would be distressing?
A. Yes. Because I know how he was raised as a Catholic. He was, he was going to church every weekend, or twice, was doing the healing group and other things. So I knew that it tormented - it might have tormented him because it was--

Q. That would be a cause of stress likely for him?
A. Definitely. It was, I think, it was the major stress.

Q. On 13 November, a practice note was taken by the receptionist. Is that right?
A. Yes.

Q. It reads this way: "Michele rang to say that Joel is very unwell since he came off his medication. She would like him to be reviewed as he was doing so much better when he was on Abilify. I advised I would pass the medication on" - meaning "the message on". Was that message passed onto you?
A. I think you refer to a very good email which was addressed to me. It was--

Q. No. Sorry, Doctor, I'm not.
A. No.

Q. I'm referring to a phone call that was taken by the receptionist and appears in the records. I'll bring that up for you so you can see it on screen at page 18?
A. Okay.

Q. Sorry, page 19?
A. It was on 13th.

Q. No. This is a different thing. It's the - sorry, yes, the 13th, and there's another email, and I'll take you to the email shortly. The email's from the 20th. If you just have a look at that page 19. This is a record kept by reception, so

page 19?
A. Yep.

Q. You'll see there reference to 13 November?
A. Yes.

Q. Can you see that?
A. Yes. I knew about this, so that's why I asked RN4 to have a discussion with Joel on the 14th. And a day later he came and had a - we had actually a conjoined appointment with Joel about that, about his compulsive use of porn.

Q. On the 13th, mum was reporting that Joel is very unwell since he came off his medication. She would like him to be reviewed as he was doing so much better when he was on Abilify. Did that concern you, that mum was reporting that Joel was very unwell?
A. Yes.

Q. It wasn't just to do with his pornography. What she was reporting to reception was that Joel was very unwell since he came off his medication, and he'd been doing so much better on Abilify?
A. Yep.

Q. That was obviously something you took into account. Is that right?
A. Yes. And I saw Joel on the 14th which - with RN4.

Q. I'm coming to that.
A. Yep.

Q. On 14 November 2019, you and RN4 saw Joel and your note from that is on page 26, "Seen with RN4. Insomniac." I'll just pause there. On the back of mum saying that he was very unwell since he came off his medication, and he'd been doing so much better on Abilify, and you then have information that he's not sleeping--
Q. Yeah.

Q. --were you concerned that these were early warnings of a returned psychosis?
A. Of course. I wanted to know why he was insomniac and we decided that he was insomniac because he was watching too much porn, so he had to give the phone. They were not living together. He wasn't living together with his mum, but he was very concerned that this porn was, was encroaching on his sleep and he was increasing in porn and I think that was the reason why he couldn't sleep.

Q. Did you write that in the notes? Is there anywhere in the notes that suggests that he was not sleeping because of the pornography?
A. I think - I think - I think RN4 has made that note.

Q. The note there is "Socialising with people from church. Has two ladies he's attracted to. Plans to ask one out. Wants to stop use of pornography.

Opposed to religious beliefs. Email noted and discussed. Given information on how to block sites--"
A. Exactly.

Q. That was the email that Joel had sent where Joel was concerned about his use of pornography?
A. Yep. So--

Q. You were aware that that was causing him stress?
A. Yeah. Yes. Definitely. But I did not know anything about his, his breaking up with the girlfriend and - but he was - that was the first time when I knew that he developed a compulsive interest in porn.

Q. Was it concerning you as a possible indicator of a relapse of his psychotic symptoms--
A. Yes.

Q. --that there was a compulsive interest in porn?
A. Yes. And we checked it out - I checked it out and there was no psychosis behind it.

Q. Given he was compulsive about the use of porn, how did you check out that there was no psychosis behind it?
A. Easy. I mean, there's two different, two different disease. Two different disorder. One is about, about voices or hallucinations, disorganisations, delusions, catatonia, negative/positive symptom. The other is driven by chasing a positive, positive feeling state.

Q. It's one thing to have a look at pornography in a way that might be described as unproblematic. It's quite different, can I suggest to you, to develop an obsession or a compulsion about pornography. That can be a disorder. Do you agree?
A. That - I don't know whether it was six months or not. As a disorder when it becomes six months. So it was a new - a new interest in him at the time. It was--

Q. You described it earlier as compulsive. Do you agree with that?
A. Yes. Compulsive. Because he, he wanted it. He, he, he was chasing it, so--

Q. You said that he wanted it and chased it so much so that it was interfering with his sleep which suggests that it was problematic. Do you agree?
A. Interfered actually we talked about. Interfered with his religious beliefs.

Q. Sorry Doctor, just before, just a moment before--
A. Yeah.

Q. --you said that the reason for his insomnia was that he had developed a compulsion in relation to porn. Is that correct?
A. Yeah. And, and also tormented by the conflict of his core values with this

new interest. He was - he did not want the porn - he wanted the porn to be controlled and that's why he ask how he can control those websites, and that's why, I think, it was beyond our scope, but actually RN4 could give him - because IT not my strength, RN4 could give him ideas how to block those sites. And I understand, psychologically, it was a huge stress because it was against his religious and core beliefs, and it was, it was definitely what he wanted to conceal from his parents.

Q. There were two problems with the issues with pornography at that time. One was that it was compulsive and interfering with his sleep--
A. This is how he describe. Yep.

Q. And the second was that it was a conflict with his religious beliefs and causing stress?
A. Yes.

Q. Did you consider that was possibly a sign of a relapse into some psychotic symptom?
A. Not the same, but it could have led to relapse. It could be, and actually this is what happened, that, that, I don't want to jump, but it, it, it had serious consequences in his life which later manifested in other things, but we will get there.

Q. On the back of mum reporting that he was unwell, and in fact ringing the practice and saying that he was very unwell since he was off his medication and had been doing better with Abilify--
A. Yeah.

Q. --on the back of that, Joel's compulsion about pornography and it causing insomnia must have concerned you very much--
A. Definitely.

Q. --that there was a risk of relapse at that time?
A. Definitely. That's why I checked it out whether it was psychotic, and, and I couldn't see any psychotic relapse at that time, but it was early warning signs of relapse. And we monitored it and that's why I gave him Zopiclone, which is a little bit - but he never filled it. So he didn't take it.

Q. I'll come to that. On 20 November there's an email that you referred to earlier at 8.15 Michele Cauchi emailed the practice to advise of her concerns about Joel. She said:

> "I'm contacting you about my son, Joel Cauchi. He isn't doing very well since going off Abilify and I know you thought it wasn't having any effect, but I have noticed a gradual decline in his condition, and judging from notes on paper he 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 is 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 am the one who looks after him when he needs it. I would like to see him being able to successfully live independently and be doing as well as he was a year ago when he first moved out of home. Thank you for your help."

A. We all did.

Q. Have you read that email?
A. In the morning when I stepped in this email was given to me, so I said RN3 that you have to talk with them. Interview mum and interview Joel. And that is what happened. RN3 went there. So I don't know--

Q. I'll stop you there. I've got more questions about the email.
A. Yeah. Yeah.

Q. In that email Mrs Cauchi, Joel's mum, was telling you a number of things that were concerning for you on the back of what she'd already told the practice. Do you agree?
A. Yeah. Yep.

Q. She said there, on the back of saying that she was very concerned about Joel and he was unwell since coming off Abilify, she says, "I'm contacting you about Joel. He isn't doing very well since coming off Abilify. It's for your attention", and she says, "I know you thought it wasn't having effect, but I've noticed a gradual decline in his condition--"
A. Okay.

Q. "Judging from the notes on paper he's left around the place I have a feeling he is now hearing voices"?
A. Yeah.

Q. She says, "He's been gradually declining since off Abilify. I think he's hearing voices", she says. "He's leaving notes around the house." There's a level of compulsion she refers to in going through half a cake of soap in one shower. In addition to that he's got stressors in relation to the volunteer job that he had with the English--
Q. Yeah. Didn't get the job--

Q. --and he was now at a loose end?
A. Yes.

Q. They were all concerns to you in terms of risk factors for him getting sick again. Do you agree?
A. Okay. The first - the first--

Q. Do you agree with what I said there?
A. Perfectly. The first - except the first sentence. Because after coming off the Abilify he was well until, until he got the cold and maybe, maybe that was breaking down when Dr B was seen. It was no problem until then. So I think maybe it was in August/September when he started to have this problem.

Now - so I agree with that. And I said it is an early warning signs of relapse unless it proven otherwise. So what happened, that I took more seriously - I took everything face value. But I have to tell you that, that his - Michele is a beautiful, beautiful mother, but is not a psychiatrist. She, she definitely described all the - all the behaviour change which made me very, very concerned. Made me to the point that, okay, it is early warning signs of relapse. It must be psychotic. So we have to go and see him and start him on a medication. So on the 20th--

Q. Sorry, I'll just pause you there. I took you earlier to the letter of Dr Stephens when you sought a second opinion in relation to the reduction of Clozapine, and Dr Stephens specifically said in that letter, "In view of Joel's limited recollection of his positive psychotic symptoms, the family are most likely to be the people to recognise any early signs of relapse".
A. Yes.

Q. And you agreed with her position?
A. So, I agree. I don’t have any conflict with you. I agreed.

Q. Yes.
A. And I agreed that it was an early warning signs of relapse and we had to act and do early intervention. And that my - because I was fully booked, so RN3 went and saw them, together and separate, I don’t know. And then next day she reported me that it was not, she couldn't see - can I continue? That, that it wasn't psychotic. So, it was a bit vague, but not psychotic. And next day I, I even, I thought I would err on the early warning signs of relapse, and I sent, I made a prescription of Abilify, because that was the - our agreement; that when he has early warning signs of relapse, then he would start taking the medication.

So next day I sent a prescription. RN3 talked with the mother, but they weren't living together, that, that he would start, start taking the medication. And I think he agreed with RN3 that he would start taking the medication. And I was reassured and I, and I was, I was going to ask, I asked RN3 to see him more and more--

Q. I'll just pause you there. Could we go--

A. --often, and I would see, I see him--

Q. I need to pause. I need to pause you there.
A. Yes, okay.

Q. And go back to 20 November 2019. It's the notes of RN3 in relation to a conversation that she had with mum.
A. Yes.

Q. It was a telephone call on the back of the email. Did you have a read of her notes--
A. Yes.

Q. --as part of your - all right.
A. We, we talked about it.

Q. Page 35.
A. We talked about - I don't know, I don't where this, this satanic control came, but it wasn't mother, it wasn't RN3. It was a misinterpretation of, of what went on between them. And yesterday I was really curious what was about it, but I didn't get an answer from RN3, what was this satanic control.

Q. Sorry, did you speak to RN3--
A. Of course I did. And, and I did not know what was this satanic control. And RN3 yesterday said in here that it was all about that he was masturbating in the shower and--

Q. I'll just pause you there. Did you speak to RN3 yesterday when she was giving evidence?
A. No, I never, no, I haven't spoken. But I saw, I was here.

Q. You listened to her giving evidence you mean?
A. Yes, yes, yes.

Q. All right. Can I just ask you to have a look, please, at page 25? This is the clinical note that was taken by RN3 after the clinic received the email from mum reporting her concerns?
A. Mm.

Q. It comes on the back of a phone call with mum re her concerns?
A. Yes.

Q. She offered ongoing monitoring, support and education, and there was a review later that day. And what she records in those notes, that you will have read, is reports from those known to Joel of changes in behaviour.

> "He's having extreme OCD with showering 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. 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".

A. Mm.

Q.

"Leaving his phone with his other at home overnight so as not to use his phone and internet for porn sites. Mother reports he is walking funny, change in his gait. He reports he's afraid of getting sick and he's wearing layers and layers of clothes to prevent it. He has been observed that he bends his head a lot and has odd movements.

Possibly, mother does not want Joel to know that she's raised her concerns of deteriorating mental health. Possibly hearing voices have been considered. Peer support has cancelled appointments. Only had one meeting and not engaged, making excuses. On last two visits of the practice, on presentation he asked for coffee and tea. It was unusual behaviour.

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 the same. Asked him to come with mother. Agreeable to same".

I'll just pause there.
A. Mm.

Q. The notes that were taken by RN3, regardless of anything that Joel had said previously, were indicative of a serious concern about a relapse--
A. Correct.

Q. --into psychosis, do you agree?
A. Correct.

Q. Of particular concern there was the reference that mother talked about "written a lot of notes at home and leaving them about". Mum had read them with some content of under satanic control and religious themes. Did you ever see, ask to see those notes?
A. Actually, I did not see any notes, and I don't think the mother made a photograph of it.

Q. Did you ever ask to see a copy of those notes?
A. There was no, no notes of that. It was just something between the mother and, and RN3.

Q. Just listen to my question. Did you ever ask the mum, that is Mrs Cauchi, if you could see a copy of those notes that he was making?
A. She, she did not collect the notes. It was in the house.

Q. Did you ever ask her if you could see a copy of those notes that Joel was writing?
A. No.

Q. It must have been, you accepted mum's--
A. Of course.

Q. At face value, didn't you?
A. Yes, I did.

Q. That there were these notes about--
A. And, and I agreed that it was early warning signs of relapse, unless it proven otherwise. So, I on the same day, I think, 21st, when, when I got that one, I, I started the medication.

Q. You started the medication because you accepted what mum was saying?
A. Yes, yes. I erred on the side of safety, and I thought it was, it was the early warning signs of relapse, which could be the relapse of schizophrenia, and sent him the medication.

Q. In relation to what was being exposed by mum's email and RN3's follow-up conversations--
A. Yes.

Q. --you thought this was the relapse into schizophrenia?
A. I thought that, yes. Yes, correct.

Q. You agree that you have to have a high index of suspicion?
A. Yes.

Q. Because of the risk of relapse?
A. Yes.

Q. Do you agree?
A. Agree.

Q. You also understood that mum was very well placed to be witnessing--
A. Yes.

Q. --these symptoms?
A. Although the mother is very, very good, and I, yes, repeated this so many times, yes.

Q. Okay, so--
A. However, he - she - is not a psychiatrist, you know.

Q. Sure, but you just agreed that--
A. Perfectly agreed.

Q. --for a long time you had regarded her--
A. Still.

Q. --as a very diligent mum--
A. Still.

Q. --very concerned about her son.
A. Still.

Q. And well placed--
A. Mm..

Q. --to tell you?
A. Mm.

Q. In those circumstances, you took that very seriously and you arranged for him - or your view was that he should commence Abilify again, correct?
A. Exactly, exactly.

Q. You thought in fact that he should commence Abilify at a higher dose than the one he had taken when he was weaned off?
A. No, it is a typo. And he also understood it was half, half a tablet. It wasn't - it was, it was just typing error that, that it was one a day.

Q. Sorry, just have a look at page 25.
A. Yeah, no, I did. One a day. But it was, it was conveyed to him half a day. Because I didn't want to do higher dose than what he was at that time when he stopped it. It was my, it was my typing error. But, but never been 10 milligram. It was--

Q. Was he prescribed 10 milligram?
A. There is a 10 milligram tablet. There's no 5 milligram tablets. It's usually half a tablet, and, and he knew that it was half a tablet. It was my, my fault. So I did not, didn't realise that. But everybody knew it was half a tablet.

Q. The prescription history appears in the brief of evidence at page 5 of these notes I've been taking you to. Do you see there that when you've previously prescribed Abilify, for example, 20 March 2019, and it says half in the morning?
A. Mm-hmm.

Q. Then when you prescribe on 21 November it says one in the morning, so you don't write half?
A. No, but it meant it. I said it was a typo. It's my error.

Q. That's two typos, isn't it? One in your clinical notes at page 25 and another one when you go to write up the prescription?
A. Yes, because it was automatically brought in by the, by the software.

Q. Are you sure that - I'm not suggesting that you're deliberately telling an

untruth, but are you sure that you are not reconstructing in your mind--
A. Definitely not.

Q. --what you now--
A. That, that note which appears in Genie, it was brought in by the software from the prescription.

Q. I'll come to that consultation note on 21 November. The consultation on that day at page 25 shows that the plan is Abilify tablets 10 milligram. Let's assume you mean a half.
A. Mm-hmm.

Q. For him to take half. Did you see Joel yourself, or was that just--
A. No.

Q. --the plan?
A. No. And, and, and then you see it on 21 November in my writing that I did not see Joel. I don't - whether is there, but in six monthly, I sent a six-month script of Abilify 5 milligram mane to chemist. But, you know, it was a typo. It was - yeah.

Q. So, you didn't see Joel?
A. No.

Q. But RN3 saw Joel?
A. Yes, and told to start half a tablet.

Q. You understood that there was an email from mum expressing her concerns and that there'd been a phone call where mum expressed those very serious concerns. Did you ever have a conversation with mum yourself?
A. Not this time. It was, it was RN3 and her.

Q. Did you ever have a conversation with mum about her concerns, about the satanic notes, at any time after 20 November?
A. No, no.

Q. Was that an error, do you think, of yours, not to bring those up and discuss them with mum?
A. I think I, I felt that I escalated it to the point of, of hoping, of, of, of a possible evidence of delusion or something. I definitely erred on the side of the safety that it was an early warning signs of relapse and accepted it face value and sent a prescription next day.

Q. Understood. You thought that Joel would take that prescription because he had previously agreed to take a prescription, to take the drug if there was any signs of relapse, is that right?
A. It was our, our agreement that he would take the medication if there is early warning signs of relapse.

Q. And you thought there was early warning signs of relapse?

A. I did.

Q. That was conveyed to Joel by RN3?
A. Yes, it was.

Q. You wrote the script for Abilify?
A. Yes.

Q. And you thought Joel would take it in accordance with the agreement?
A. Honestly, I thought he was going to take it. However, I have to tell you that on the 20th and the 21st, RN3 told me he wasn't psychotic. Early warning signs of relapse, not necessarily psychosis.

Q. Sure. But it wasn't, you had to have a high index of suspicion?
A. Yes, I was, yes, I did.

Q. You had to have high regard for what mum was telling you?
A. Mm-hmm.

Q. And you would expect, wouldn't you, that Joel might not have insight into the signs of when he was becoming unwell, because he'd had such limited memory of them, correct?
A. Yes.

Q. You also would be conscious that a patient like Joel might cover up his symptoms because he didn't want to experience the side effects of medication, having lived medication-free?
A. No, I wasn't aware at that time that he had any side effect on, on that medication, that type of side effect, you know. I thought that he was, he was quite happy with the Abilify. He had more side effect on the, on the Clozapine. So, I did not expect that barrier to take the medication. So basically, I really hoped and almost believed that he was going to take the 5 milligram Abilify next morning.

Q. In the email that mum sent on 20 November, she specifically says when, she says that she feels he's hearing voices and says, "He quite possibly won't let on what's going on in his head, but I think you need to know how he is".
A. Yes.

Q. You were an experienced psychiatrist, you would be aware that patients, including Joel, might not be forthcoming about experiencing symptoms?
A. Mm.

Q. You agree?
A. Yes. But we also very experienced psychiatrists and nurses who known him for long time, and we also had this kind of sixth sense that we would know that he was covering up or he was genuinely psychotic, or..(not transcribable).. psychotic. And RN3 who worked in multiple places from acute to extended rehab, I believed that she couldn't find any, any evidence of psychosis. It was just early warning signs of relapse.

Q. There was nothing that Joel was saying that indicated psychoses, but RN3 accepted what mum said about what she was experiencing, and so did you?
A. I did. But it is just a collateral history. We have, we have to base our assessment on the assessment of the patient. We take the collateral history as one important thing. But our--

Q. Well in that case, why did you prescribe Abilify?
A. Because I erred on the side of the safety and I did not want him to become psychotic. So, it is more like - okay, early warning signs of relapse, they are non-specific symptoms of distress which could become relapse. In the literature, early warning signs of relapse is very useful. The sensitivity to pick up psychosis is 82%. The specificity is..(not transcribable)..so there is lots of false alarm which does not indicate that it is due to psychosis. So, you need to understand that, and then our job is that's why we were experienced psychiatrists and nurses, who were experienced--

Q. I'm going to stop you there. Mr Lynch, your barrister, can ask you any questions if he thinks that you've missed something. On 20 November what mum was reporting was excessive behaviour. That was on the back of the obsession or the compulsion about porn. He was writing a lot of notes. Mum read the notes. They had content of satanic control and religious themes. The desire for porn was in conflict of them. She was reporting a funny change in his gait and you accepted those symptoms as described by mum, correct?
A. Yeah. Yes.

Q. When Joel was seen by the nurse, the mother was again reporting her concerns.

> "Mother reports signs of deterioration. He was struggling to cope with his independence. His unit was very untidy and messy. After ceasing Clopine, he was able to drive a car but this was now a struggle".

So there were signs when RN3 saw him that there was decline in his mental health? Do you agree with that?
A. Yeah. It was definitely a distress, a very high distress time.

Q. That was all supportive of him being placed back on Abilify to prevent a relapse, correct?
A. Yeah. Yes, I wanted him to restart Abilify to prevent a relapse.

Q. In addition to the symptoms I've already told you about, from the 20th, he reported that he was afraid of getting sick and was wearing layers and layers of clothes to prevent himself getting sick. That was possible paranoia. Do you agree?
A. It was possibly something to do with his, his, his - I don't know. Phobia of germs or, or, or cold or something and didn't want to get sick.

Q. He has been observed that he bends his head a lot and has odd

movements. That's consistent with what mum was saying about a change in his gait?
A. Yeah, yeah.

Q. That might be evidence of psychosis?
A. It's all come together, all the early warning signs of relapse.

Q. You prescribe Abilify. You said that you wanted him to take half a tablet but you didn't speak to Joel or his mother yourself?
A. No. No, I didn't because I had full clinic and I - that's why I work with nurses. That it was well within the scope of a mental health nurse.

Q. Did you say that you had a conversation with RN3 that day?
A. Definitely, many.

Q. Did you tell her to advise Joel to take half a Abilify?
A. Exactly.

Q. On 21 November, there's a consultation note taken by RN3 when she sees Joel on his own to discuss psychoeducation?
A. Mm-hmm.

Q. She makes a phone call to the home line to advise his parents that Joel has a script for Abilify but he has chosen not to have it filled at this time. When did you first find out that Joel had chosen not to have the script for Abilify filled even though you thought he would?
A. Maybe the next day but not on the same day.

Q. Was that of concern to you?
A. I can't, I can't remember - it was concern but, you know, it was weekend. He is a private patient and, and we all - like, we have to agree on the symptoms that he believes that he is experiencing early warning signs of relapse. From outside, from behaviour, judging from the mother letter, he was. But inside, and I know that time because you told me yesterday and also I read the collateral history, he was actually attributing his, his distress to having contracted HIV. So, on the same day when we prescribed - I prescribed his Abilify, he went to emergency department and got double retroviral agent and started to take that. This is what I know from retrospective. So, in his mind he felt that the early warning signs of relapse wasn't psychotic but was more to do with the fear of STD.

Q. Well, the fear of STD doesn't explain the excess - doesn't explain writing a lot of notes at home, leaving them about with satanic content of religious belief?
A. No, no. But his--

Q. And it doesn't explain the change in gait?
A. No. But it's also - it very well explains his internal torture and the domain, cultural religious domain of his preoccupation with pornography, sex, and women.

Q. You understood that that would be a considerable stress to him?
A. Definitely and--

Q. And that the stress--
A. --he, inside, attributed his symptoms, his distress to this one.

Q. The distress itself might be a contributor to him becoming psychotic? Do you agree?
A. Yes. He could have become psychotic and I wanted him to take the medication.

Q. You had an agreement with him, didn't you, that if there were signs or symptoms of psychosis he would take the Abilify?
A. Yes. But eventually, he's a private patient and he decides whether he wants to take the medication by his own. And, and we using what we call adherence therapy, exploring, resolving the, the ambivalence about medication. He inside, he knew that it wasn't psychotic. He knew that it was due to his preoccupation with pornography.

Q. Are you suggesting that at this time Joel did not in fact become psychotic?
A. Retrospectively, a week later I was sure that he did not because he didn't take the medication--

Q. That's not my question. Sitting there now in the witness box, when you review the symptoms that Joel had at that time and what has happened subsequently--
A. Yeah.

Q. --do you believe that he was becoming psychotic at this time?
A. On 20 and 21 November I did but I didn't know anything about the others. You know, the--

Q. Listen to my question, if you don't mind. Sitting there in the witness box today, do you accept that Joel was becoming psychotic around this time? That is, that you were right the first time around?
A. I felt that he exhibited early warning signs of relapse and he could become psychotic. That was I thought--

Q. Do you now accept that he was becoming psychotic?

LYNCH: Your Honour, plainly my friend's questions is at cross-purposes with the witness. If my friend is putting that, looking through the retrospect scope now, with the knowledge of the awful killings that took place by Joel last year, there is some cause for her now reassessing what she observed and concluded back in November--

DWYER: That's not my question and I'll withdraw it and I'll ask--

HER HONOUR: We seem to be going over the same words and what the

doctor is saying is that there were early warning signs of a relapse.

Q. Correct me if I'm wrong, but you didn't think that Joel was psychotic?
A. At that time--

Q. At that time.
A. --wasn't psychotic. Just early warning signs of relapse and we, we had to hit on that.

Q. That's what you thought at the time?
A. Yes, yes.

HER HONOUR: And now your question?

DWYER

Q. Do you now accept that they were early warning signs of psychosis?
A. Hard to say that. A week later when I saw him he did not take the medication and he did not have any symptoms. The symptom resolved by taking dual antiviral agent and it was slowly, slowly leaked out to us by the mother phone, phoning us on the fifth and - fourth, and on the fifth he called or he went to RN3 and said that he had a sexual - the intersexual encounter around November something and he thought he contracted HIV. And he told that - so, it was a syndrome which was to me, at that time, psychotically based but a week later, I had the explanation that it was not psychotically based. And I was as assertive as I could be to encourage him to take medication--

Q. Doctor, he did not--
A. --but he did not take the medication and in hindsight, it wasn't even necessary because the early warning signs of relapse gone by solving the problem of his fear of contracting STD.

Q. Doctor--
A. It wasn't psychotic. That's the answer.

DWYER: Sorry, your Honour.

HER HONOUR: I don't think that this witness is going to change what she says today but we have the experts coming next week.

DWYER: Yes, sure.

HER HONOUR: So, I don't know that we can get any further and I'm conscious of the time. It seems that the position is that no -

Q. And correct me if I'm wrong--
A. Yeah, it wasn't.

Q. It wasn't?
A. It wasn't and honestly I think--

HER HONOUR: In her opinion, he wasn't psychotic.

WITNESS: It wouldn't have changed the outcome and in hindsight, it wasn't necessary--

DWYER

Q. Sorry, Doctor, you're suggesting by that--
A. --the medication--

Q. --that at no time after you stopped seeing Joel in 2020 did he develop psychosis? Is that your evidence?
A. Exactly--

LYNCH: I object to that. The four years intervened--

WITNESS: No psychosis.

LYNCH: --and it's impossible for this witness--

HER HONOUR

Q. Just one moment, please.

LYNCH: --to express an opinion about what happened after four years absent any contact.

HER HONOUR: I think the question should be, do you think that he did develop psychosis?

WITNESS: No.

DWYER

Q. Do you think that he did develop a psychosis?
A. No. It wasn't the psychosis. It wasn't even early warning signs of relapse. It was based on his fear of STD. It was based on his sexual frustration, what he told us later on, about prostitutes and women and sex.

Q. Your--
A. That is my honest answer.

Q. So, on 13 April 2024 Joel killed six people and he wounded another ten people. Is that consistent with a person who you saw when he was being treated from 2012?
A. Absolutely not. During the eight years, I met - I looked after Joel, he never had one psychotic relapse. He never had one issues with safety to self or others and he was never preoccupied or fascinated with weapons.

Q. Do you accept that on 13 April 2024 he had developed a psychosis that explains why he killed six people and injured ten?
A. Do you ask my opinion?

Q. Yes.
A. I think when he was first psychotic--

LYNCH: Your Honour, I object to this. The experts, all five of them, have identified factors based on the four years of history, the Cellebrite phone messages, the internet searches, all which lead them to conclude based on all the visual material, the body worn videos, that they formed a view. This witness hasn't read that material. She hasn't had the opportunity to consider all of that vital information that leads the experts to express a view about that subject. And it's a futile exercise, in my respectful submission, for my friend to pursues this line of questioning and it doesn't assist your Honour in any way.

HER HONOUR: That is the context with which I'll understand her evidence, Mr Lynch, but I'll allow the question but it is with that knowledge that I have and that in that context that she doesn't have the same background that the experts who have the benefit of the entire brief.

LYNCH: As your Honour pleases.

HER HONOUR: If that question is - on that day?

DWYER

Q. On 13 April 2024 when the events at Bondi Junction unfolded, do you believe that Joel was suffering from a psychosis?
A. I have to answer you based on my knowledge that in 2001, 2002 when he was psychotic, the main, main domain of his problem was disorganisation. I honestly believe that his - that is my opinion, that was nothing to do with psychosis. He couldn't have organised himself to do what he did. I think it might have been, might have been due to his, his frustration, sexual frustration, pornography and hatred towards women. That is my opinion.

Q. You understand that the view of the expert psychiatric panel is that he was suffering from a psychosis on the 13th of--
A. Yes, I read them.

Q. You disagree with them?
A. No. Read them. Read them.

Q. I said do you disagree with them?
A. On that point, yes. On that point of highly organised behaviour to kill six people, injure ten, he has to be very organised. And at the time when he was psychotic, he was so disorganised that he couldn't put two words together. He had to go to hospital.

Q. On 5 December 2019 Joel was seen by RN3 and discussed at a clinical

meeting. He was encouraged on that day to start medications, Rexulti, especially if he noticed any early warning signs or deterioration. Were you part of that discussion?
A. Yes. It was a precaution. I gave him the, I gave him the pills, and I wanted - I was assertive as I could be to take the medication. But he did not take it because he didn't believe that he was psychotic. And in hindsight, he wasn't psychotic. And I honestly believe--

Q. Sorry Doctor, please, we're trying to get through this. I'm trying not to interrupt you--
A. Okay.

Q. --but if you could just listen to my questions.
A. Me too.

Q. On 5 December 2019 were you part of the decision making at that clinical meeting?
A. Yes. I, I gave him the prescription. I gave him the tablets. Like here, if you feel that you, you have early warning signs of relapse please take it, but he didn't have by that time.

Q. The management plan at that time was for him to restart the medication and begin taking the Rexulti. Is that right?
A. If he - because he said that he only didn't take the Abilify because of dysphoria. Didn't say about sexual function and 5 milligram - 5 milligram Abilify doesn't cause sexual dysfunction. So--

Q. Sorry, could you have a look please at page 23 of the notes.
A. Yes

Q. RN3 writes a consultation note?
A. He felt dysphoric on it, he said. Rexulti. I gave him the trial pack. If he thinks that he is - he needs that because if he identifies early warning signs of relapse--

Q. The management plan was to restart the medication and begin taking the Rexulti--
A. No. The management plan--

Q. --and that reads there, "He advised Joel prescribed management plan is to restart the medication and begin taking the Rexulti." Do you see that?
A. "I advised Joel's mother that Joel is to start taking Rexulti"--

Q. Just read above that, if you don't mind. There's "examination" and then above that.

HER HONOUR: Have we got that on here?

DWYER: Above the word "examination".

WITNESS: Okay. Examination. Reports feeling mentally - speaking freely about current situation. Embarrassed about talking--

DWYER

Q. Do you see, sorry, Doctor, third line down from the top, "Advised Joel his prescribed management plan is to restart medication and begin taking the Rexulti. He wants to discuss this with Dr A as he feels mentally well"--
A. Yes. Because he disagreed that he had early warning signs of relapse.

Q. Your plan was for him to restart the Rexulti, but he wanted--
A. When he is ready. I can't pressure people to take medication. We have to have an understanding why he's taking the medication and he, he insisted that he didn't have early warning signs of relapse. He attributed it was gone. Whatever it was, was on 2021 November he solved the problem by taking the double retroviral agent. He didn't have any problem with those behaviour, which was mother described. He was good. He was having holiday. He was, he was having good time, and--

Q. Doctor, please, on that day he agreed to see mental health staff and he requested if he could talk to you by phone or Skype today. So that suggests that you were not at that meeting and that he requested to speak with you by Skype or phone?
A. I can't just talk with people Skype or phone on the, on the spot. That's why I have nurses--

Q. I'm not being critical of you--
A. No. I couldn't.

Q. --but that's what it says. Is that right?
A. That was, that was - that couldn't happen so I had, had an appointment with him in January.

Q. That's 8 January 2020?
A. Yes.

Q. That's a month later and that appears at page 21?
A. Yes. And I said--

Q. On that day Joel was seen by yourself with RN3?
A. Yes.

Q. You write a note that he was "totally well and doing well"?
A. Yes. It was true.

Q. "Euthymic and apsychotic. Continue no meds"?
A. Yes.

Q. The plan there--
A. Changed.

Q. It changed--
A. Changed. And, and--

Q. --from taking the Rexulti to taking no meds?
A. Exactly. So I was assured that in hindsight he didn't have to take the medication and wouldn't have changed the outcome.

Q. There's no reference at that meeting of any discussion with Joel about the risks of relapse. Do you agree with that?
A. We always talked about the risk of relapse, how to monitor it, and how, how to - because we did not know that he's going to leave us at that time. We had - we have kept in care, we have kept in under monitoring, and we have - we had not discontinued the care.

Q. Do you agree that there's no reference in the notes to any discussion of the risks?
A. We had - we had discussion of the risks, that's why it went too long.

Q. Do you agree there's no reference there in the notes to a discussion?
A. Definitely is not - there's - I can't see anything. But it was.

Q. Do you agree that there's no reference there to a discussion with Joel's mum about how he's going at that time?
A. I don't remember talking with Joel mum, but RN3 might have talked with the mother.

Q. Do you agree there there's no reference to a discussion with Joel's mum?
A. It's not written, but then lots of things are not written and happen, so.

Q. According to your billing records, that was a 75 minute meeting--
A. Yeah. So must've been--

Q. Sorry, an attendance of more--
A. Must've been a lot of discussion about risk, but I did not document. Sorry.

Q. What do you think about the quality of your note if there was a lot of discussion of the risk at that time on 8 January on the back of the symptoms that had been reported by Joel's mother?
A. I think you are right. I did not write it down.

Q. Your view at that time was that Joel was mentally well?
A. Yes.

Q. What did you think was the explanation then for the--
A. What he told me. He told me what was it.

Q. My question was going to be, what do you think is the explanation for what his mother had noticed in relation to the satanic notes, the obsession and the compulsion in the shower and with pornography--

A. Simply--

Q. --and the strange gait?
A. Simply. When you - when you look something from outside it's not the same when you examine somebody inside. So the behaviours what he describe, I don't know where the satanic control came, it was, as I said to you, it must be a religious domain to, to the - to the conflict what he was going through and the behaviour what he was going through. That's the difference between a outside parent description and the specialist follow-up and comprehensive assessment. We took it, took it face value, but it did not - it did not become--

Q. You knew that Joel's situation with respect to his parents was somewhat challenging because, for example, in spite of the concerns expressed by mum, when RN3 had a discussion with dad on 21 November--
A. That. That was..(not transcribable)..

Q. Sorry, just wait for my question. Please, Doctor. The information is - this is page 24 for my friends:

> "Information given to father who became adamant that he did not want his son to go on medication as it will kill him. Father spoke that he himself had been traumatised by demons when awake, and hears voices, and is not on medication."

Here's the situation for Joel. Mum was reporting those symptoms, which you thought were early warning signs?
A. Yes.

Q. Back at home Joel had internal conflict because of the compulsion about pornography and religiosity. His father, who himself suffered from schizophrenia, and was hearing voices and suffered religiosity, was adamant that he didn't want his son to go back on medication because it would kill him. His father spoke about being traumatised by demons when awake and hearing voices and wasn't on medication?
A. Yeah.

Q. And then you had Joel presenting as totally well. But you must've at that stage--
A. It was on 21st. I, I did not see Joel on the 21st--

Q. No. At some point in January when you saw him, he presented as totally well--
A. Okay.

Q. But you must've had a high suspicion--
A. Yeah.

Q. --still that he might be suffering the early warning signs of psychosis?
A. I did. I said to you - and the father told about that, that no medication on

21 November when they didn't live together, so the father always openly said that kind of thing. We know that. It hasn't changed. It hasn't changed anything. But at the same time, 21st of - he presented to two places at that time. To emergency department and the sexual health clinic for the double retroviral thing, and he started to take them. And the mother thought that he's taking my medication.

The aunty who said on 4 December to the mother, "That's the name of the medication. Do you know that", and the mother talked with us and said, "No. We did not - we did not prescribe it." RN3 talked with the GP who said did not prescribe it. And then 5 December he volunteered that he was - he volunteered to RN3 that he was taking that for prevention. And he asked on the 31st to take a sperm - I know from yesterday - frozen and it was for a person who believes they contacted HIV from a brothel - prostitute. It was totally normal. Because I looked at it. Yesterday I went home and went online, and it was totally normal to request the sperm to be frozen.

HER HONOUR

Q. Thank you.

HER HONOUR: Let's move a little further forward now.

DWYER

Q. You last saw Joel face to face on 8 January 2020?
A. Yes.

Q. What I put to you was you must have still had suspicion at that time that there may be symptoms of psychosis, given the conflict at home and what had been reported by mum. Do you agree with that?
A. Last, last saw him in--

Q. Face to face on 8 January?
A. In January. Yes. I was absolutely sure that he wasn't psychotic, and that early warning signs of relapse was a false alarm. It was not psychotically driven.

Q. On 14 February 2020 Michelle rang again to express her concerns about Joel functioning at home and his probable move to Brisbane. She said:

> "His self-care is poor. His father went round there to put the bins out, the place was a mess. Dishes in the sink. He appears more isolated and irritable, and is occasionally swearing."

When you read that were you concerned that, in fact, you might be wrong?
A. No. I put it in the context because he was living with the parents at the time. His, his house, which was mess, was under repair and, and I know that he had psychosocial impairment or disability, so he wasn't really a tidy person. And he was living with the mother. And what he told me that he was sexually

frustrated, that he couldn't bring girls up to the parents' house.

Q. Did you have no concerns at all by that stage--
A. I thought it was his frustration about, about sex, about girls, about prostitution, about, about pornography.

Q. By that stage had you been able to put all of mum's concerns to the side and satisfy yourself that he was completely--
A. It, it was - it was congruent with the context.

Q. Sorry, I'll just finish my question. By that time had you been able to put all of mum's concerns to one side and satisfy yourself that he was mentally well and he didn't need to go on a--
A. No. I validated mother's concern, and I talked with him, and he told me that. And he told me, I think when I saw him..(not transcribable)..when was it, sorry.

Q. You saw him on 17 February 2020 for the last time on Skype?
A. I'm sorry. 17. 17 February. I think it's missing 17 February. Where is that?

Q. That's page 20 of the notes, or they can come up on the screen.

HER HONOUR

Q. There we are. It's on the--
A. 17 February is here. Yeah. Okay. And I - it, it was a long Skype appointment, and he was back to his very normal self. Good personal hygiene. No tics. Mentally aware. No sign symptoms of psychiatric disorder. I did not, you know, that compulsive porn was not talked, talked about.

DWYER

Q. By that stage, we can all read that note. By that stage had you satisfied yourself that you could put mum's concerns to one side and that he was mentally well on that day?
A. Yes.

Q. And there was no further risk of relapse?
A. Okay. What did I write? He was staying with his parents at home. Flat was under renovation. People interested taking over lease, can't ..(not transcribable)..up. Okay. I think it was at one stage he said that the parents were, were supporting his move. I think it was in January when said that the parents were - are supportive of his move.

Q. At that stage did you consider that there was a risk of relapse for Joel, given what had been reported to mum and his ongoing--
A. Look, I was - high suspicion. Yeah.

Q. Please just wait for my question. Did you consider that there was a risk oof

relapse for Joel?
A. Always. Always without medication.

Q. That's why he required ongoing monitoring and support. Correct?
A. Yes. Yes. Why I wanted to keep him in my care.

Q. Particularly as he was approaching a stressful transition to Brisbane?
A. Exactly. That's why I didn't - I, I did keep him in care and, and, and monitoring by the nurses.

Q. On 17 March 2020 you were due to see him again. Is that right?
A. 16th. I think 16 March I was going to--

Q. 16 March?
A. Yeah. Yeah.

Q. We see at page 19--
A. Yes.

Q. "Appointment on 16 March at 2.30. Appointment cancelled by the practice. Living in Brisbane. No longer eligible for Skype appointments." You had planned to see him?
A. Yeah.

Q. Could we have a look please at page 19. There's a note there, which appears to be taken by reception.
A. It was Receptionist who told me I was ready for a Skype and Receptionist said--

Q. Sorry, just hold on a minute, doctor, and wait for the question.
16 March 2020 it reads, "What will happen with Joel, who will follow him up unless he comes to face to face? A." Is that you?
A. Yes. Dr A.

Q. So, you have typed in "What will happen with Joel, who will follow him unless he comes face to face"?
A. Okay, just a minute.

Q.

> "He is living in Brisbane now and can no longer Skype. His Skype is not working today, and he has no sound, so we cancelled and then found out he had moved. Need to discuss what you would like to do as he has declined seeing you face to face"?

A. That was - that is the receptionist.

Q. So your note is, "What will happen with Joel, who will follow up with him"?
A. Okay, "Also note Brisbane please, he will need to have a" - that is my answer was, I - "Okay refer him back to his new GP in Brisbane, please. He

will need to have a new bulk billing psychiatrist or mental health service, public mental health service in Brisbane. Thank you".

Q. Okay, so just pause there, please. Just to clarify then, so you write, "What will happen with Joel? Who will follow him up unless he comes--
A. Yes.

Q. --face to face?"
A. Exactly.

Q. And then there's a note about the Skype not working and then you find out he's not eligible?
A. Yes.

Q. And your answer to the reception is, "Okay, refer him back to his new GP in Brisbane please. He will need to have a new bulk billing psychiatrist or mental health service--
A. Yes.

Q. --in Brisbane"?
A. So, I was a bit--

Q. Sorry, just wait for my question if you will. Your plan was at that stage for him to have ongoing monitoring and follow up?
A. Yes.

Q. You knew that there was a risk--
A. Yes.

Q. --always for him?
A. Yes, yes.

Q. You had wanted to monitor him for the rest of his life?
A. Yes.

Q. But he was now leaving and moving to Brisbane?
A. Yes.

Q. And you needed to find, the practice, to help find a bulk billing service in Brisbane for him--
A. Yes.

Q. --is that right? So, what was done after that?
A. Okay, yes. So, I was confronted. I tried my best to follow him up, but I am a private psychiatrist. And, and I was confronted that I couldn't see him again, continue to see him, because he'd - before he said that he would always come back and see me face to face. But he told the receptionist that he cannot come because of budget, something, to come to see me.

So, what happened that then the government, I realised that the government

removed the rebate from the Telehealth appointment. I had no choice, I had no choice but let him go and refer him back to his referring family GP, because at that time he did not have a GP in, in Brisbane. He told the receptionist as soon as he has a GP, he would let us know.

But on the 17th, on 16, 17, he did not have a GP, and I couldn't see him face to face because he declined to come back, and I couldn't see him with Telehealth because there was no rebate, and I'm a private psychiatrist. I couldn't do anything. I had to let him go and refer him back to his family GP, Dr Grundy who referred him.

Q. The initial note on that reception document suggests that you had initially intended to refer him to a GP in Brisbane, is that right?
A. Because I was looking for a GP in, in Brisbane, but I did not know anybody in, I know, I didn't know anybody in Brisbane. I didn't, he did not have a GP. If he would have said, "I have a GP", I would have done the referral.

Q. You decided instead to refer him back to the GP in Toowoomba, is that right?
A. Yes, because I had to act reasonably quickly because he declined to see me face to face.

Q. Did you give consideration to continuing to see him by Skype, even though you couldn't claim--
A. Yes, I did.

Q. Sorry, just excuse me, wait for my question if you will. Did you give consideration to continuing to see him by Skype even when you found out that you couldn't charge Medicare?
A. No, no because there was no rebate, and I am private psychiatrist. I don't see people free. I never, I never charged him any extra but the rebate I was getting.

Q. Did you give consideration just for continuing to see him for a short time--
A. No.

Q. --until there was another person in place, a GP and psychiatrist in place?
A. No, I did not.

Q. You understood, didn't you, that it wouldn't be sufficient for him to just see a GP, he would need to be referred to a psychiatrist?
A. No, no. By that time, I, when, when he moved to another city and I did not deliver any specialist mental health care, he could have been just monitored by a GP with mental health skills, because they have a skill set of monitoring people.

Q. I'm going to suggest to you that you are reconstructing that in your mind now?
A. No, I didn't. Why, why would I?

Q. You previously gave evidence that you understood that there was a risk of relapse for Joel because of the serious schizophrenic illness that he suffered, do you agree?
A. Which went away. Which, which wasn't, which was not an early warning signs of relapse, and I documented that.

Q. Earlier I took--
A. Okay, it was November, and it was December, January, February he was well. So, the early warning sign, not every early warning sign of relapse becomes relapse, and he did not relapse.

Q. All right. I just want to make sure we're not at cross-purposes. Earlier I put to you that treatment-resistant schizophrenia is a chronic, relapsing, remitting brain disorder?
A. Yes, exactly.

Q. And usually requires lifelong care and treatment, including antipsychotic medication?
A. Yes, and mental health care, yes.

Q. And you agreed with me when I put that?
A. Yes.

Q. So, you understood, didn't you, that Joel, when he was discharged from the practice, would require ongoing lifelong care and treatment, including monitoring and perhaps antipsychotic medication at some stage--
A. Yes.

Q. --in the future?
A. Yes, yes.

Q. All right. You also said earlier that you wanted to keep him in psychiatric care for the rest of his life. He needed--
A. Under my, my psychiatric care.

Q. He needed psychosocial help and monitoring, correct?
A. Yes.

Q. So that when Joel was discharged from the practice, your intention surely was for him to have a GP and a psychiatrist to follow him up in the future?
A. Yes. Look general practitioner, yes, but there is, like if I can, I was ready to facilitate his care, transfer of care, to another psychiatrist in Brisbane, if a psychiatrist would have taken him. And I think there was three psychiatrists who, who was he referred after, after he left. So, he knew, he was told, he was told that he needs ongoing mental health care, and he asked his GP in December. After my discharge he had another GP in Brisbane and he asked the GP to refer him to a psychiatrist, and he knew what he had to do, so he did it. So in the meantime, I am a private psychiatrist, I have to let him go, and the best thing I could do to refer him back to his family GP. And guess what? I not just referred him back with this letter, but I also called the GP on the phone.

Q. I'm going to come to that letter, and you'll have every opportunity to explain that you called him.
A. Yes.

Q. I'll come back to the question I asked you, which was this. You've previously indicated that you accepted that treatment-resistant schizophrenia is chronic, relapsing, remitting brain disorder. It requires lifelong care and treatment, including potentially antipsychotic medication. You accepted that?
A. Yes.

Q. You understood that you were seeing him monthly, and then at one point weekly?
A. Yes.

Q. After symptoms were reported by mum, to make sure that ongoing monitoring took place, correct?
A. Yes.

Q. You then, when he was discharged from the practice--

LYNCH: Your Honour, I object. She wasn't seeing him.

DWYER: Sure. I'll withdraw it.

Q. You saw him monthly--
A. The nurses.

Q. --and then you arranged for the nursing staff to see him weekly--
A. Yes.

Q. --after the symptoms were reported, correct?
A. Yes, yes.

Q. You understood that there was an ongoing risk of relapse, correct?
A. Ongoing risk of relapse, yes.

Q. So you wanted to make sure that Joel had ongoing treatment--
A. Yes.

Q. --from a general practitioner and psychiatrist--
A. Yes.

Q. --correct?
A. Yes.

Q. There was a follow up letter--
A. Yes.

Q. --from the practice to Dr Grundy, his treating GP in Toowoomba?

A. Yes, exactly.

Q. Because he had not yet got a GP in Brisbane?
A. Exactly, yes.

Q. Did you write that letter to the GP?
A. Yes, I did.

Q. All right. Can I have page 113? The letter is signed by you--
A. Yes.

Q. --to Dr Richard Grundy?
A. Mm-hmm.

Q. It reads there,

> "Unfortunately, Joel has moved recently and currently resides in an ineligible Skype area and as such I'm not longer able to offer Skype appointments. My receptionist has contacted Joel to advise of this change. Joel has indicated he will be unable to attend face to face appointments with me. I am therefore discharging Joel back into his and your kind ongoing care. Please recall Joel to discuss his options and referral to an alternative psychiatrist if required. In the future, should Joel move into a Skype eligible area or wishes to see me face to face, I'll be happy to. However, I need a new referral for that".

A. Yes.

Q. I'm going to suggest to you that there are three problems with that referral process. Firstly, that it was back to the GP in Toowoomba without ensuring that he had a GP in Brisbane. Do you accept that, yes or no?
A. Yes.

Q. Secondly, there is no indication in there that Joel will need a psychiatrist ongoing for monitoring. Do you accept that that was--
A. It was at the discretion of the GP.

Q. Do you accept that it was a mistake--
A. No.

Q. --for you not to put in that letter? Please listen to my question.
A. No, it wasn't mistake.

Q. For you not to put in that--
A. It was not error on my part.

Q. I'm going to suggest to you that there was a mistake for you not to put in that letter as the expert there with the psychiatric training that he needed ongoing psychiatric monitoring and review. Do you accept that or not?

A. Ongoing is there and care is there.

Q. "I'm therefore discharging Joel back into his and your ongoing care".
A. Yes.

Q. That's referring to the GP, isn't it?
A. Yes, exactly. And there's no error.

Q. Then you say there, "Please recall Joel to discuss his options and referral to an alternative psychiatrist--
A. Exactly.

Q. --if required".
A. Yes.

Q. So, my suggestion to you, you can accept it or not, is that it was an error for you not to include in that letter reference to the face that Joel would require ongoing psychiatric monitoring and review. Do you accept that?
A. When I said, "if required", because I would always have had him back and that's why if required.

Q. All right.
A. And--

Q. I'll try that again. I'll just ask you to really focus on my question, and I'm asking you to reflect. Because the aim here is to learn to see if there any opportunity to prevent tragedies in the future. You've conceded that it was an error that this was, or it was an error in the referral process that there was a GP in Toowoomba not Brisbane.
A. Mm.

Q. The second thing I want to put to you is that letter should have included specific instruction that Joel required ongoing monitoring by a psychiatrist, given his condition. Do you accept that?
A. No. It was not an error on my part is in that letter. It's just how you read it. And that is it.

Q. All right. And the third--

HER HONOUR

Q. I think there is some confusion here. So, the wording is to an alternative psychiatrist if required. What did you mean by that?
A. That--

Q. An alternative psychiatrist?
A. If required I can always be there, and I said I always, I always see him face to face or even Telehealth. I did not know that the government later on reinstated that things, so I was always open and if required. Because the GP knew Joel and, and as - I didn't put it in my notes because this is what I am, so

- but I did call Dr Grundy and Dr Grundy told me there's nothing problem, just, just refer him back to me. I know the family, I know him. I was very familiar with him. So, he did not have any problem to my satisfaction, I was satisfied that I referred him back to the GP who looked after him and he knows his needs for future treatment.

Q. Sorry, did you think that Joel would require ongoing psychiatric care when he moved to Brisbane?
A. Mental health care, which can be, which can be, which can be delivered by, Dr Grundy is a very, very good mental health professional too. He, he looked after Baillie Henderson Hospital, so he, he knows about mental health. And that's why I talked with him on the phone and said he would recall him, and he would discuss it with him. And that's why I felt totally, totally relieved.

Q. Okay, thank you.

DWYER

Q. Dr Grundy was going to be based in Toowoomba, not Brisbane, he wasn't going to be the ongoing reviewing GP was he?
A. Yes, but you know what is interesting, after he did not--

Q. Sorry, is the answer to my question yes or no? He was not going to be the ongoing reviewing GP, was he?
A. At the, at the time Joel said it would until he finds a new GP in, in, in Brisbane. And it was interestingly that he did not see me on 16 March, but three days later he saw Dr Barkla who is in Toowoomba.

Q. Doctor--
A. So, he was in and out of Toowoomba. He just did not see me face to face, because he couldn't commit himself to come monthly, but he saw Dr Barkla three days later.

Q. Doctor, sorry, please. If Mr Lynch is interested in exploring this, he can.
A. Yes.

Q. The third thing that I'm going to suggest to you is wrong with that letter is that there is nowhere in that letter where you refer to the recent concerns expressed by mum, that she thought he might be hearing voices, that she had found satanic notes, that she had noticed changes in his gait?
A. No. Because the mother said not to say anything about it, and I was, I was totally, totally relieved that it wasn't a psychotic break and wasn't early warning signs of relapse.

Q. Do you accept that it was an error for you not to include reference to the recent symptoms that mum--
A. No, I don't accept that.

Q. You don't accept it, all right.
A. Okay.

Q. Page 79 of the notes suggest that any letter sent to Joel was returned to sender. So the practice couldn't be satisfied, could it, that there was a notation to Joel about his forthcoming arrangements?
A. Yes, he, he wasn't living at that time, at that..(not transcribable).. Joel knew that he was going, he talked with the receptionist what was the steps that he knew that as soon as he gets a GP, I will transfer - I will facilitate the transfer, okay.

Q. You last saw Joel at the face-to-face appointment on 17 February?
A. Yes, I did.

Q. And you didn't see him at the Skype appointment subsequently because it was cancelled. So, the last conversation you had with Joel was 17 February 2020, is that correct?
A. Yeah.

Q. At that time, you anticipated that you would speak with him again in March, correct?
A. Exactly.

Q. But in fact you never spoke to him again, is that right?
A. Yes.

Q. Did you make any effort to, after eight years of being his treating psychiatrist, to try and speak with him at least over the phone or on Skype for one final conversation where you could discuss the arrangements going forward?
A. No, it was an effort of system like my receptionist talk with him. So, I said my doors are open and he knew that. And, and he knew what would be in the content of this letter because, because the receptionist communicated it to her - to him that he can always come back.

Q. You've been his treating psychiatrist for eight years. With the benefit of hindsight sitting there now, do you think that you should have arrange for a final consultation where you discussed with Joel the risk of relapse and a handover process so that you would discuss who else would be reviewing his mental health care in the future?
A. Okay. I could not because I am a private psychiatrist and he did not want to see me face-to-face. And I could not follow him up by telehealth. So, that is a very unfortunate end, but it wasn't an abrupt end. It was just an unfortunate end.

Q. Can I suggest to you that you could have done that but you just couldn't charge for it but there could have been a Skype call?
A. You said that, yes.

Q. Or a phone call? Do you agree with that?
A. You said that, yes.

Q. Do you think with the benefit of hindsight that that should have happened?
A. Benefit of hindsight--

Q. So that you could discuss with him, for example, the risk of relapse and what signs to look out for and his need for ongoing review by somebody in terms of his mental health--
A. His risk of relapse and his - he was a person who was always worried about his relapse. His risk of relapse, early warning signs of relapse and early intervention was nailed into him so he knew about it and he demonstrated that he followed what he learned from us, from the clinic practice. He followed it. As soon as he could, he found a GP. It was his, his - he did not - the GP did not contact us so basically, I couldn't do anything else. That is what my final - I couldn't do anything else.

Q. When he was medicated and well, Joel followed instructions. Do you agree with that?
A. Mm-hmm.

Q. Yes?
A. Yes.

Q. You agree with that? But when Joel became unwell, there was no guarantee that he was going to be capable of following instructions or having insight into his own illness? You agree with that?
A. But I followed him up and I, I was 100% sure that he wasn't psychotic and he did not take the medication. He has autonomy. He has, he has judgment and I thought his judgment was fair at that time that he attributed his symptoms to the fear of STD. That was just that and it wasn't psychotic--

Q. You gave evidence earlier that at handover you spoke with Dr Grundy.
A. Yes, I did.

Q. You're aware that Dr Grundy's evidence is that he does not believe that happened? He does not accept that there was any phone call?
A. And I did not document it and - but I did because it was a variance and I always talk with the GP if there's a variance of, of my--

Q. You have no memory of speaking to Dr Grundy though, do you?
A. I have.

Q. You're saying that sitting here now--
A. I have. I have--

Q. --five years after the event, you have a specific memory of speaking with Dr Grundy--
A. Definitely.

Q. --even though there was no note there?
A. Definitely. I didn't do note because it was after I done my letter.

Q. What do you say that you spoke to Dr Grundy about?
A. Yes. I said that unfortunately I wanted to follow him up but there was no, no rebate, and he totally understood it and he said, "Can I, can I send it back to you? I will send it back to you?" and he said yes, "I am the family GP, I know him very well and I will recall and I will do my best". And this is what he said. He could deny it. And I said, I can tell it and you don't believe me. I did not write it. I take the responsibility for it that I did not write it.

Q. Did you discuss with Dr Grundy in this phone call that - any of the risks of Joel's relapse given his mum's concerns?
A. No. I, I clearly remember I did not discuss the relapse - not - the false alarm of early warning signs of relapse.

Q. Your evidence is that that was not a mistake because you thought Joel was totally well by then?
A. Yes. He was well by then.

Q. In November 2020 there was information received from Dr Sarkar. It's at Tab 293 at page 126. Tab 293 that's the notes. Page 126. Do you recall any discussion or correspondence with Dr Sarkar?
A. I have a policy that when somebody requests - I actually was happy that he found a psychiatrist and - before a GP, and I, I just provided the collateral information. Nobody called me on the phone. It was just - it's a usual practice in psychiatric circles that we - some of them just give the last letter but I - my thing is I give the first one, the first assessment, and the last three GP letters.--

Q. You don't recall any conversation with Dr Sarkar, do you?
A. No, no.

Q. It's in fact your reception staff who send - says--
A. Yeah, yes.

Q. --write, "Dear Dr Sarkar, please find collateral information"--
A. Yeah, yep.

Q. --"as requested,"--
A. Definitely.

Q. --"from Dr A regarding Joel Cauchi"?
A. We don't do phone calls unless the psychiatrist calls me or said, "It's not enough. Can you give me more"--

Q. Did you find out around that time that he was seeing a Dr Sarkar?
A. Yes, because that - these letters couldn't go out with my--

Q. Did you give consideration to any discussion with Dr Sarkar at that time of any risk factors to Joel?
A. No. I thought he was, he was going to call me. I was happy that he found a psychiatrist, really. I was very happy.

Q. Did you give any consideration to a discussion with Dr Sarkar about any possible risk of relapse or concerns for Joel?
A. No, no. I thought I was very happy that he found a psychiatrist and that I thought that psychiatrist would call me. Usually if I accept a new patient and has, has a previous psychiatrist, I would contact the previous psychiatrist but not every time.

Q. There was nothing to stop you contacting that psychiatrist though, was there?
A. No, but I cannot add any more to this question.

Q. Would it be ordinary practice to provide the discharge letter to Dr Sarkar? That is a--
A. A ordinary practice in my practice that I give the first assessment and the last three GP letters. And I don't know whether there was lots of things in, was enough.

Q. I take it that even if you had spoken to Sarkar, you wouldn't have raised any concerns for Joel because you didn't think there were any.
A. No.

Q. Do you agree?
A. No, I wouldn't have, I wouldn't have raised those early warning signs of relapse, that's correct. Which wasn't an early warning sign of relapse.

Q. In January there's a phone call made by [redacted], on 19 January 2021, and after that the practice manager at the practice writes a letter saying, "Following on from your phone call this morning, please see the following collateral information being copies of letters to his previous GP".
A. Exactly what happened, the second GP got the same information.

Q. Dr Pietsch, then, in November 2023 contacts the practice following his consult with Joel. At this stage it's been three years since there's any contact between the practice and Joel. Did you make any enquiries as to how Joel was doing at that stage?
A. He called me. It was good. So I--

Q. Who called you?
A. Dr Pietsch, and we had a good phone conversation, and he said that the mother was there or the mother also confirmed that he's good. So, he, he mentioned in this phone call that I can't see any reason why, why he can't get a driver's licence. The M is there because of the schizophrenia would stay and the mother is - and he said I can remember that the mother was there and that--

Q. Is there anything in your notes to indicate that you had a phone call with Dr Pietsch in November 2023 or at any time?
A. Just a minute. Dr Sarkar--

Q. Can I suggest to you that there's nothing in your notes to that effect?

A. No, because it was discharge patient.

Q. He was a patient that you'd seen for eight years--
A. Dr Pietsch, yes, it's there.

Q. There's a letter--
A. 16th of November, emailed, similar comprehensive collateral information.

Q. There's a letter sent by Dr Pietsch, isn't there, to the practice?
A. This was to qualify his mental health history for renewal of dual driver's licence. He couldn't, he couldn't find any reason. He actually called me.

Q. He called you because Joel had gone to see him in relation to getting a licence?
A. Yeah. And he called me, and we talked on the phone.

Q. There was no discussion at that time in relation to Joel's - any ongoing monitoring of Joel's mental health though, was there?
A. No. He said, "I, I - first time I see this bloke and he's really good. He says he says schizophrenia and he hasn't had any problem. The mother is here, and I can't see why he can't have a driver's licence and Medicare for driver's licence". And we, we agreed to put the M on.

Q. Did you raise any concerns with him at that time of the possible risk of relapse and the need for ongoing monitoring?
A. No.

Q. Can I ask you to have a look at page 10 of the medical records? There's a letter you sent to him, Dr Pietsch. "Dear John, thank you for your recent request for information relating to Joel who I last consulted with in April 2015". Could you have that on the - sorry, page, tab 8.10.
A. I can't see it.

Q. Page 10, that'll come up shortly. Can I suggest to you while that's coming up, on 13 November you received a letter from Dr Pietsch which says,

> "Dear Dr A, I'm seeking some clarification regarding Joel's mental health history. Though I understand you haven't seen him for a good few years now. I met Joel for the first time today and the context of him being seen as a new patient at Northpoint in order to have renewal of his driver's licence which is expiring tomorrow. I got collateral information from his mother Michelle. Joel wasn't frankly psychotic at this point. Apparently, the M class was only ever implemented when he was commenced on Clozapine in the early 2000s. He's been off medication for a number of years without readmission or major relapse. I could not find a reason why he requires M on his licence to be honest".

A. Yeah.

Q. Then he goes through medical list. Can I suggest to you that it wasn't a phone call. It was rather a letter than came from him on the--
A. No, it was a phone call, I remember it was a phone call and--

Q. On 16 November 2023 you write to him, "Dear John, thank you for your recent request for information relating to Joel who I last consulted with in April 2015". That was clearly incorrect, wasn't it?
A. Yes, but I didn't see this letter. It might have been a typo and definitely--

Q. It's got your signature on it, that letter, hasn't it?
A. Yes, so, it was my fault. Sometimes it does that. That it was not April 15, it was February 2020. But I talk with Dr Pietsch on the phone.

Q. You say there, "I've attached four GP letters which I hope will address your questions". You don't refer to any phone call in that letter, do you agree?
A. Yeah. He did - he wasn't, wasn't going to be his doctor. He was just going to make sure that he can have driver's licence and he requested, it was basically the same thing. Last three GP letter which was, which was kind of showing that my April 2015 was a typo and the first letter which I always send.

Q. In relation to this letter, do you - at this stage you knew then that Joel was back in Toowoomba?
A. I knew that he wasn't back in Toowoomba. He was visiting Toowoomba parents.

Q. Did you give any consideration at that time to contacting Joel or to speaking with his parents?
A. No. No, not at all because the--

Q. Was it your view that he--
A. -mother, and he said that he is good. So, I didn't- even know who's psychiatrist he was under. I already thought, actually hoped, that he was seeing the Brisbane psychiatrist. I didn't know anything about the other.--

DWYER: Your Honour, I note that we're sitting till 4.30. Might we have a five minute break, please?

WITNESS: Yeah.

HER HONOUR: Yes. We'll take a five minute break, thanks.

SHORT ADJOURNMENT

HER HONOUR: Dr Dwyer?

DWYER

Q. I'm coming to the end of my examination. I want to put to you your reflections on thing that the practice did well, and whether or not you have any suggestions for what could have been done better in terms of Joel's care while

at the practice. Do you understand?
A. Mm-hmm.

Q. In relation to what went well, can I suggest to you that you recognised that there was a risk for Joel of relapsing, given his chronic treatment-resistant schizophrenia. Do you agree with that?
A. Mm.

Q. And that you arranged from 2012 through to the beginning of 2020 very regular monitoring by Joel from both a psychiatrist and an experienced clinical mental health nurse. Can I suggest to you that that was very good practice?
A. Thank you.

Q. In relation to the decision to reduce Joel's Clozapine, you arranged for a second opinion in 2015, which was good practice, and then there was very careful titrating down of the dose of Clozapine while Joel was regularly monitored. Can I suggest to you that that was very good practice?
A. Thank you.

HER HONOUR

Q. You have to say something to be recorded.
A. Thank you. Thank you. Thank you. ..(Not transcribable)..

DWYER

Q. After that period of time when Joel was taken off Abilify he continued to be monitored on a monthly basis by both a psychiatrist and the experienced mental health nurse. Correct?
A. Thank you.

Q. And then also, once mum raised concerns, that is Michelle Cauchi, raised concerns that she had about his declining mental health, that was instantly actioned by yourself and the mental health nurses. Do you agree?
A. Thank you.

Q. Can I suggest to you it was very good practice that when mum raised her concerns in October 2019, you arranged for Joel - your initial plan was that he be recommenced on an antipsychotic medication. Can I suggest to you that was good practice?
A. Thank you.

Q. You also arranged for Joel to be seen weekly for a period of time, rather than monthly, to monitor those symptoms. Can I suggest to you that was good practice?
A. Thank you.

Q. Your evidence is you cared a lot about Joel. You had a long-term relationship with him. Is that right?
A. Yes. Thank you.

Q. You wanted him to be monitored by yourself for the rest of his life, as long as you were practising. Correct?
A. Yes.

Q. Your intention, can I suggest to you, when he left you was for there to be ongoing monitoring of his mental health. Correct?
A. Yes.

Q. Do you accept that after Joel was discharged from the practice he fell through the cracks and was not regularly monitored in terms of his mental health?
A. Yes.

Q. On reflection, do you think that there is more that you could've done by way of handover to ensure that Joel was seen after his move to Brisbane?
A. No. Because I handed over to the original GP who knew the family and Joel well, and I hand it over and I felt that a private psychiatrist I, I correctly done the exit, which is a private psychiatric issue, and I can't change the system.

Q. We'll come to some system changes shortly.
A. Yeah.

Q. I accept that your belief, on the basis of the way that Joel was presenting at the time of discharge, you've told the Court that you did not think he was psychotic, but you remained concerned about the risk of psychosis, didn't you?
A. Always. Yes.

Q. You understood that by the time of his discharge in March he had not been medicated for about eight months?
A. Yes.

Q. That increased the risk of him becoming psychotic, given his ongoing condition?
A. The opposite. The fact that he did not become psychotic in November. It decreased the risk of becoming psychotic later on.

Q. I'm focusing on, again, your reflections of whether or not you could've done anything differently. Just to remind you, between October 2019 and 14 February 2020 there were eight occasions when either Michelle or Joel had contacted the clinic to raise concerns about their condition, or functioning, during that time. On 17 October was when Joel's mum rang concerned about his mental health and physical health. On 13 November, Michelle rang to say Joel was very unwell since--
A. Yes. Yes. Yes. Yes.

Q. --coming off medication and would like him reviewed. Just let me finish these, if you will. On 20 November, there was the email from Michelle about changes in Joel's behaviour, and the notes about satanic control and religious

themes. On that same day, she raised concerns in person about his deterioration and the return of his symptoms of psychosis. On 28 November, Michelle was contacted during a consult and the information was that Joel was to restart Abilify according to your instructions. On 4 December, Michelle telephoned in relation to her concerns that he was taking HIV medications. On 28 January Joel contacted Dr B wanting advice on men's sexual performance, and that was raised with you. On 14 February, Michelle rang to raise concerns about Joel being messy at the flat; having problems functioning at home; being isolated; irritable; with poor self-care.

When you look back on that and reflect on it, sitting there now, do you agree that those symptoms that were being reported were very different to what you had seen of Joel from 2012 through to 2018 when he was being medicated?
A. I do agree. However, I am an experienced psychiatrist in an experienced team, and we attributed, and we didn't attribute it to the psychotic relapse. And I don't know how many times I have to tell you, and I'll tell you again, that in hindsight I don't believe it would have made any different to the outcome if he took the medication. And I was assertive enough. He didn't take the medication. He had tried not to take the medication. And that is where I am.

Q. I just want to give you an opportunity, when you reflect on it do you think that those concerns that I have just read to you should have been passed on to the GP, at least Dr Grundy, for his consideration when he referred Joel on, or dealt with his mental health?
A. At that time, because we were sure that it wasn't a psychotic break, I thought it wasn't a mistake, and I don't think - I don't think it was a mistake.

Q. You've read the reports now, have you, that have been written by expert psychiatrists, including Dr Heffernan, a consultant psychiatrist based in Brisbane, and Dr Nielssen, a consultant psychiatrist based in New South Wales?
A. I read the synopsis of that.

Q. Dr Heffernan, I just want to give you an opportunity to comment on his opinion. He says - 4.3 for my friends if you're following - "For individuals with treatment-resistant schizophrenia, there's an increased risk of relapse, readmission and adverse impacts on recovery when Clozapine is ceased." I think you've agreed with that to date. Is that right?
A. Yes.

Q. He says:

> "However, the initial decision to reduce the dose of Clozapine, particularly with augmentation strategies, such as Aripiprazole, was a reasonable consideration at the time, given he was stable, reported some side effects to Clozapine and had a good support and network."

He goes on to say:

> "At some point the objective of medication treatment seemed to shift, however, from a reduction in the dose to a cessation of medication, albeit that that happened progressively. Reduction versus cessation are different clinical pathways."

And he goes on to suggest that "cautious monitoring, advice, a second opinion, an identification of early warning signs was necessary under those circumstances." Do you accept that?
A. Accept his opinion.

Q. Do you agree or disagree?
A. No. I disagree because I am not - I, I disagree when it comes to Joel and my management. I did my best. I did - I did find that he wasn't psychotic, and, and because of that his likelihood to become psychotic later on is less rather than more. But anyway, he was constantly at risk of relapse, because it is what happens that even people who, who never had a psychotic relapse for 19 years, they can have a 25 years. So it's ongoing. So until the person dies, you can't say that they were just first episode psychotic, you know. You just--

Q. Dr Olav Nielssen says this at paragraph 136:

> "Dr A left it to Mr Cauchi's long term GP to refer him to another psychiatrist, but the correspondence did not mention his mother's concern that he had relapsed and might need to resume treatment. Given their long therapeutic relationship, and the risks associated with ceasing medication completely, it would have been appropriate for Dr A to liaise with Joel's mother regarding his condition and care, and to perhaps have arranged a further fully rebated tele-health consultation in April 2020 when he was looking to be referred."

Firstly, do you accept that it would have been appropriate for you to liaise with Joel's mum about his condition and care?
A. I had ample opportunity to liaise with her, and I - and I - and, and I don't think I have missed out anything. And I would not have done any extra appointment without Medicare rebate.

Q. Do you accept that at the time of discharging Joel it would have been appropriate for you to have at least a phone call with Joel's mum to advise her of the risks?
A. The risk was well known all the time, and the mother was - mother was, maybe not on the day, but it was just the days before or one, it was always communicated with. And the mother never complained about not being communicated with. And even I got a letter from her to thank, thank me just before this whole inquisition started, that I was - she thanked me about my contribution and apologised to me that I was going to be brought into this. She knew everything about what's happening. And - say no.

Q. Do you object to giving evidence in these proceedings when you were the treating psychiatrist for Joel for eight years, and the last psychiatrist to be involved in any ongoing monitoring of him?

LYNCH: Your Honour, I object.

DWYER: I withdraw the question.

WITNESS: Thank you.

DWYER

Q. Mrs Cauchi, Joel's mother, rang repeatedly and emailed the practice repeatedly and raised her concerns in person about Joel's decline in mental health from October 2019 through to February 2020 in circumstances where you have previously accepted that his family would be best placed to understand his decline, and when that was the view of the treating doctor in 2015. Do you think now that you made a mistake when you thought that Joel was completely well by February--
A. No. And I have communicated via the nurses with the mother up to her satisfaction, and she actually wrote me a letter to say that she was satisfied with my - with my - and I can show you this letter if anyone else--

Q. Dr Nielssen says this at paragraph 137, "In retrospect the complete cessation of medication was a mistake given the very high probability of relapse in a person with such a severe condition." Do you accept that?
A. No. It is not - I don't accept, because it was with the hindsight of what he did four years later.

Q. The final issue is this. You accept, don't you, that the evidence from the psychiatric experts is that on 13 April 2024 Joel was suffering from a psychiatric condition--
A. Yes.

Q. --psychosis linked to his severe treatment resistant schizophrenia, and that that is the reason for the terrible acts--
A. Yes. They have indirect - they have indirect evidence because he was killed, and I accept that everybody has an opinion.

Q. Can I ask you to comment on this. What do you say to the suggestion--
A. I mean, it--

Q. Sorry, just please listen to my question. It's my last question. What would you say to the suggestion that you refuse to accept that Joel was psychotic on 13 April because you don't want to accept yourself the failings in your care of Joel?
A. I did not fail in my care of Joel, and I refuse. I, I have no error on my behalf. That is my answer.

DWYER: Nothing further.

CHRYSANTHOU: I'm not going to finish in 12 minutes, and I understand Mr Lynch has an application about evidence tomorrow. I have much longer

than 12 minutes. Mr Lynch has said he has questions to ask. From our perspective, I'm not sure if it's of assistance, that I start now for five minutes before Mr Lynch has to make his application or if we deal with the AVL application and then just continue the evidence tomorrow. I'm in your Honour's hands.

HER HONOUR: I think we start with you tomorrow.

CHRYSANTHOU: Thank you.

DWYER: So the AVL application, can we deal with that in the next ten minutes? Mr Lynch has an application that the doctor give evidence by AVL tomorrow.

LYNCH: That's so. Dr A has indicated that she has a full list of patients tomorrow. She was anticipating to deal with them. Plainly she won't be able to accommodate all of them but if she can appear via AVL, then their interests won't entirely be cast aside for the purpose of completing her evidence. So, my application is that she continues her plans to return to Brisbane this evening to make herself available via AVL tomorrow morning at 9.30 for as long as required, so that those patients' interests can be safeguarded as far as possible.

DWYER: I think Ms Chrysanthou wants to be heard on that application.

CHRYSANTHOU: Your Honour, we oppose that application. There's a number of reasons. The first is that obviously the doctor is a very important witness in the inquest and I have instructions to ask her a number of questions. In fairness to my clients and in fairness to the witness, it should be under the same circumstances in which she's already had to answer questions. Second, there has, in the exchanges that have occurred, being overlapping and talking over each other et cetera, -no-one's fault. It's just perhaps the witness's demeanour.

I'm not criticising you, Doctor, I'm sure I would be the same if I was in the witness box. And I think it'd be very difficult given the manner in which the questions are being asked and answered for us to comprehend the doctor's evidence and for her to comprehend the questions that she's being asked. I've also noted, I haven't had this problem, but some people around me have not always understood the doctor's accent and that will be exacerbated via AVL. So we oppose the application. We think her evidence should continue as it has started. We anticipate we'll be less than an hour tomorrow.

FERNANDEZ: I also oppose the application. I may have questions depending on anything that Ms Chrysanthou does not address. Whilst I don’t intend to go back to the medical records, it might be necessary to do so. To try to do that over AVL is very difficult as opposed to being here in the courtroom and putting all the material up on the screen. I also support the submissions made by Ms Chrysanthou.

MATHUR: Can I just raise I will be asking questions, and I will ask for Dr A to be shown documents. I don't have a view in relation to whether it's AVL or otherwise, or in person.

HER HONOUR: I hear your application, Mr Lynch, and your submissions and the reasons why you're asking that the doctor appear via AVL tomorrow from Brisbane. And primarily it's so she'll be able to see some of her patients. I think on balance that it's in the interest of this inquest that she appears in person tomorrow and so I'm going to decline your application.

LYNCH: Your Honour pleases.

HER HONOUR: We will adjourn now.

DWYER: We did have Dr Grundy planned for tomorrow. I'm grateful to my learned friend Ms Mathur. I think we may be able to move him to the following day. It's still anticipated that the GP's evidence will be much shorter.

HER HONOUR: Yes.

Q. I'm sorry that we are taking longer than we initially thought, Dr A.

DWYER: Your Honour, could I just confirm a 9.30am start tomorrow?

HER HONOUR: Yes.

DWYER: I think that was what was planned.

HER HONOUR: Yes. We'll start at 9.30 tomorrow. Unless there's anything else, we'll adjourn.

<THE WITNESS WITHDREW

AUDIO VISUAL LINK CONCLUDED AT 4.22PM

ADJOURNED PART HEARD TO WEDNESDAY 14 MAY 2025 AT 9.30AM