IN THE NEW SOUTH WALES STATE CORONER'S COURT

STATE CORONER O'SULLIVAN

WEDNESDAY 14 MAY 2025

2024/00139002 - BONDI JUNCTION INQUEST

NON-PUBLICATION ORDERS MADE

PART HEARD

AUDIO VISUAL LINK COMMENCED AT 9.34AM

<DR A, RESWORN(9.34AM)

HER HONOUR

Q. Have a seat, thank you.

HER HONOUR: Ms Chrysanthou.

CHRYSANTHOU: Thank you.

WITNESS: Can I just, can I just give an apology about my yesterday behaviour, that I was short at times with Senior Coroner Assist, Dr Peggy Dwyer. That was because I'm suffering from acute pain, I'm on medication. I was, I was late for my flight, and I was too long in here and mentally fatigued.

HER HONOUR

Q. Yes, have a seat.
A. Thank you.

Q. I understand it is stressful and it's tiring, and it was a long day. Could you please let us know if you need a break at any time today.
A. I want to finish.

Q. I know.
A. By lunch.

Q. I'm sure you do.

<EXAMINATION BY MS CHRYSANTHOU

Q. Doctor, my name's Sue Chrysanthou.
A. Yes.

Q. I think you've already heard in the Court that I act for a number of families of victims from last April.
A. Yes, I thank you.

Q. Thank you.
A. Thank you for representing them.

Q. Thank you. On 20 February 2012, that's when Mr Cauchi - and without any disrespect to him, I'll call him Joel - was referred to you?
A. Just keep calling him Joel.

Q. Joel, right. He was referred to you on 20 February 2012, that's right, isn't it?
A. Yeah, 12.

Q. He had been in the public system since he was 17, so for about 11 years at that point, isn't that right?
A. 12, mm-hmm.

Q. 11 or 12 years?
A. Mm-hmm.

Q. Yes. So, you just have to answer me, because there's a transcript.
A. Yes.

Q. I can see that you're nodding, but someone has to record what you say.
A. Yes.

Q. The reason he was transferred to the private system was because he was compliant in taking his medication in the public system, isn't that right?
A. And he was symptom-free as well on clozapine.

Q. Yes, and he had been symptom-free since 2008?
A. Yes, good.

Q. He wasn't symptom-free, was he, between 2001 and 2008?
A. Look, I can't honestly answer this. Because Dr Stephens said in 2015 that he was positive symptom free for - on clozapine for 14 years. That was answered in the letter. So, on the--

Q. Are you saying you don't know?
A. Yes, I know, because I asked, and I thought he was symptom-free for ten years by that time. This is what he and the mother told me at that time in 2012.

Q. No, what the mother told you in 2012 - Mrs Cauchi - was that in 2008, he'd had a relapse. Do you remember being told that?
A. I don’t think it's the mother told me that.

Q. All right. Well, I'll find the document in a moment--
A. Please.

Q. --about that.
A. I don't remember that.

Q. Do you remember receiving when you were first referred Mr Cauchi as a patient - Joel - a letter from his mother explaining the background?
A. Okay. What happened in 2008--

Q. No, no. I know you want to finish today, and I know you have patients that are relying on you, so you need to listen to my question and answer my question, and you'll be given an opportunity, when Mr Lynch asks you questions, to explain things further if you need to.
A. Mm.

Q. My question is, do you remember receiving a letter from Mrs Cauchi when Joel was first referred to you in 2012?
A. Correct.

Q. In that letter - and I'll bring it up in a moment - she explained to you the history of his treatment over the last ten, 11 or 12 years, do you agree?
A. Yes.

Q. An important part of that history, I want to suggest to you, was that when Joel was first diagnosed, when he was 17, he was prescribed an antipsychotic called olanzapine, is that right?
A. Yes.

Q. That's an antipsychotic drug?
A. Yes.

Q. That is a drug that balances dopamine and serotonin levels to help regulate mood, thoughts and behaviours. Is that right?
A. Yes.

Q. And that is a drug recommended for early onset schizophrenia?
A. First line treatment, yes.

Q. First line treatment. It failed, didn't it?
A. Yes.

Q. Then after that drug failed, he was then prescribed risperidone, wasn't he?
A. Yes.

Q. That replaced the olanzapine, that's correct, isn't it?
A. Yes.

Q. That is also an antipsychotic drug?
A. Yes.

Q. That also balances dopamine and serotonin levels in the brain to help regulate mood, thoughts and behaviours?
A. Yes.

Q. It blocks dopamine effects, doesn't it, that's how it works?
A. Yes.

Q. It can reduce symptoms that are caused by excess dopamine?
A. Yes.

Q. That also failed, didn't it?
A. Yes.

Q. It's right, isn't it, that you're not allowed to go on clozapine or Clopine - whatever we're going to call it, the brand name or the generic name - unless the patient has failed on two earlier drugs?
A. Yes.

Q. Two earlier antipsychotics. So, this is a third line treatment, isn't it, clozapine?
A. Yes.

Q. You understood, didn't you, when you looked at his history, by reason of the fact that he had failed when it came to the first two antipsychotic drugs and had been on the clozapine for ten years, that he was a chronic schizophrenic? That's what his diagnosis was, chronic schizophrenia?
A. He had first episode schizophrenia at that time.

Q. Well, you keep saying "first episode". He did have a first episode when he was 17, that's right, isn't it?
A. First long episode, yes.

Q. Well--
A. Long episode, yes.

Q. Are you saying the episode lasted eight years?
A. Okay. I know in 2008 he was switched from one brand to the other. That's why he had breakthrough psychotic symptoms. But it wasn't a relapse. It was breakthrough psychotic symptom. It was the same episode.

Q. Well, let's talk about that. In 2008 the brands changed?
A. Yes.

Q. It was the same drug, clozapine?
A. And I remember that, yes.

Q. It changed from Clozaril to Clopine, is that right?
A. Yes.

Q. In that change, because of that change in medication, he demonstrated psychotic symptoms, didn't he?
A. It's called breakthrough psychotic symptoms.

Q. But you accept, don't you--
A. Yes.

Q. --that because his drug regime was not correct--
A. Yes.

Q. --Joel exhibited psychotic symptoms in 2008?
A. It was, it was, it was documented, and I had to accept that.

Q. Right.
A. Temporary.

Q. You understood that when his dose of Clopine was increased--
A. Yes.

Q. --at that time to 600 micrograms--
A. Milligrams.

Q. --milligrams, sorry - 600 milligrams, his symptoms subsided?
A. Yes, correct.

Q. You understood when you first met him in 2012 that as at 2008, at least, the antipsychotic drugs were containing his symptoms caused by his chronic schizophrenia, do you agree with that?
A. Yes.

Q. When he first came to see you, he was on 550 milligrams of clozapine at night, is that right?
A. Yes.

Q. That had only recently been reduced from 600 milligrams in the public system?
A. Yes.

Q. Between 2008 and 2012 he was on 600 milligrams?
A. Correct.

Q. It's right, isn't it, that when it comes to dosing with these antipsychotic drugs, psychiatric patients can often become somewhat immune - or not completely immune, but their metabolism learns to digest those drugs in a way that can make them less effective at times?
A. Mm-hmm.

Q. Is that right?
A. If somebody smokes or eats barbequed meat, yes, yes. Definitely that can, that can what is called induce, induce the liver enzymes to metabolise the drug

faster.

Q. That's why you have to keep checking blood tests with clozapine and checking whether the dose is correct?
A. Not necessarily. Because we are, we are following people clinically. We check clozapine level if we think there is a non-compliance or there is a toxic side effect. Because the blood - we have a very narrow, very narrow therapeutic window, and the toxic side effect can be, can be bad. So that is what happened before the mental health team decreased the medication.

Q. That's right, isn't it? In order to assess the therapeutic value of a drug like clozapine, you assess the patient's behaviour?
A. Clinically, yes.

Q. A clinical assessment--
A. A full clinical assessment.

Q. --of behaviour, mood?
A. Yes.

Q. That's how you assess if the drug is having therapeutic value, isn't that right?
A. Exactly.

Q. It's not the blood test that tells you--
A. No, not the blood test. The blood test is--

Q. --whether there's a therapeutic value in the drug, do you agree?
A. Sometimes, yes. Because we have a therapeutic window, the 400 microgram per litre, which is for treatment-resistant symptoms. 200, 250 microgram per litre is for average non treatment-resistant psychotic disorders.

Q. Do you mean nanograms?
A. Micrograms.

Q. Right. Well in relation to testing the amount of the drug in the blood, as you've referred to yesterday, I want to suggest to you that there's no paper or guideline that supports what you said yesterday in relation to non-therapeutic levels in the blood?
A. There is ample.

LYNCH: I object to that. Your Honour, the pathology--

WITNESS: Ample.

LYNCH: --reports themselves set out explicitly the therapeutic range of serum clozapine in each and every blood test that comes back with a result.

CHRYSANTHOU: Well, they don't say that actually. My friend should read

exactly what it says carefully. But also, I'm going to be putting to the doctor that the view of a pathologist - not an expert pharmacologist, not an expert psychiatrist - about the therapeutic value of the level of an antipsychotic drug in someone's blood is useless.

WITNESS: In terms of--

HER HONOUR: Well it's also something that - remember we've got the experts next week, so you can put it, get the answer, and then we move on.

WITNESS: With clozapine is the exception. But the others, atypical and typical, yes. Because clozapine primarily works on the 5-HT2A receptor and not D2. So with D2 antagonist, we need just 20, 40% of the occupancy. So that is clozapine, that's why. We not assessing it by D2 occupancy. We assessing it by blood levels.

CHRYSANTHOU

Q. But that's not quite correct. clozapine is an antagonist to both receptors?
A. Yes. And more the serotonin than the dopamine.

Q. Yes, but it also is a dopamine antagonist as well, isn't it?
A. Yeah. And we need, for antipsychotic effect, 20 to 40% dopamine D2 receptor occupancy. And we don't do that in, in, in, in, in clozapine. We do it clinically, and the blood test is just guiding us.

Q. Right. So you accept it's a clinical assessment?
A. Yes. But we still do blood tests for establishing toxicity and establishing when patient are not improving, so we take a blood test, and if it is below 400, we increase it to be above 400 and below 1,000.

Q. Right. That's right. If the antipsychotic medication is ineffective - if clozapine is ineffective, you take the blood test and you seek to increase the level above 400--
A. Yes.

Q. --to deal with the fact that the drug has been ineffective?
A. To deal with treatment-resistant schizophrenic symptoms, mainly positive symptoms.

Q. But otherwise, the amount of the drug in the blood is not an accurate way to assess whether it has therapeutic value?
A. Yes. I, I disagree with you. This is the only way to assess, but not the side effects. Because side effects can come, even with lower dose. But the efficacy is clearly, clearly related to the drug serum level.

Q. Only insofar as it relates to serotonin?
A. I don't think you have any degree in medicine. So, it's not serotonin. It is serotonin 5-HT2A and dopamine. But we don't do the serotonin 5-HT2 blockade. We just measure the dopamine 2..(not transcribable)..scientifically,

but not in clinically. We just know what is the neuroleptic threshold, and that is what the blood levels show us.

Q. Do you keep up to date on all the recent papers--
A. Very much.

Q. --about the use of clozapine and how to measure levels--
A. Very much.

Q. --in the blood and what effect they have?
A. Excellently. So--

Q. So which papers have you read which support what you just said?
A. I just attended a, a psychiatric congress conference in Madrid, which is the European psychiatric conference. Heard Professor Istvan Bitter talk about exactly this one and whether do we need side effects for psychotic medication - antipsychotic medication to be effective.

Q. Have you got the paper from that conference?
A. Yes. I do. Not paper.

Q. Can you produce that to us?
A. Is there. Yes.

Q. You can produce the paper to us?
A. I think what we can do--

LYNCH: Your Honour, this is not an exam in the form of a clinical knowledge guide. If the paper's available and it's sought, it will be produced.

CHRYSANTHOU: Thank you.

WITNESS: Yes. It will be. It will be available.

CHRYSANTHOU

Q. There was a conference last week in Brisbane where this topic was discussed. Were you at that conference?
A. Of course not. I, I was working.

Q. So you didn't read the paper from the conference last week in Brisbane about this topic?

LYNCH: Your Honour, I object to this line of questioning. This is a pre-trial exercise--

CHRYSANTHOU: Your Honour, the doctor just--

LYNCH: --with respect, and it offers no assistance to your Honour in resolving the issues.

HER HONOUR: I think we need to move on from this, Ms Chrysanthou.

CHRYSANTHOU: I can move on.

Q. I want to suggest to you you're not up to date, and in fact what you've said about measuring the therapeutic value of the drug clozapine, by looking at the levels in the blood, particularly what you said yesterday about that, is just not correct?
A. Sorry? I disagree with you strongly.

Q. Thinking back to Joel, when he came to you he was also on another antipsychotic drug?
A. Yes.

Q. Which it was known as Abilify?
A. Yes.

Q. That's the tradename. Is it aripiprazole?
A. Yes.

Q. The reason he was on a second antipsychotic drug was to control his secondary OCD that had arisen as a side effect from the clozapine?
A. It's correct.

Q. And that's why he was only on 5 milligrams as opposed to 10, because it was a secondary drug for that purpose?
A. Yes.

Q. Generally, if you were to start someone on Abilify on its own, you would start with 10 milligrams, wouldn't you?

LYNCH: Well, what condition, your Honour, is the question?

WITNESS: This is not a question from me.

LYNCH: I object to the--

HER HONOUR

Q. Just one moment.
A. I did not start--

LYNCH: I object to the question.

HER HONOUR

Q. Just one moment, Doctor.

LYNCH: It depends for what condition.

HER HONOUR: Yes. I think that's right.

CHRYSANTHOU

Q. Well, the only condition I'm asking about - I'm not asking about depression or bloating. The only condition I'm asking about is schizophrenia. Do you understand?
A. Yes. But I, I think that your question in the - has to be relevant to this case, and I did not start the medication. It was started by the mental health--

Q. Don't worry about the relevance of my questions, can you just answer them. Abilify is an antipsychotic drug?
A. Yes.

Q. It can be prescribed on its own to patients diagnosed with schizophrenia?
A. Yes.

Q. And generally when it is, the starting dose is 10 milligrams. Isn't that right?
A. I would say the starting dose is not 10 milligrams. Is the average dose is 15 milligram which, which provides 60, 80% of occupancy and, and block - not - occupancy of data receptors in the mesolimbic area. That is my answer. Ten to 15 milligram provides 6(as said) to 80% of D2 receptor occupancy, and that is not a dopamine D2 blockade. It's a partial agonist, or antagonist, depending on how much dopamine is around the synaptic cleft.

Q. When he came to you--
A. So in some way it is a dopamine enhancer, and in psychosis, in the mesolimbic area, it's an anti-dopamine. So it's a, it's a, it's an antipsychotic.

Q. There is value in prescribing it on its own?
A. Yes. In monotherapy. Sometimes it's first line in first episode schizophrenia. Very often used, but more often used in, in treatment-resistant depression and OCD, because they have very good effect in there.

Q. So Joel was on both of these drugs the entire period that you treated him until you took him off clozapine in 2018 and then Abilify in 2019. Is that right?
A. Yes.

Q. And in considering whether the clozapine had a therapeutic value, as you gave evidence yesterday, you took into account, didn't you, that he was also on Abilify?
A. Yes.

Q. And that those two drugs were interacting together?
A. Yes. But I also knew that the drug wasn't enough. Five milligram is almost like a placebo effect in psychosis.

Q. Well why would you - well it's got side effects, doesn't it, Abilify?
A. I don't think it has - 5 milligram has a major side effect, and--

Q. It has side effects, doesn't it?
A. What? I don't think so it has major side effect. Five milligram usually very well tolerated, and until, until 2019, that I never heard that she had - he had side effects from Abilify. It was, he said, he felt dysphoric on it. Dysphoric. And dysphoria is not depression. It's some unpleasant feeling.

Q. He wanted to come off it, didn't he?
A. He did, definitely. He always wanted to decrease his medication.

Q. And that's because he had side effects?
A. He wanted to be drug-free, because he felt that, that the Abilify was originally given for his OCD, and by stopping or withdrawing over six year, or, or how many years the other one, the major drug which caused the most side effect, he did not feel that that drug give him any, any benefit.

Q. Why did you keep him on it for an additional year if it was your view that it was some sort of placebo?
A. Because I am cautious. Because I was there - he wanted to come off the drugs quicker, and I was there to make it slowly and cautiously.

Q. The reason you kept him on it for another year after you took him off clozapine is because you were of the view that it did have a therapeutic effect?
A. I don't - I never believed in that. But it is your explanation.

Q. So you give drugs to people, do you, even though it has no effect?
A. No.

Q. Is that what you were saying?
A. No. I wanted to do it cautiously and under close monitoring. I wanted to do any medication change there. But even though it didn't have antipsychotic effect, it could have had effect on his general psychopathology. The anxiety, the OCD, or the depression, which he did not ever have. But I, I was cautious to reduce every medication as slowly as we could.

Q. Now you diagnosed him, when you saw him, with chronic paranoid and disorganised schizophrenia, didn't you?
A. That is when I did not have the discharge summary by the mental health team, and was based on, on my suspiciousness. In the first assessment, as I explained, that he may be covering up or I - you know, in the first assessment, you are healthy suspicious about what patients report.

Q. Sorry, when did you say you got the discharge summary?
A. After I saw him first time.

Q. So you're saying, are you, that you diagnosed him, in your first letter to Dr Grundy, with chronic paranoid and disorganised schizophrenia--
A. Yeah. It was a, it was a working diagnosis.

Q. In no correspondence to Dr Grundy did you ever tell him that you changed

your diagnosis, did you?
A. I don't think it was important, because it became true later on that he had a long treatment-resistant first episode psychotic episode until 2008. So by the time he was with me, four years later and taking the drug - I mean eight years later, he didn't have any further relapse, and I didn't have evidence that he was chronic. It was - I didn't have evidence that it was a multi-episode schizophrenia.

Q. Let me just go back to what you told Dr Grundy, which is at tab 793 on page 88.
A. The first letter?

Q. These are your notes.

HER HONOUR: We'll just see if we can get that up.

CHRYSANTHOU

Q. So you've set out a DSM-IV diagnosis. Do you see that?
A. That was a working diagnosis, yes. On the--

Q. Well you don't call it a working diagnosis, do you?
A. We call it working diagnosis in the mental health field.

Q. Okay. Well you've said "DSM-IV diagnosis". Do you agree?
A. Axis I. Yes.

Q. And there's no adjective which in any way limits it to be something other than a DSM-IV diagnosis?
A. No. That was my impression.

Q. And you've diagnosed him with "Chronic paranoid and disorganised schizophrenia. In control on Clopine. OCD." Do you see that?
A. Yes.

Q. You've done Axis I to Axis V under your diagnosis?
A. I did.

Q. That's a formal way for a psychiatrist to set out a formal diagnosis of a patient?
A. At that time, DSM-IV, yes.

Q. You never wrote to Dr Grundy and changed that diagnosis, did you?
A. I, I don't think there is a difference between--

Q. Can you answer my question. You never wrote to Dr Grundy and changed that diagnosis, did you, in eight years?
A. Maybe I did. I don't know. That's--

Q. So you think there might be a document somewhere for us?

A. Might be a document when I, when I, when I spoke with Dr - when I ask him to refer Joel to Dr Stephens, and, and maybe somewhere in my notes that is first episode psychosis.

Q. All right. We'll have a look for that for you. Now just if you could please turn to page 327. This is the discharge summary you're referring to?
A. Yeah. Which I got later. Yeah.

Q. So you got this sometime after 19 April 2012. Is that right?
A. Mm-hmm.

Q. So after you got this, did you send a subsequent letter to Dr Grundy changing your diagnosis?
A. No--

Q. No, you didn't?
A. --I, I don't think it was necessary.

Q. I'll just show you, because I asked you about it before, the letter from Mrs Cauchi that you received. That's page 341. Do you remember receiving that letter?
A. Yes.

Q. Do you remember seeing the paragraph, if we just go down a bit, that starts, "He was on 550 milligrams of Clozaril for several years". Do you see that?
A. Yeah, yes.

Q. You see you were told there, when you first saw Joel, that his condition deteriorated at that time, and that's when it was increased, and Abilify was added?
A. Yes, and the brand has changed.

Q. While you were his doctor, you understood that the antipsychotic medication that he was on controlled the symptoms of schizophrenia that he had. Isn't that right?
A. Definitely. Yes, yes.

Q. I just want to ask you about signs of relapse. Coming off clozapine, a person coming off clozapine - and Joel was on that drug for some 15 years, wasn't he?
A. From 2003 to 2018. It's 15 years, yes.

Q. You understood, didn't you, taking him off that drug completely, there was more than 50% chance of relapse?
A. I can't tell you that.

Q. You're not sure what--
A. Maybe, maybe - the relapse is very difficult to, to, to estimate, but we don't - we know that in selected cases, in first episode schizophrenia, they would not

relapse at all. Now it is 14% in the literature, that 14% after first episode schizophrenia will relapse. Multi-episode schizophrenia I think more, more vigorous.

So, it's the first five years, very common, the, the guidelines, first five - after first episode schizophrenia, they, they recommend, once it's remitted, you have to keep the antipsychotic at full dose for, for one years for relapse prevention, and if multi-episode schizophrenia, then five years. So, he was kept on clozapine - if you say he was last relapse, or had deterioration from 2018, he was actually kept on medication - help me - eight years, so it was beyond the guidelines what he had. What we had.

Q. You've been very careful--
A. Very careful, yeah.

Q. --yesterday and today to describe it as first episode schizophrenia. That's not how it was described as far as your review of the notes are concerned--
A. Okay, I still disagree.

Q. --in any of your medical notes?

LYNCH: I object to that, your Honour.

WITNESS: I still disagree what you say.

HER HONOUR

Q. Just one moment.

LYNCH: There's a document in the notes that identifies with precision the reason for the termination of clozapine in the report back to ClopineCentral that articulates the condition and the reasons why the drug was stopped, and it refers expressly to first episode--

WITNESS: Thank you.

LYNCH: --schizophrenia having remitted completely.

CHRYSANTHOU: A first episode--

LYNCH: In 2017.

CHRYSANTHOU

Q. There was a first episode--
A. Thank you.

Q. --of schizophrenia, but it wasn't the only episode. You knew that, didn't you?
A. No. It was to me still first episode schizophrenia. Treatment-resistant--

HER HONOUR: I think we went through that thoroughly yesterday.

WITNESS: --schizophrenia lasting long time.

HER HONOUR: That's the doctor's opinion.

CHRYSANTHOU

Q. You were asked some questions yesterday that I read the transcript of last night, and I'm just trying to understand. You were asked about early warning signs of relapse?
A. Yes.

Q. An early warning sign of relapse is a sign or evidence of psychosis, isn't it?
A. No, that's, that, that's not true. I have to educate you.

Q. I don't want to be educated. I just want you to answer my questions.
A. No. Early warning signs of relapse is not psychosis.

Q. It is a sign of psychosis--
A. Early warning signs of relapse--

Q. --is what I'm putting to you?
A. No, it is actually, as I said to you, in the literature, it picks up 82% of psychotically driven early warning signs of relapse. The specificity is 62. So it has false alarm 62% of cases. So, what I'm, what I'm saying, that early warning signs of relapse either driven psychotically or non - or, or not psychotically driven. It's a bunch of symptoms put together which alerts the clinicians and the patient that they might relapse.

So, what we do when we - we, we diagnose early warning signs of relapse, doesn't matter which cause, we deliver early intervention. And by the early intervention, this go back, or they can go further. It depends. When he had early warning signs of relapse, I erred on the side of safely, wanted to medicate him and it looked, after what happened, that it actually went away with early intervention, just counselling, and he medicated himself with retroviral agent and it went away. So both nurse--

Q. What is a relapse?
A. --testified that he wasn't psychotic.

Q. What is a relapse?
A. Relapse is acute, positive symptoms of psychosis and they have to have - the symptoms of psychosis has to have hallucinations of different modality, delusions, disorganised format thought disorder, not just tangentially - not just tangential speech, but disorganised thoughts and behaviours and catatonia.

Q. What I'm putting to you is an early warning sign of relapse is either evidence of psychosis, or evidence that psychosis is around the corner?

A. Not evidence of psychosis. It can be, it can be an, an imminent psychotic relapse, but we have a nice window of opportunity to treat it.

Q. Joel Cauchi demonstrated behaviour as reported to you that had never been reported to you before?
A. Correct.

Q. And his mother had never made complaints of the type that she made from October 2019?
A. Correct.

Q. Ever, had she?
A. Correct.

Q. For the first time in October 2019, shortly after he came off the Abilify--
A. Five months after.

Q. --Ms Cauchi reported behaviour to you that you had never seen in Joel before. Do you agree?
A. Yes. And, and I responded it - to it.

Q. And she reported to you an obsessive or preoccupation with sexual matters, didn't she?
A. Yes.

Q. Joel exhibited to you paranoia about getting a sexually transmitted infection, didn't he?
A. I don't think it was paranoia. I, I think it was a reality based, not paranoia, it wasn't dopamine excess. It was, he had a sexual encounter with a prostitute which we know, which we knew later, 5 December, that it wasn't, it wasn't a pathological paranoia. It was a reality based fear.

Q. So you didn't think it was paranoia that after one sexual encounter, he thought he should go on anti-HIV drugs?
A. That was not my decision. It was, it was, it was what he was concealing from us until, until, until he was able to tell us 5 December. At that time, our job was to find out whether he was psychotic or not.

Q. So, he was concealing things from you, you realised, on 5 December?
A. Yes, and I, I told my team, "Gosh, gosh, I hope that he did not seroconvert", But then 5 December, he called and confirmed that it wasn't seroconversion. It was given by a doctor for prevention.

Q. You knew that he had been concealing things from you by 5 December?
A. Yes, that was the first time I do, but then he started to come out. And he did not conceal about - to me about the porn interest, because I even talked with him with RN4 on 14 November. So, we know that he was looking for relationship and looking for connection and, and, and was interested in sex.

Q. Prior to that, prior to the end of 2019, he'd never raised with you porn?

A. The sex, never.

Q. Never raised with you sex?
A. No.

Q. Do you think that it's some sort of coincidence that the first time Joel became preoccupied with porn and sex and had concerns about getting an STI was only months after you took him off an antipsychotic?
A. Five, six months after. Yeah, and it wasn't psychotic. So that is my--

Q. No, I'm asking you, are you saying it's a coincidence that for the first time ever - this is an adult man, he's about 36 at this point. For the first time ever, after being in care at that point since he was 17, for the first time ever, he exhibits an obsession with porn, a preoccupation with sex, and a concern about getting an STI, and this is months after you've taken him off the antipsychotic. Are you telling her Honour that you considered that to be some sort of coincidence?

LYNCH: Well, your Honour--

WITNESS: I, I'm telling--

HER HONOUR

Q. Just one moment.

LYNCH: --I object to the question.

WITNESS: I'm telling that--

HER HONOUR

Q. Just one moment, Doctor. Just wait for Mr Lynch.

LYNCH: The well-known impacts of antipsychotic drugs are a reduction in libido. That's uncontroversial. My friend's putting the proposition it's a coincidence that once he's been off the antipsychotics for five or six months, it's a mere coincidence. Well--

CHRYSANTHOU: I'll thank my friend for helping his client answer questions--

HER HONOUR: Well, that was the evidence--

CHRYSANTHOU: --but his client had told us repeatedly that she considered the 5 micrograms of Abilify to be basically a placebo with basically no side effects. I gave her plenty of opportunity to tell us if there were any, and she didn't offer a reduction in libido as one of them--

HER HONOUR: Well, there was the evidence yesterday--

CHRYSANTHOU: --and in fact, yesterday, she gave evidence to the contrary.

WITNESS: Yes, and--

HER HONOUR: I remember that yesterday that was the evidence that I heard, was that--

WITNESS: I would, I would like to answer your question.

CHRYSANTHOU

Q. Thank you.
A. He was 30, or I don't know how many years old. He just broke up with his girlfriend of five months, and he was exposed to his hormones and was until there, he wasn't even having any sexual relationship. Now, at that time, there was a rise of pornography, and I have evidence how many men of his age is engaged in pornography in Australia. There is - there even the literature calls it epidemic, which is scientifically not true, but at that age of 30, how many men are viewing pornography? Do you know?

HER HONOUR

Q. Look--
A. This is what I say that, he wasn't--

CHRYSANTHOU

Q. I can say I don't know--
A. --he wasn't--

Q. --how many men at the age of 30--
A. -- he was, he wasn't--

Q. --are viewing pornography.
A. --a person - he was a 30 year old man who was exposed to pornography like every Australian man at that age, and he become interested in it. And he--

Q. He was 35.
A. --he was 35.

HER HONOUR

Q. Can I stop you there, Doctor?

HER HONOUR: We really--

CHRYSANTHOU: I'm going to try to move on from this.

WITNESS: Yeah.

LTS:DAT

HER HONOUR: Yes, we do need to. Just ask the direct questions and--

WITNESS: Yeah.

HER HONOUR: --move onto the next question.

CHRYSANTHOU

Q. I want to suggest to you that you understood, at the time he exhibited a preoccupation with sex and pornography, that that was a direct result of him being taken off the Abilify earlier that year?
A. I didn't see any, any connection between the two. I thought it was a - it's a new phenomenon. And it - I felt it was normalised in my, in my, in my concept. And he ask for help and we helped him.

Q. At no time during your treatment of him did he exhibit any violent behaviours, did he?
A. That is - I swore that during my eight years of treatment, at no time he exhibited psychotic symptoms, any risk to self and other and any preoccupation with the weapons.

Q. Yes, so he never told you that he had any interest in knives, did he?
A. No.

Q. And he never--
A. No.

Q. --said anything to you which would make you think that he was considering any act of violence?
A. No.

Q. One of the parts of his diagnosis is paranoid, and the other part is disorganised schizophrenia?
A. Yes, disorganised, yes.

Q. You made a suggestion yesterday that what Joel did on 13 April was organised.
A. Mm.

Q. I want to suggest to you that your evidence about that is not correct. Do you agree?
A. I don't have an evidence. It was just a conjecture on my part, and I shouldn't have, shouldn't have done that. I shouldn't have speculated four years later after I completed his treatment. Yes, so it was a, it's a, it was a conjecture. It wasn't a--

Q. Do you withdraw what you said yesterday about that?
A. I said that as I honestly believed that when he was psychotic in 2001, 2002, he was very disorganised. Wouldn't have been able to organise himself to plan that attack.

Q. You understood he was homeless before he carried out the attack?
A. Perfectly well, because I got - okay. We will, we will show you some documents later on.

Q. You're talking about the letter--
A. Which letter?

Q. --from his mother? The email from his mother, is that what you're talking about?
A. What date you talking about?

Q. The one that you got recently, is that the one you mentioned in court yesterday?
A. I didn't mention anything in court. I, I just gave the copy of Michele Cauchi's email after the attack in May when his(as said) son died, and he came - she came in to the, to the practice, but I wasn't there--

Q. Going back to my question--
A. --and that was an email.

Q. --you understood that he was homeless?
A. (No verbal reply)

Q. You understood he was homeless?
A. From that letter, yes.

Q. So that doesn't sound very organised, does it?
A. I did not know he was homeless. I, I lost touch with him in 2020.

Q. No, when you gave your evidence yesterday and you claimed that he conducted or carried out an organised attack which was contrary to your understanding of his psychosis in 2001--
A. Yes.

Q. --I want to suggest to you, you knew when you gave that evidence yesterday that he was homeless at the time he carried out the attack?
A. Yes, and he was--

Q. And that is not organised at all, is it?
A. To me, he had to organise. I, I know the circumstances--

Q. No, it's not organised to be homeless, is it?

SPEAKER: Your Honour, can I - I've just taken it--

WITNESS: Organised, of course.

HER HONOUR

Q. Sorry, just one moment.

HER HONOUR: Ms Chrysanthou.

WITNESS: The attack.

LYNCH: Your Honour, this is--

CHRYSANTHOU: Your Honour, this witness gave evidence yesterday, which was allowed, and it was contrary to all the expert evidence.

HER HONOUR: All right.

CHRYSANTHOU: It caused great distress and publicity in relation to the reasons why Mr Cauchi did what he did on 13 April. The witness has already said that she'd engaged in conjecture. She hasn't gone so far as to withdraw her evidence, even though I've invited her to do so. I'm entitled to put to her that the evidence she gave yesterday was dishonest, because it was shocking evidence to me and my clients, and I'm entitled to raise it.

HER HONOUR: You are. She has said today that she shouldn't have said that. It was conjecture. It was speculation on her part. We can move on from there to does she withdraw it, does she think something different now.

CHRYSANTHOU: Yes, that's what I'm trying to do.

HER HONOUR: Yes.

CHRYSANTHOU

Q. Do you agree that what you said yesterday about Joel being organised in the way he carried out that attack, you should not have said?
A. It was a conjecture on my part, and I should not have speculated that.

Q. Do you withdraw it?
A. Yes.

Q. Thank you. I just want to ask you about some recommendations, or some recommendations you referred to in evidence yesterday. What recommendations were you referring to? Were they the Queensland Health recommendations in relation to the safe use of clozapine therapy?
A. It's - it is the College guidelines. It is the World Psychiatric Association guidelines, and in the general guidelines in many countries, that first episode psychoses after remission has to be followed up with one year of antipsychotic medication before we consider withdrawing it. Multi-episode is five years.

Q. But that doesn't apply to treatment-resistant schizophrenia?
A. It applies for treatment-resistant or treatment not resistant. It is just a difficult to treat kind of diagnosis. It's not--

Q. Have you been able to identify any documented--
A. These are College guidelines.

Q. --recommendation that supports what you've just said--
A. It's the, it's the--

Q. --or supports what you said yesterday about this?
A. --it's the College of - it's the, it's the Royal College of - Australian College of Psychiatrists guideline. Schizophrenia guideline. I think it was written by, 2017 by Dr Galletly, Cherrie Galletly.

Q. You gave evidence yesterday that your prescription of Abilify and then subsequently Rexulti in the end of 2019, you gave evidence to the effect that it was unnecessary?
A. Yes.

Q. I want to suggest to you that the reason that you prescribed each of those medications was you considered that Joel was about to, or was having, some sort of psychosis?
A. Early warning signs of relapse, not psychosis. Early warning signs of relapse which has remitted. The nurse who saw him on 20 21 didn't confirm psychosis, so we treated as early warning signs of relapse. Did not take the medication, and my responsibility is not to medicate the person who doesn't have psychosis.

Q. At what point - if you have recommended an antipsychotic to a patient, at what point if they refuse to take it would you have acted under the Mental Health Act?
A. 21 November I recommended and I thought he was taking it. And even the mother said that he's taking some medication on the fourth. But it wasn't the medication I prescribed. So, we confirmed on December 5 that he, he didn't take it. And when I ring - when I - I think I saw him on 8 December, he was fully remitted and he did not - he was able to--

Q. That's not the question I've asked. Can you listen to my question.
A. And he--

Q. My question is, at what point, if you've prescribed a medication to a patient and they refuse to take it, would you take further steps?
A. Only if I am convinced that the person is psychotic and have limited insight or no insight, and then his condition exposes risk to further deterioration or risk to public or to self.

Q. I want to suggest to you, you did know he had limited insight at the end of 2019?
A. No, I think--

Q. Because--
A. --on 8 December, I said his insight was good, he was not psychotic, and he was able to give a reasonable account that I had the belief that it wasn't

dopamine excess or psychotically driven early warning signs of relapse. And it's remitted fully. And then I confirm in January and I confirm in February as well.

Q. You've said earlier this morning that 5 milligrams of Abilify was of little effect--
A. Yes.

Q. --or was like a placebo, right?
A. Yes.

Q. Why would you - if you had had early warning signs reported to you for Joel by his mother, why would you bother prescribing 5 milligrams of Abilify if that was your view of the effectiveness of that amount of that drug?
A. That's a very good question. Because this is what we do, psychiatrists. It's not confirmed as psychosis, but it still has effect on general psychopathology. And that is what it does. It - anxiety, it has effect on mood, it has effect on OCD. So I thought if he start taking it, it might help to alleviate the early warning signs of relapse, but it was not necessary in hindsight.

Q. You've said that a few times. Thank you, we've understood that's your position now. Your records show that you in fact prescribed 10 milligrams, as you were asked about yesterday, as opposed to 5. Do you remember those questions and answers?
A. It was always 5, but it was a typo. And, and she - and he knew, and RN3 knew, it was 5 milligram. It was just a typo on the prescription.

Q. I want to suggest to you that you're wrong about that and your records are correct, and what in fact occurred is, because the early warning signs had been reported to you, and because you understood 10 milligrams was a starting dose, a minimum starting dose for Abilify, that's in fact what you prescribed?
A. So, I have to tell you that it was 5 milligrams and it was my error, and, and I said when I did the prescription, print it out, it went into my notes. So - but RN3 and he knew that it was 5 milligram.

Q. If it was 5 milligrams, contrary to the evidence you first gave this morning, I think you're now accepting that 5 milligrams of Abilify does have an effect on patient?
A. It does help anxiety and, and lifts his mood, and if he, if he has OCD, it can help with OCD. So it's basically--

Q. So you agree?
A. --it's anti-anxiety. Yeah.

Q. You also agree then that taking him off the 5 milligrams of Abilify that he'd been on for 15 years could have an effect?
A. Absolutely not, in terms of psychosis. What it could have effect, it could have effect on, on mood, on anxiety levels. But - like a placebo, but nothing else.

Q. Do you agree that the evidence you've given about Abilify and the effect or the non-effect of 5 milligrams this morning is completely inconsistent?
A. I don't think so. It's, it's might be misunderstood by you.

Q. So, I'm the one that's misunderstanding, is that the problem?
A. Correct.

LYNCH: I object.

CHRYSANTHOU

Q. I just want to--

LYNCH: This is badgering the witness, your Honour, in a way that's unfair and unacceptable.

HER HONOUR: The evidence I've heard today - this is what I understood - is that the Abilify can have an effect on a psychopathology, but has no effect on psychosis.

CHRYSANTHOU: I don't think that's what the doctor said, your Honour.

WITNESS: I did say that.

HER HONOUR: I've got notes.

WITNESS: Sorry.

CHRYSANTHOU

Q. You agreed yesterday, when Dr Dwyer asked you questions, that stressors that could be reduced by a drug like Abilify could lead to behaviours and moods in a patient diagnosed with schizophrenia that could lead to psychosis, do you agree?
A. What? I don't understand. Can you, can you repeat this question? It was totally inconsistent question.

Q. You gave evidence yesterday about the sort of things, such as stressors, that could affect a patient diagnosed with schizophrenia to go into a psychosis. Do you remember that evidence?
A. Definitely. That is the, that is the key things about early warning signs of relapse. The relapse comes most of the time with exceptional stress or an accumulation of daily stress. Stress.

Q. So if a patient--
A. And response, and the response with early warning signs of relapse. And that can go to relapse or, or back to normal.

Q. So, if a patient is on a drug that affects those stressors and the likelihood of

those stressors occurring, that drug can prevent a psychotic relapse?
A. I don't think so. It is not in the literature. Only - and, and I know that - prevention is, is still need. I mean there is a huge, huge scientific evidence for it, that for prevention, we don't actually need less, less milligrams as psychotic - acute psychotic treatment. We just have to be around the neuroleptic threshold, which is 60, 80% of dopamine D2 receptor blockage. That is for treatment and relapse prevention. Maybe relapse prevention a slightly tinier dose, like, like in the literature they say 10 milligram Abilify is enough for relapse prevention, but 5 milligram, and I swear, is not enough for relapse prevention.

Q. So why did you prescribe it?
A. I did not. I took him off. I, I, I--

Q. No, no, you prescribed it. We know that you prescribed it.
A. Yeah, and I, I took him off.

Q. And you thought he took it?
A. And then, and then--

Q. So why did you do that--
A. In November I did.

Q. --if your evidence that you just gave is true?
A. Because he had early warning signs of relapse. And I did not prescribe it in an antipsychotic dose. I, I prescribed it in 5 milligram, what he was taking, to cut the edge of the anxiety and help not to develop the psychosis. Because it wasn't psychosis. You have to understand that it wasn't psychosis.

Q. Yes, you've said that.
A. My nurse next day and the same day saw him and he - she reported that it wasn't psychosis.

Q. Did you ask him why he wrote the notes that had the satanic material in it? Did you ask him why?
A. That was very good that you told me. Because the mother didn't mention about the satanic material, and I thought that you, you would ask RN3 where does this satanic material came from. Because I couldn't confirm it.

Q. Did you ask him--
A. Yes. There was no satanic material--

Q. You saw RN3's note?
A. --in his, in his, in his account. There was no satanic. It was excessive showering, it was notes left around, but not - nothing - I don't know where this satanic material came from, and definitely not from the mother to me. It was something between RN3 and the mother that, that it was - I, I always thought that it must have been - I don't have any copy of those things, mother didn't make photocopies, and I think it must have been a domain of his inner turmoil; the moral, cultural and, and religious domain of his, of his, of his anxiety about

sex, women and pornography.

Q. Doctor, before you saw him on 28 November, you were aware that RN3 had written a note which said "plus, plus, plus many notes"?
A. Mm-hmm.

Q. Right, lots of notes, which contained something to do with satanic material. You saw that?
A. Which I couldn't confirm with Joel.

Q. Right.
A. And the mother as well.

Q. No, the mother told you--
A. It was something--

Q. --in an email that he was hearing voices?
A. The mother did not say anything about--

Q. She thought he was hearing voices?
A. --satanic control. It didn't say that he hearing voices. He appears like hearing voices, but not - she never told that she(as said) was hearing voices. It was mother thought that he might be hearing voices.

Q. Did you ask him, "Why did you write those notes that your mother's found around the house?"
A. He - I did.

Q. Well, that's not in any of your notes, is it?
A. No, no.

Q. That you asked him about that?
A. No, I did not. I didn't. But I, I said it wasn't psychotically driven. It was more what RN3 said, that he was spending long time in the shower and was washing himself.

Q. No, I'm asking you what you asked him on 28 November. You had been told his mother thought he might be hearing voices. You'd been told he'd been leaving notes around the house that she thought were satanically driven. Did you ask him on 28 November, "Why are you writing those notes?"
A. I don't think I, I asked him specifically what was the content of the notes or what did he write, but it was - he was saying that it was, it was due to his tormented mental state about sex and pornography. And he was very, very worried that he got - he contract - later on, later on - that he had this dangerous sexual encounter and he might have contracted HIV.

Q. Hearing voices, is that a sign of psychosis to you?
A. It was never--

Q. Is that a sign of psychosis?

A. Yes, if, if--

Q. Is that evidence of psychosis?
A. --if it was evidence, yes, it was. But there was no evidence that he heard voices--

Q. Well, there was?
A. --and he denied.

Q. His mother had given you evidence, hadn't she?
A. No. That is not evidence. That is just a description - an outside description of a son who, who didn't even live with. It was an opinion of the mother.

Q. I just want to ask you a different topic. Your last appointment with him on 16 March?
A. Correct.

Q. Why do you say it didn't happen?
A. What didn't happen?

Q. Why didn't that appointment go ahead on 16 March?
A. I wanted to follow him up on Skype, but at that time he was in Brisbane and, and my receptionist confirmed with him that he was in Brisbane. And, and, and the government removed the rebate from the telehealth appointment, so I couldn't get the rebate for that telehealth - so I tried. I'm a private psychiatrist.

Q. Are you saying the appointment on the 16th did not go ahead--
A. Yeah.

Q. --because of the Medicare rebate?
A. I tried to follow him up. I offered him face to face, but he did not accept it, and I, I didn't have any other choice as a private psychiatrist. Just let him go and refer him back to his Toowoomba GP, because he did not have any GP at that time in Brisbane. And he said when he would have GP, he would let us know.

Q. If we just go to page 19 of the notes--
A. It's something--

Q. --it says that the appointment didn't go ahead because his Skype was not working?
A. That was one of things, and then the government did not, did not remove the - remove - sorry, the government did not pay for the appointment because he was, he was in Brisbane, and that time, I couldn't Skype or do telehealth with anybody in Brisbane. I couldn't get rebate for it.

Q. Did you actually believe his Skype wasn't working?
A. It's not relevant, because I - even if the Skype wouldn't have--

Q. No. Did you believe his Skype wasn't working, or did you think he was trying to avoid you?
A. I didn't even have any opinion about it. Once the - my - the receptionist said "Dr A, I have to cancel it because the government removed the rebate from the appointment". So as a private psychiatrist, I offered him face to face--

Q. You've said that. Please. You've said that--
A. Yes. Face to face appointment.

Q. No, no, wait. I'm asking only about this one appointment on the 16th. You had an appointment booked.
A. Yeah.

Q. According to the notes it was going to proceed, except his Skype wasn't working. Do you agree that's what the notes say? They're in front of you.

LYNCH: Your Honour, they don't just say that. They also say that he was no longer eligible for Skype appointments, on p 19, at the foot of the page.

HER HONOUR: Yes. Says five.

CHRYSANTHOU: Yes. Afterwards. But it says--

WITNESS: It was at the same time. I didn't - it wasn't sequential for me. It was - when I, when I was going to have an appointment, it was cancelled by the receptionist because of these two reasons. One reason was enough.

CHRYSANTHOU

Q. If his Skype was not working, do you accept you could have just spoken to him on the phone?
A. No, because it was agreed that he was - it was going to be telehealth appointment. I wouldn't have been able to have any rebate for, for phone - follow-up phone appointments. And that is something which is a private psychiatric issue. It's nothing, nothing that I am cruel, or something. It is just what it is. It is - I am - I have a front of the office, which is the admin, and admin tells me that it cannot go ahead because there's no rebate. And that is what it is.

Q. And the rebate is about $240. Is that right?
A. No. 100.

Q. Pardon?
A. Because I never, never, never charge him extra. It was bulk bill at that time.

Q. So how much--
A. I don't even know.

Q. --was this appointment worth from Medicare that didn't go ahead?

A. It was a - three or $400 at that time.

Q. I want to suggest to you that it was about $240?
A. Which did not go ahead because it was cancelled, because that was the telehealth - it was a telehealth appointment which government pays for it. Like usually it's not as high. I don't know why it was that high.

Q. I just want to go to a different topic.
A. Yeah.

Q. After Joel left your care, you had requests from other practitioners for his clinical notes. Do you agree?
A. Yes.

Q. You never sent his clinical notes, did you, to those other practitioners?
A. We don't send patients' clinical notes with, with private psychiatrists. We don't. We don't. They have to specifically ask for the whole file to be transferred. And nobody wants the whole file to be transferred. They ask for collateral history, and this is within psychiatric, psychiatric circles. It's understood. Some psychiatrists just give the last letter. My policy is the last three GP letter plus the first assessment. That is what I did. And they have - they can come back to me for more if they wish.

Q. I want to suggest to you--
A. But they didn't come back to me.

Q. --that you were asked for all clinical notes. So, for example, I'll take you to page 133 of tab 793. On 26 November 2020, Cornwall Street Medical Centre sent you a form asking for medical records transfer, and it says "all clinical records". And then if we go over the page, at 134, Joel signed that. Do you see that?
A. It was impractical because nobody wants his all clinical notes.

Q. Doctor, you were asked for a transfer of his records - "all clinical notes". Do you agree?
A. Okay. That is an average letter they used to write, and we never do the whole clinical records unless they come back that they need the whole clinical records. And I, I cannot do anything more. Just tell you this.

Q. And if you look at what he signed off on, on page 134, he asked for a health summary with relevant correspondence and results, he asked for all clinical records, and he asked for details of any CDM. What's a CDM?
A. I don't know.

Q. And there's some acronyms there, or PIP items?
A. I don't know.

Q. You did not send that, did you?
A. It was not me. It was my receptionist, and we - as I say, we have a general understanding that we don't send the clinical records.

Q. Well that was a failing on your part, wasn't it--
A. No.

Q. --to not send his full clinical records--
A. It was, it was, it was--

Q. --to the new doctor who requested it in November 2020?
A. It was in harmony with peer reviewed, and peer understandings of what we do when, when it's asked from us.

Q. All you sent were a few letters that you'd sent to Dr Grundy. Isn't that right?
A. This is exactly what we do with every request.

Q. You didn't send any record to Cornwall Street on 26 November 2020, or in November 2020--
A. Cornwall--

Q. You did not tell Cornwall Street in any document, did you, that you had formed the view in February 2020 that Joel needed to be monitored by a psychiatrist every month?
A. That letter to the GP, not month. I actually said in the letter of the GP - just a minute. I think it was misunderstood many times, but--

Q. Do you want us to bring that letter up? Which one - you're looking at your Grundy letter from--
A. I actually made a photocopy this morning. So I think this letter was - to me, to my knowledge, was enough. Okay. Where is it?

Q. We can bring it up for you, Doctor.
A. Okay. Here--

Q. Which one are you talking about?
A. Okay. The letter discharge. So:

> "I received advice from Medicare regarding the parameters of Skype eligibility. I tried to follow him up, but he moved recently in ineligible Skype area and no longer able to offer Skype appointment. My receptionist has contacted Joel to advise of this change".

Q. So we've got it up on the big screen for you, Doctor. It's up on the big screen for everyone. We've all read it.
A. Yeah.

> "Joel has indicated that he will be unable to attend face to face appointments with me due to the distance for travel for appointments. So I'm therefore discharging Joel back to his and Dr Grundy's kind ongoing care."

I did not specify monthly, two monthly, whatever.

> "Please recall Joel to discuss his options and referral to an alternative psychiatrist if he doesn't want to come back to me. Needs an alternative psychiatrist. In the future, should Joel move into a Skype eligible area or wishes to see me for face to face, I would be happy to. However, I will need a new referral."

Because by that time I discharged and deactivated him.

Q. Yes. But you agree in February you thought he needed monthly review by a psychiatrist?
A. I did not tell it to the GP. I did want to do monthly appointment, because I wanted to see him through to stabilise it. That was our understanding. That--

Q. It was actually twice a month, wasn't it? Once with you and another separate appointment with the psychiatric nurse, wasn't it?
A. Yes. What we did with him, we actually--

Q. Can you answer my question please.
A. --supported through--

Q. Just answer my question.
A. --his role transitions--

Q. In February 2020, it was your view that Joel needed to see you once a month--
A. Yes.

Q. --and to separately see the psychiatric nurse once a month?
A. Yes. It was, it was a good care which he was happy, and the mother was happy with.

Q. You didn't tell the GP that in your letter in March, did you?
A. No. I think that this GP, I called him on the phone after that and we had a chat. I, I did not specifically remember the monthly appointment. He did not need monthly specialist appointment. I did it because, because of wanting to know that he is going to move safely and, and I wanted to see he finds a, a GP in, in Brisbane and then I could facilitate the transfer of his care through the GP, you know, that is what I say.

Q. You said yesterday he needed psychiatric care for the rest of his life?
A. Yes. Ongoing, ongoing care. It is in the letter.

Q. Your medical records say that he needed to see you once a month, and a psychiatric nurse separately once a month, as at February 2020?
A. I did continue to see him monthly because there was so many psychosocial issues which needed to be done, and we helped him and--

Q. We understand why you've said it.

A. Yeah.

Q. But you said it. That was your view in February 2020 in your clinical records?
A. I did not think he was needing monthly appointments at that time.

Q. That evidence you've just given is false, isn't it?
A. That's why - ongoing, ongoing care I said. Ongoing care.

Q. The evidence you just gave is false, isn't it? You did think he needed to see a psychiatrist once a month?
A. Not false. It is just not saying that monthly, okay. It said ongoing care.

Q. Do you agree, on reflection, given you were asked by a new doctor in November 2020 to send all clinical records, that had you sent all of your clinical records to that doctor, Cornwall Street Medical, in November 2020, that they would have reviewed them and formed a view themselves that Joel needed monthly review?
A. Okay. For a - as, as I said to you, that was a GP request and we don't send the clinical records. It is, it is more like a letter to GP to GP, not from a specialist to GP. So, because it was a GP request, we just did what every psychiatrist would do, and I don't think I, I deviated from, and every psychiatrist - even did more than many of the psychiatrists, because every psychiatrist would possibly give the last letter. But I did give three letters - and this was, was policy - and the first letter. And I, I, I cannot say anything more about this.

Q. But Dr Sarkar - you know Dr Sarkar?
A. Yes.

Q. Are you saying he's a GP?
A. Dr Sarkar was a psychiatrist and he got what everybody gets.

Q. You just said it was a GP request. Do you agree you're wrong about that; that the request I've asked you about, on page 134, on 26 November 2020, is from Dr Sarkar, a psychiatrist? Do you agree? You're wrong about that?
A. Which one?

Q. It's not a GP request?
A. Okay.

Q. The one I've been asking you about from November 2020?
A. Okay. Maybe, maybe it wasn't the GP, but I thought it was a GP and my receptionist thought it was a GP, so we gave, gave what we always give. This is - and if they not happy, they come back for more.

Q. You failed, didn't you, as a psychiatrist, by not providing Dr Sarkar with all the clinical records that he sought?
A. I don't think I failed. I - what I did, I gave what everybody would have given at this time, and if the psychiatrist, or the GP, needs more they come back for more.

Q. Do you agree that the GP letters that you provided Dr Sarkar, and that you'd previously sent to Dr Grundy, were wholly inadequate to describe the care that Joel needed?
A. I said ongoing care, and psychiatrist. It was in the letter. I don't know how you interpreted. This is what it is. You can interpret it as well, or you can interpret it is what you interpret. It is what it is. And I - he, he knew, he was well, well equipped, that he needed ongoing psychiatric care, and he said he would find a GP and he will have a bulk billing psychiatrist and what - this is what actually he did, because he was told.

Q. What was the use of having a new doctor who had no idea about his 20 year mental health history because you didn't hand over the notes?
A. I did hand over enough that first, first letter which showed the - showed how he came to me and the symptoms, and the last three, that he was good. That, that is enough for a psychiatrist. And if they wanted to have anything more, they can call me, they can ring me, they can ask me. Apparently this Dr Sarkar was happy with my collateral history.

Q. Dr Pietsch also asked you about Joel, didn't he, in November 2023. You were asked about that yesterday?
A. Mm.

Q. And you sent him the same four letters, didn't you?
A. Yes. And Dr Pietsch also called me on the phone, and we did have a discussion on the phone.

Q. Yesterday, you said you had no record of speaking to Dr Pietsch?
A. No record, because I did not document. He was already discharged and I didn't document.

Q. So are you saying nothing was documented in your system after a patient was discharged. Is that your evidence?
A. It was my mistake that I did not document that phone call.

Q. No. Yesterday you said the reason it wasn't documented was because he had been discharged?
A. Yeah. And that's--

Q. But were you trying to say that because Joel had been discharged, you didn't document anything?
A. I, I forgot the document, but it was the letters what I sent, and I did not document that I talked with the doctor.

Q. Well, it's just not true, the evidence you gave yesterday. You did document--
A. What did I document?

Q. --communications--
A. Did I?

Q. --in your system after Joel was discharged, didn't you?
A. My receptionist documented those things. That when, when, when, when they asked, I told the receptionist "Just follow the policy and send them the usual thing, what we do". So, I don't document these things. I - and I - yes, I failed to document that I talked with Dr Pietsch. But Dr Pietsch actually was very helpful and said that he's - he had collateral from his mother and it was all, all about the driver's licence. And we didn't talk whether he was followed up by a psychiatrist or not.

Q. I want to suggest to you that - I mean, you've given three statements in this matter. Did you refer to your conversation with Dr Pietsch in any of those statements, to your recollection?
A. I don't think I did have because, because it was how many, three years after, four years after I discharged him.

Q. So, you're saying that conversation just came to you yesterday as you sat in the witness box when Dr Dwyer was asking you questions?
A. Yes, because he called me and I remembered that. And I was remember that vividly because he said the mother said everything was right and he was right, so I was happy. I was very, very - you know, if psychiatrist hearing from a patient, I thought he, he might have had psychiatrist in background. I did not ask whether he had psychiatrist in background. I was just accepted what the GP said and said, yes, put M on his driver licence. That is what it is.

Q. Do you agree that you failed by not passing on Joel's full clinical records to subsequent medical practitioners who asked for them?
A. I don't.

CHRYSANTHOU: No further questions, your Honour.

WITNESS: I don't, because that is peer reviewed and peer accepted practice.

CHRYSANTHOU: I call for all of those peer reviewed documents that the doctor has been referring to throughout her evidence in relation to the passing on of clinical records.

WITNESS: Yes, good. Thank you.

HER HONOUR

Q. Now, we'll just see if there's other questions, Doctor.

FERNANDEZ: No questions, your Honour.

ROFF: No questions, your Honour.

FRECKELTON: No questions, thank you, your Honour.

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

WILSON: No questions, your Honour.

HER HONOUR: Ms Mathur.

<EXAMINATION BY MS MATHUR

Q. My name is Ms Mathur, and I appear for Dr Grundy. You understand that?
A. Yes, thank you.

Q. I understand that yesterday, you understand that Dr Grundy does not accept that there was a telephone conversation between you and him in March 2020 for the purposes of a handover?
A. Yes, yes.

Q. Do you understand that?
A. Yeah, now, now you're saying that, I accept that he doesn't have recollection.

Q. Not only not a recollection, but he states that it did not occur. Do you understand that?
A. He said that he doesn't have memory of that, yes.

Q. What I'm going to suggest to you is that on every occasion that you have been asked to give an account in relation to the handover in March 2020, your evidence has changed. Let me take you to the first occasion.
A. Good, please.

Q. The first occasion that you were asked to give an account in relation to your handover with Dr Grundy was in your first statement dated 7 June 2024, and I'm going to draw your attention specifically to paragraph 121 of your first statement, volume 19, tab 790 page 18. Can you read to yourself what is written there at paragraph 121?
A. Yes. Yeah, it - it's basically word to word for--

Q. Wait Doctor. Have you read that paragraph to yourself?
A. Yes.

Q. I would also ask you to read paragraph 122 to yourself.
A. Yes.

Q. You accept, don't you, that in your signed statement for the purposes of this inquest, you said, "I updated his referring GP Dr Grundy in my letter to him and asked him to recall Joe to discuss his options and referral to an alternative psychiatrist if required". Correct?
A. Mm-hmm.

Q. And it's correct to say, isn't it, that in your signed statement, you further said at paragraph 122, "I had no further active involvement in the treatment of Joel after this point in time". Do you accept that that is what is written--

A. Yes.

Q. --in your signed statement?
A. Yes. That was my reaction to the first coroner, coroner report based on my notes, but then, then--

Q. I'm going to come to then.
A. --I went through many times and I remembered.

Q. Yes, I'm going to come to then.
A. Yes.

Q. But do you accept that in your first statement where you give a detail of your contact throughout your treatment period, that nowhere in your first statement do you mention a follow-up phone call with Dr Grundy?
A. Yes, because it wasn't documented in my notes and I was at that time adhering to my notes.

Q. It's correct to say, isn't it, that when you received the letter from those assisting the State Coroner, it was never suggested to you that you should limit any details simply to your notes. Was it?
A. Yes, but I didn't remember at that time, and I was just doing it like an automatic pilot to finish the coroner report in time, and I did not--

Q. That was--
A. --I did not reflect on it, but then, you know how human memory can - when you go through again and again and again, and just, just popped in the mind that I, I did talk with him. And that is how the second statement comes.

Q. I'll come back to the way in which memory works in a moment, but let's go to your second statement, which is now written roughly five years after the events in question. And your second statement is found in volume 19, tab 791, and it's page 4 that I'd like to draw your attention to.
A. Mm-hmm.

Q. I'm drawing your attention to J on that page, and again, I'd ask you to read to yourself both the question and the answer?
A. So, should I read it, or you read it?

Q. No, if you could just read it to yourself so you could re-familiarise yourself as to what you've said in your second signed statement?
A. Okay.

Q. It's correct to say, isn't it, that in the second signed statement, almost to the day five years after the events in question, namely the handover, you say for the first time, "I recall having other communications with Dr Grundy about the discharge". Now, do you use the word "other communications" in the plural, namely more than one?
A. No, other communication in the, in the form of a phone call.

Q. And you say there, "Albeit undocumented", and then you use the word, "I believe we discuss the unusual variance in his discharge pathway"?
A. Yeah.

Q. Do you use the words "I believe" because you're unsure?
A. No, because--

Q. Or because that's your best recollection?
A. Because it was my best recollection as a psychiatrist, when there is a variance in my care or discharge or something, I always call the GP and, and then it just dawned to me that I did actually, and I remember talking with him on the phone. Whether he called me back or I called him or it was the receptionist who organised the phone call, it happened and I clearly recommend - remember. And I also remember that their office couldn't find my discharge letter, which my current receptionist, who is my practice manager, actually was able to locate that we actually got a written receipt that they, they received my, my letter. So, it was received, so.

Q. Let's go to the third time you've given evidence--
A. And you have that in, in your file, that, that it was received.

Q. Yes, there's no dispute that Dr Grundy did receive your letter.
A. That was very good, thank you.

Q. But let's go to what you said yesterday, which is the third occasion on which you've been asked to give an account of this phone call, noting that on the second occasion, you said that what's discussed is the unusual variance in his discharge pathway. What was the unusual variance? Was that the Skype which was prohibited because of Medicare billing?
A. Yes, that--

Q. Is that the unusual pathway?
A. The unusual was that I wanted to follow him up. I wanted to keep him in my care, but because of the government not paying for the telehealth, that I had no choice but let him go and he didn't want to see me face to face, and I told - and I, and, and I remember clearly that Dr Grundy said that "I am his family GP. I know the family very well. It's very good that you refer him back to me. I accept it and I will, I will talk with him about refer to another psychiatrist".

That was it, and I offered any kind of facilitation of that transfer. And that was my mind, that if he find a GP in Brisbane, I would have been the person who facilitated the care. And I know that he actually went to a GP and had three psychiatrists referral on - during that year, and one referral to Belmont Hospital for, for follow-up. And he still saw Dr Barkla after he didn't see me in March, who has a psychiatrist. So he was, he was looking for care, and he knew he had care. He needed to have a psychiatric care. So it wasn't that.

Q. Doctor, take a breath.
A. Yeah, but he did know.

Q. Yes, take a breath. I'm going to refresh your memory as to what you said yesterday in court, which was similar to what you've just said now, and that is that you say in the conversation with Dr Grundy--
A. Yeah.

Q. --that Dr Grundy said to you, "I am the family GP. I know him very well and I will recall and I will do my best"?
A. Yes.

Q. That's what you said yesterday?
A. Exactly.

Q. Do you accept that?
A. I clearly remember that we had a very good discussion, yes.

Q. Do you accept that, yes?
A. Yes.

Q. That's different, isn't it, to what you said the conversation was about in your second signed statement, where, in your second signed statement, you said the conversation was about the "unusual variance in his discharge pathway", and you make no mention whatsoever about Dr Grundy saying to you, "I'm his family GP, I will take care of it, I will refer him". Correct?
A. Sorry.

Q. Do you agree that there is a difference there in what you've said?
A. Sorry, I thought it was implied in it and it is my error that I did not write the whole story. It was--

Q. So just stop.
A. Yeah. I thought it was implied.

Q. Do you say implied in the words "we discussed his unusual variance" is Dr Grundy saying to you, "I'm his family GP"?
A. Yes, because he was.

Q. Is that the words that you say were implicated?
A. Yes, I thought it was implicated. So, it my - it is my slack, slack writing, yeah, I agree. But I thought it, it, it was implied.

Q. Take a breath. I'm going to ask you another question. I'd ask you to assume this: that Dr Grundy will give evidence that he is and was never Joel Cauchi's family GP. That's the first point. Secondly, that to his memory, he has never treated Joel Cauchi's mother. And to his memory, the last time he treated Joel Cauchi's father was some 15 years earlier.
A. Okay.

Q. Now just accept that that's the anticipated evidence of Dr Grundy. Would you like to reconsider what your memory is about the words said by Dr Grundy

to you in that phone call?
A. I still remember that he was - he knew him well, he referred him to me, and he was well familiar with his background, and also, he gave yearly referral letters. And, and many times we were -when he had some physical problem, I rang him and, and he made an appointment to see him for - with a medical problem.

I remember I talked with him a few times in the phone. And he was his family GP because he knew him well. He, he gave me I think 2018 an indefinite referral, which I didn't like to get from, from GPs. I really like the yearly referrals. And I think that was a point which, which I would like to make. That if, if I would have had yearly referrals, that it might have, might have helped me to kind of write to the, the GP every year, and not just when I change something. Because--

Q. Well, just stop.
A. Yeah, because otherwise--

Q. Just stop. Stop.
A. --the psychiatrist, I just write--

Q. Stop, stop--
A. --to GP when I--

Q. --Dr A, just stop.
A. --stop something.

Q. Are you suggesting that Dr Grundy did not send you a annual referral letter?
A. Mm-hmm. Mm-hmm. 2018, he gave me an indefinite referral.

Q. Yes, but you're not suggesting that there wasn't correspondence between you and Dr Grundy during--
A. Well, definitely there was, but only when I change something.

Q. Sorry?
A. Only when I changed something. A medication.

Q. You wrote to Dr Grundy when you changed the management or treatment plan of Joel Cauchi, correct?
A. Yes. Only.

Q. And that was primarily your letters back were brief, and they effectively informed Dr Grundy of the reduction of--
A. Yeah.

Q. --Clopine and/or the cessation of Clopine and/or the cessation of Abilify, correct?
A. Yes.

Q. So, just coming back to your memory, do you say now that you assumed that Dr Grundy was the family GP because he knew Joel's history well, or do you maintain--
A. I assumed--

Q. --that Dr Grundy - wait.
A. I assumed--

Q. Wait. You assumed, okay. Just going back to your memory again.

HER HONOUR: Just, sorry--

MATHUR

Q. I understand yesterday your evidence was--

HER HONOUR: I'm sorry, Ms Mathur. I'm not clear. Are you saying that - you're making a distinction between the family GP and Joel's GP?

MATHUR: No.

Q. There's no--

HER HONOUR: Is that intentional?

MATHUR

Q. --there's no dispute that Dr Grundy was Joel Cauchi's GP.

HER HONOUR: Right.

MATHUR

Q. And correct me if I'm wrong, but I understand now that you withdraw your evidence that Dr Grundy said, "I am the family GP", and you've used that expression because you assumed he was the family GP. Is that correct?
A. I think it's a blurring of what mean family GP and private GP. He was his long-term GP who knew from, from the beginning of the psychotic illness to the time of the last referral, which was 2018, 2018 I think. The - in the final referral. Can you, can you - and after that, I don't know how many letters I wrote to him.

HER HONOUR

Q. I think you said that in 2018 there was an indefinite referral from Dr Grundy?
A. Yeah, okay.

Q. All right. Sorry, we'll just stop you there now. Listen to the next question. I think it's a separate--

MATHUR

Q. Yesterday you said that you are sure that the discharge letter dated 19 March 2020 to Dr Grundy was written by you, correct?
A. Mm-hmm.

Q. And you're certain of that, is that correct?
A. Yeah.

Q. Are you as certain of that fact as you are of this telephone conversation that you say took place?
A. I, I cannot deny that I remember talking with him. And I know, that is, that is not documented, so, that is what - that's why I wasn't writing in the first, first statement. And later on, I remembered. It's just how memory works.

Q. Yes. Just in terms of how memory works, what I suggest to you is you in fact did not write the letter of 19 March 2020, and that the receptionist in fact wrote the letter of referral to Dr Grundy. Do you agree or disagree?
A. I always have templates. Templates. And it must have been after the template, and I signed it. He - she didn't sign it. So, I must have - there must be a template, and I just put something else, which is, which is, which is - I - because I signed it. It cannot go out unless I sign it. And if there was a template, I just put something extra in it.

MATHUR: If we could have on the screen tab 792D of vol 19, and p 5.

Q. I'm taking you to the signed statement of the receptionist, and drawing your attention to paragraph 36 of that statement. Again, can I just ask you to read that to yourself?
A. Mm-hmm. Which one? The--

Q. Paragraph 36?
A. Yeah. It was based on a template, and he might have twinkled with it, but I have the final letter, and I signed it, and this is how it went out.

Q. So, the correct position is that you did not write the letter--
A. I take responsibility--

Q. --but that you--
A. --that it was my - I authored it, and it wouldn't have gone out with my--

Q. I appreciate that your signature's on it.
A. Yeah.

Q. But it's not correct to say, is it, that you wrote the letter?
A. Look, how to say that. It has - I take responsibility for that letter that I have a template with the receptionist use. He might - she might have put something in, and - about the circumstances why, why, why the appointment was cancelled. But basically, it was my wording, because the template is my

wording. And the last, last bit of putting it together and sending it, my wording. They cannot do it without my signature.

Q. So, bringing that discharge letter up on the screen, we've seen it a number of times. What I'd like to suggest to you is that this letter to Dr Grundy did not in fact give him any clear direction as to what you were asking him to do with respect to the care and management of Joel Cauchi's mental health. Do you agree or disagree?
A. I think it is a very generic letter, and it--

Q. Was that an agreement to the proposition?
A. I think if, if, if it was for a GP who didn't know him, yes. But because he knew him well, I think it was an understanding what did it mean.

Q. But let's look at the understanding, and the critical words here, would you agree, are in the third paragraph, the second sentence, where it says "If required".
A. Mm-hmm.

Q. Do you see that?
A. Yep.

Q. Now, that is effectively telling Dr Grundy, the general practitioner, who firstly you'd accept has not been involved at all in the care, management, treatment or monitoring of Joel Cauchi's mental health for the period 2012 until 2020, correct?
A. But he had constant kind of feedback from me, and--

Q. Yes, the feedback I think we've discussed.
A. Yes.

Q. The feedback was brief, and the feedback effectively said that there was a titrating down of his antipsychotic and of his Abilify, correct?
A. Yes, I think in between doctors, it was--

Q. But just come back. Just focus--
A. --it was sufficient, yeah.

Q. Take a breath. Just focus. Dr Grundy was in no position, was he, to make an assessment as to whether or not further referral was required in the absence of being given a proper and fulsome handover of Joel Cauchi's mental health presentation in let's say the last 12 to 18 months. Do you agree?
A. I think he, he knew that he was well, in the last 18 months he knew, because it was again my memories with the, with the, with the phone call what I followed up. But it was - I agree, it was - it, it didn't happen because it wasn't written down. So, I think with a, with a GP like Dr Grundy, who is so experienced in the mental health--

Q. Well, let's stop and pause and consider that--

A. --that I think it was implied, and he, he, he knew that what means "if required", because I was there. I said, "My doors are open. If required a different psychiatrist, refer him to a different psychiatrist. But I am always happy to have him back". And that is mean "if required". But also, the average monitoring of a - he did not require psychiatrist skill set of monitoring. And, and it was well within a GP like Dr Grundy's skill set of monitoring him. Every GP--

Q. Stop--
A. -- can monitor--

Q. --pause. Pause. Dr Grundy's skill set. Yesterday you gave evidence that he was highly skilled with respect to the treatment and management of people with mental health based on your evidence that he had worked at Baillie Henderson Hospital. I'd ask you to accept this: that it is anticipated that Dr Grundy will give evidence that, yes, he has worked at the Baillie Henderson Hospital, a public hospital in the outskirts of Toowoomba, but his treatment of patients at that hospital is with respect to their general medical problems, namely and for example, infectious rashes. But he is not involved in the care and treatment of mentally unwell people.

So, just pause and reflect on that. Secondly, I anticipate Dr Grundy's evidence will be that, about 40 years ago, he acted as a registrar of a rotation as a training registrar in the psychiatric unit for three years, but that was now obviously some time ago. And lastly, that Dr Grundy does not see himself as having the skill set to monitor, manage and treat a man diagnosed with schizophrenia.
A. Mm-hmm.

Q. So, when you speak of his expertise, is this an assumption that you make with respect to Dr Grundy?
A. It is an assumption, and in psychiatric circle, he was one of the preferred GP for psychiatric patient to go to because his interest. It was perceived interest in mental health. And I think because of what he said about his experiences, he was - he just needed to be an average GP who has some interest in mental health. Because, because Joel did not have psychiatric symptoms at that times, and it was just monitoring for, for his mental health. That was - and it was well within the skill set of every, every GP in Australia. Is a GP skill set in Australia. And he was a little bit known to Joel because of their experience for the last 20, 20 years or something. So, you know--

Q. What I suggest to you are these three propositions. Firstly, that there was no phone call after 19 March 2020 when the referral letter was sent. Do you agree or disagree? Just simple. Agree or disagree?
A. Disagree, because I did remember. So I do remember.

Q. There was never a conversation where Dr Grundy said to you, "I'll recall Joel Cauchi". Do you agree or disagree? Just simple, do you agree--
A. Maybe didn't say "I will recall". Maybe he said that "when he comes to me", and, and that was it.

Q. And there was no conversation where Dr Grundy said to you, "I will refer him to a psychiatrist". Do you agree or disagree?
A. Because I was always open. So, I - he could have referred him back to me.

Q. Yes, but that doesn't answer the question.
A. What was the question?

Q. The question was, but Dr Grundy never said to you that "I will refer him to a psychiatrist"?
A. If needed, yes.

Q. You say he said "I will refer him to a psychiatrist, if needed"?
A. Right now I can't recall the exact word, but it was along the line that I felt that I could have - I could trusted him that he was going to recall him, and he was going to assess him, and in the best scenario, if he goes back to him, that he, he would be looked after. But I, I did not know that Joel - because I - the receptionist said, "Joel, you don't have a GP. We will refer you back to your original GP". And Joel knew that, but Joel didn't go back to him. He found a GP sometimes and in, in, in two months later, or three months later, and request psychiatric referrals. That is what I know.

So, regarding that phone calls, I can't recall the perfect wording, but it was along the line that I trusted Dr Grundy, that he knew that I discharged him because of the problem with the item numbers, and it was a - it's private psychiatric issue, he understood it, and he said "Yes".

Q. That's the height of what may have occurred?
A. Yeah. Yeah. This is what my understanding. So, I was satisfied that I did the right thing.

MATHUR: I have nothing further, thank you, your Honour.

WITNESS: Thank you.

HER HONOUR: Thank you. In court 2, does anyone have any questions of the doctor?

CHIU: No questions, your Honour.

CASSELDEN: No questions, your Honour.

JORDAN: We have no questions, thank you.

HER HONOUR: Thank you. We might take the morning adjournment before we go to you, Mr Lynch.

LYNCH: If your Honour pleases.

HER HONOUR: We'll resume at 11.45.

SHORT ADJOURNMENT

HER HONOUR: Mr Lynch.

<EXAMINATION BY MR LYNCH

Q. I believe you gave some evidence the other day where you made reference to principles of adherence therapy or concordance therapy. Do you remember giving that evidence?
A. Yep, yes.

Q. Can you explain to her Honour what those principles are in a brief way?
A. Very briefly. I am a concordance or adherence therapy and RN2 and the nurses also very experienced adherence therapy.

Q. Can you explain the principles?
A. Yeah, principle is basically is, is applied to patients to take their prescribed medication, which is for a diagnosed medical condition. So, first, you need to know that they are on a medication which is prescribed, and that this medication is good for them. So - and they might have problem adhering to them, like sometimes they stop or partially adhered to them for various reasons.

The principles of that, that we work with the patient, equal person. So, they are voluntary patients. We use cognitive behaviour therapy, motivational approach to find out their ambivalence about taking the medication, explore it with various, various cognitive therapy and, and other therapy practical reasons, and resolve the problem what they have. So, they, they would volunteer actively participating in their treatment, and not passively.

Q. Would you make suggestions but expect them to either agree or disagree and you would have discussions about any disagreement?
A. Yes. Cognitive behaviour. So, we, we, we, we have modules of, of pros, cons, risks, benefits, and eventually it honours the patient choice, an active participation in accepting the treatment, and according to this adherence therapy, the patient has the ultimate choice to decide whether to take the medication or not, and we can't force them. We can just, we can just motivate them and exploring what is the barriers and how to--

Q. You can force them if you exercise your power under the mental health legislation, providing they satisfy the criteria under the legislation--
A. Yes.

Q. --at the time--
A. It's very strict.

Q. Just let me ask the question, please. At any stage of your eight years' contact with Joel Cauchi, did you ever form a view that he could be subject to involuntary treatment as opposed to voluntary treatment?

A. During my eight years of treatment of Joel, he never showed any signs of psychosis, never showed any signs of symptoms of being risk to himself or others, and never been preoccupied with weapons or, or, or any dangerous act. So, I never ever could have override his decision and regulate him or put him under Mental Health Act.

Q. In those circumstances, if he declined to take medication which you had prescribed and recommended--
A. Yeah.

Q. --he was entitled to do so, on your understanding?
A. Yeah. That's why we had long discussions with him, because we used the adherence therapies, principles, RN3, me, and we listened to the patient, we listened to his, his symptom signs and basically decided that we can't force the medication and he was well enough and insightful enough to not to take the medication. To refuse.

Q. Did you form the view, or form a view during the period you treated him, that he was attempting to mask symptoms from you at any stage?
A. The masking is a wrong - it's a wrong word in English, because it's usually applies to people with ASD, autism, and that is an adaptive masking. With, with people in the severe mental illness, they can, they can misrepresent themselves. They can, they can, very short period of time, they can pull themselves together and, and represent themselves as well.

Q. Pretend that they--
A. Pretend.

Q. --are not suffering from something--
A. Yes.

Q. --when, in fact, they may well be?
A. Yes, yes. So that - but, but in a longer interview, every GP or every psychiatrist would say that if you give them at least 30 minutes, they cannot continue to do - there's always leaking and, and that's why we need specialist skills to do that. And this is also a different term of concealing. Concealing is a deliberate approach that what I think Joel was doing, when he concealed that he had a girlfriend, he broke up with the girlfriend and then he had a dangerous sexual encounter. Concealed that voluntarily, not psychotically driven, from us, as later on said, and the mother, because he was embarrassed about it.

Q. He may have withheld some information from you in relation to those matters you've identified?
A. Concealed.

Q. But did you ever form the view that he was pretending--
A. No.

Q. --that he was well--

A. No.

Q. --when he was not well?
A. No, and he was underneath a very anxious, insecure young man who was always frightened of relapse. He was always frightened of psychotic relapse.

A. I think you saw him on a monthly basis, approximately monthly, except when you were on leave over the eight year period that you--
A. Yes.

Q. --that he was treated by you, is that right?
A. And I committed myself to the monthly treatment, even it wasn't required specialist way, but I did want to see him through the transition to stabilise in Brisbane where he wanted to go.

Q. Over those numerous consultations with him, do you think you developed the capacity to get to know him and to know his--
A. Yeah.

Q. --frailties and his strengths, amongst other things?
A. Yes, I, I think over eight years, we had a very good rapport, and not just with me, but with all the nurses and including the administrative staff. But I had the capacity to--

Q. Was the therapeutic relationship a wholesome one, so far as you concerned?
A. Wholesome one with me, with, with the nurses. I mean, he, he could just come in and ask anything. He could write an email. He could, could - he felt the doors were always open for him and his mother.

Q. I think you've given evidence to this effect, but just to be clear, at no stage in any of your consultations with him over the eight years did he suggest or reflect any propensity for violence towards people?
A. No, not at all. Even, even in the beginning, he was shy and frightened of, of any violent - forbidden kind of violent actions or thoughts or images.

Q. Were you ever able, did you consider, to compel him to follow any advice you may have offered, may have offered him?
A. Never I had the - never I formed the opinion that his insight was impaired to the degree that I had to, had to override his autonomy.

Q. So far as his capacity was concerned, you've given evidence that he was an intelligent man. Did you think that throughout the period you saw him, he had relevant capacity to make decisions--
A. Yes, yeah.

Q. --as to whether or not he would--
A. Yes.

Q. --follow your advice in relation to taking medications that you'd prescribed?

A. Always, but as I said to you, it was a shared decision, and I not overriding him, I was working with him. And with - in, in regards his intelligence, I think his IQ was 120 and his procedural IQ was 102 when the, when the mental health team did that, did that assessment. He, he did the art - Bachelor of Art, majoring in German by the time - at the time when I took him over. And he did the TESOL, he was a teacher, finished a teacher degree by October.

Q. Just focus on my question if you would.
A. So, he was good.

Q. Did he have capacity throughout the period, so far as you observed, to make autonomous decisions in relation to his care?
A. Well done, and, and he was reporting everything which was not okay for him.

Q. After you discharged Mr Cauchi back to Dr Grundy, her Honour has heard evidence that in the subsequent years following that discharge in March 2020, Joel returned to Toowoomba from time to time to, on some occasions, live at his parents' house when his other accommodation was unavailable?
A. Yeah.

Q. Was any attempt or contact made by him or his mother or his father or anyone on his behalf to resume therapy or contact with you or your practice?
A. Yes, that was an unfortunate thing that nobody has thought about me, not the mother, not the father, not Joel, although I know that the mother remembered me.

Q. So, the answer is no--
A. No.

Q. --there was no attempts to resume contact with you after the initial separation in March 2020?
A. No, and it was very unfortunate, yeah.

Q. In the notes which I won't take you to, but between pages 91 to 110 of tab 793, there are copies of your handwritten clinical progress notes that were subsequently converted to electronic form from about 2015. Is that right?
A. Yeah, yes.

Q. From 2015 until the discharge in early 2020 - in fact, from about December 2015 to February 2020, can you accept from me that you consulted Joel on 47 occasions?
A. Yeah, it must be true, yeah.

Q. That sound about right, bearing in mind the frequency of contact?
A. Yes.

Q. And your credentialed mental health nurses saw him - between RN3, RN2, and RN4 - on some 77 occasions?
A. Yeah. Must be, must be true if it is, if it is--

Q. Please accept from me. In the same period, Dr B saw - she's a psychiatric who worked at the practice--
A. Mm.

Q. --saw him on 5 occasions, you can accept from me?
A. Yeah.

Q. And there was another psychiatrist who worked in the practice, Doctor --
A. Yes.

Q. --who saw him once I think--
A. Once.

Q. --in that period between 2015 and 2020?
A. Yeah. That was with handover, and because I was on leave.

Q. So, Dr B and Doctor saw him when you were away on leave I take it? That was the reason why they stepped in?
A. Yep. I, I handed over, and they saw.

Q. And in the same period, you suggested Dr Grundy seek a second opinion from Dr Nicky Stephens in 2015--
A. Yes.

Q. --is that right? And you've looked at the notes, I take it, in your 47 consultations, and the nurses' 77 consultations, and Dr B's five consultations, and the single consultations with the two other psychiatrists, Dr Stephens and Doctor. Did anyone observe symptoms of psychosis--
A. No.

Q. --in the period?
A. No. Not - none of them.

Q. That totals about 130 separate consultations over the period between 2015 and 2020. Would you expect that if a person had resumed or relapsed into a psychotic condition, that one or more of those clinicians would have identified--
A. Yes.

Q. --such a relapse?
A. Definitely. They were well equipped to identify.

Q. You've given some evidence about the serum clozapine levels in the context of effectively weaning Joel off clozapine in the period from 2012 to 2018 I think.
A. Sure.

Q. The drug was ceased entirely on 31 May 2018?
A. Six years.

Q. Before I go to that, can you explain to her Honour your understanding of the difference between first episode and multi-episode schizophrenia--
A. Yes.

Q. --again, in a brief way, if you could?
A. Yes. First episode schizophrenia is the first psychotic break. It can be - the, the symptoms are positive symptoms, mainly delusion, hallucinations, or disorganised thinking behaviour and catatonia. And cognitive symptoms, I mean, I mean these are not - they are also kind of not positive. It's more like deficit symptoms. And negative symptoms, which are the 5A, and the cognitive symptoms. The 5A I told yesterday that it was the blunted affect, the alogia--

Q. You don't need to go through the symptoms again if you would.
A. --no, good, good, good, good. So, these symptoms can fluctuate over time, but usually, respond to, to first episode psychosis, six to eight weeks of adequate treatment with a antipsychotic, second generation, this is number 1. If they don't respond, then, then use a second agent, which was risperidone. Didn't respond. And then they didn't respond over time, they ..(not transcribable)..is the clozapine. She - he was given clozapine, and he responded to clozapine very, very well. And during 2008 when they changed the brand, he had that little bit of breakthrough psychotic symptom. But I really don't know what were they, but it was a bit of worsening of mental state.

So, to me, it was a long episode of first psychosis which responded fully to clozapine. But I know that other expert might say that it was multi-episode during 2001 and 8, but irrespective, whether it was multiple or first episode, to me, it was first episode. The guidelines is that you can stop the antipsychotics.

Q. Can--
A. You can wean off the antipsychotics and see what happens.

Q. Can both first episode and multi-episode schizophrenia both be treatment-resistant?
A. Yes, they can.

Q. They commonly are?
A. Yes. Most of our clozapine patients in the clozapine clinics in the public service, they are not responding fully, and that's why they have - constantly having attenuated psychotic symptoms and huge amount of negative and cognitive symptoms.

Q. Can first episode and multi-episode types of schizophrenia both be chronic conditions?
A. Yeah. Is - they can. Can. Chronic - that's called multi-episode - is, is episodic. But the episode can be chronic.

Q. And both can be treatment-resistant forms of schizophrenia?
A. Yes. Definitely. And most of, most of the schizophrenia patient in clozapine clinic, chronic.

Q. The term "treatment-resistant schizophrenia" is often defined on the basis that two antipsychotics have been tried and weren't sufficiently--
A. Yes.

Q. --effective?
A. Yes.

Q. And clozapine becomes indicated--
A. Yes.

Q. --to treat--
A. Yes.

Q. --the patient. And the definition of treatment-resistant schizophrenia is having tried two, you needed to go to the third phase--
A. Yes. Yes.

Q. --antipsychotic?
A. And they, they can--

Q. Is that correct?
A. Exactly. And they can fully respond to clozapine, or partially. And they become chronic.

LYNCH: Could p 170 of tab 793 please be displayed?

Q. Do you have a copy of your clinical notes there? It will come up on the screen I think.
A. Yes, it was when we terminated the clozapine--

Q. Let me ask the question first please. Were you obliged, as part of the Clopine accountability measures, to inform ClopineCentral, I think it's referred to, when clozapine was discontinued for any patient?
A. Yeah. When, when patient stops the medication, or we wean them off, then we have to notify Clopine connector.

Q. And is this form at page 170 completion of that obligation by you setting out the reasons why the drug was discontinued?
A. Yes.

Q. At the foot of the page, I think it reads "Ceased due to medical reasons not listed above", and someone's written, "Recovered from first episode psychosis and--
A. "Remained".

Q. --remained well with no relapse over the past 16 years"?
A. Yes.

Q. Now, is that the reason, in a nutshell, that you gave to ClopineCentral as to

why the drug was discontinued?
A. Exactly.

Q. In your view, was that an accurate--
A. Yes.

Q. --encapsulation of the reason, in a very--
A. Yes.

Q. --brief form?
A. In - even in multiple episode schizophrenia, after five years of recovery, it is in the guidelines that you can, can try weaning.

Q. But you were of the view that this was not multi-episode psychosis--
A. No. No.

Q. --it was first episode psychosis?
A. Exactly.

Q. But you're saying that, even if you were mistaken as to that description--
A. Yeah.

Q. --your cessation regime of clozapine was such that it met the expectations for multi-episode--
A. Yeah.

Q. --schizophrenia, do you?
A. Yes. Can I just explain. In 2008 when he was - changed the brand, and he had deterioration of mental health. It, it wasn't a new episode.

Q. I'm--
A. It, it, it wasn't a new episode in 2008.

Q. You're given that evidence, and I'm not taking you to that at the moment.
A. Okay.

Q. But are you saying that the cessation regime that you employed between 2012 and 2018 for clozapine would have satisfied your understanding of the duration of cessation required, whether it was first episode or--
A. Yes.

Q. --whether it was multi-episode?
A. It was well, well beyond that, yep.

Q. Because you spent six years between--
A. Yeah.

Q. --2012 and 2018 gradually and cautiously reducing the dose of clozapine at a very modest and conservative rate. Is that fair to say?
A. Too conservative, yeah. Too conservative rate. Too.

Q. The rate is set out in the notes, and perhaps I won't need to take you to them again, but each time you reduced the dose of clozapine, you would write to Dr Grundy, would you not, and--
A. Yeah.

Q. --update Dr Grundy on the change in the medication dosages--
A. Yeah.

Q. --and give him an account of how Joel was progressing, from your perspective in the relevant period that was covered by your--
A. Correct.

Q. --letter back to Dr Grundy, is that right?
A. And always involved the mother. Before and after.

Q. The serum clozapine levels were a measure of the level of the clozapine drug that was effectively circulating through the patient's blood system and having an impact on their brain?
A. Yeah. Yes.

Q. Is that an oversimplification, or does that--
A. Yes, that was--

Q. --put it in a nutshell?
A. --that was basically for symptom control. So, when, when you are in the therapeutic window for treatment-resistant schizophrenia, is anything about 400 microgram per litre. If you below that, what would you expect from a treatment-resistant schizophrenic episode? I would expect breakthrough psychotic symptoms below 400 microgram per litre. It - it's - but, if the person has non treatment-resistant schizophrenia, then it could go down to 200 microgram per litre which below that, you would expect breakthrough psychotic symptom and relapse.

Q. Are you saying that on low doses of clozapine, if the patient still was possibly vulnerable to relapse--
A. Psychotic.

Q. --you would expect--
A. Yep.

Q. --relapse to--
A. Yes.

Q. --occur--
A. He, he was still psychotic and nothing for remission underneath of the medication that I would expect breakthrough symptoms and - I wouldn't call it relapse. It's, it's, it's because it's the same episode. But it would break through and, and, I would say it is return.

Q. And that would be a warning signal that the medication likely would have to be--
A. Continued.

Q. --continued or increased?
A. Increased, yeah.

Q. Is that right?
A. Yeah.

Q. Between the period from June 2014 until end of May 2018, over some four years, you continued your reduction of Joel's doses of clozapine, and set them out in letters to Dr Grundy on each occasion. In that period, the reduction went from 425 milligrams in about May 2014, gradually whittling down, or tapering down, to 12.5 milligrams in April 2018--
A. 18, yes.

Q. --is that right?
A. Yes.

Q. And on each reduction, on each occasion you reduced the prescription, you wrote a letter to Dr Grundy informing him about that step that you've taken, and also reporting how Joel was progressing--
A. Yep.

Q. --in general terms, is that correct?
A. Correct.

Q. You sent many letters to him in that four-year period keeping him up to date with how Joel was progressing in therapy, is that correct?
A. Yes, yes.

Q. You decided to - after the cessation of clozapine, you continued to see Joel on the same basis, monthly by you and at least monthly by the--
A. Yeah, yeah.

Q. --credentialed mental health nurses, is that right?
A. I did not discharge him, because I wanted to continue and I knew that he needed to be in ongoing care. And I did not want to change the frequency because I was monitoring him closely.

Q. He remained on the Abilify 5 milligrams a day, is that right?
A. Yes, for another year.

Q. What was your understanding of the indication for the initial prescribing of the drug Abilify, which started before--
A. Me to..(not transcribable)..--

Q. --you saw him in 2012?
A. My understanding was that it was given to, to reduce the burden of

side effects such as the OCD--

Q. Side effects of the clozapine?
A. Of clozapine, which was the OCD and the weight - metabolic syndrome. So he lost 20 kilo on it. So basically it was - it's a very good, very common combination of clozapine and, and Abilify for, for a treatment-resistant schizophrenia.

Q. A common side effect of clozapine is--
A. Yes, it's common.

Q. --weight gain - significant weight gain, is that right?
A. Huge. Yes, huge weight gain, metabolic syndrome. So, it works on the, on the body.

Q. You've touched on this earlier, but a 5 milligram daily dose of Abilify is a therapeutic dose?
A. No, it is not. It is, it is definitely not blocking the, the dopamine D2 receptors sufficiently to prevent relapse or, or create a relapse.

Q. Is it your experience that a 5 milligram dose of Abilify would not safeguard--
A. No, no.

Q. --a schizophrenia patient, first episode or multi-episode--
A. No, no. It would just--

Q. --from relapse--
A. It just would--

Q. --on its own?
A. It just would help with anxiety, depression and, and OCD and general psychopathology stuff. Sleep.

Q. Did you ever alter - until the end of 2019, did you ever alter the dose of--
A. No.

Q. --5 milligrams per day?
A. No, I just kept him, and--

Q. You said that the 10 milligram script which you wrote in November or December 2019 was a typographical error--
A. Okay.

Q. --and that you understood--
A. Yes.

Q. --that others, including the nurses involved--
A. Yes.

Q. --and Joel himself appreciated that that was--

A. Yes.

Q. --not intended to double the dose--
A. No.

Q. --but to keep it as it was?
A. I can tell you simply there is no 5 milligram tablet. Just 10. And we always halved it.

Q. Can you just explain again, in as brief a way as possible, why you determined that the Abilify should cease in June 2019?
A. It was driven by Joel. Joel said he wanted to stop the medication, and he didn't tell much side effect, but I thought it was something to do with his tics, which was quite pronounced at times, and I agreed, let's - there is no reason for the schizophrenia to continue that. And we just said what happens if, if I accept that we, we stop it and continue monitoring what happens after that. It was not necessary at that time for schizophrenia or any other, other things, and he, he reported that after stopping, the tics was better. But the tics was there always, and it came and gone in a fluctuating way.

Q. In the period between the end of May 2018 and June 2019, Joel was not receiving any clozapine whatsoever in that--
A. No.

Q. --year long period, is that right?
A. Not after June 2018.

Q. May her Honour take it that in any of the consultations or contacts you had with Joel in that year-long period, there was never any suggestion of any relapse--
A. No.

Q. --in his schizophrenic psychotic condition?
A. No, in, in fact, there was no negative symptoms, and the--

Q. There was no what?
A. No negative symptoms, and no, no cognitive symptoms. Which was, which was evidenced by his proceeding with the studies, was doing practice teaching and passed them. And, and his personality kind of came alive. So he, he caught up with developmental delays like self-care. So he was able to move into independent accommodation in 2008(as said) October, away from the parents. Was able to look after himself. I mean it's not perfectly, but - not perfectly to the parents or mother's expectation, but it was like every other person who, who's first time going away from home.

Q. Was there a consistent improvement in his activities of daily living as well as his--
A. Personality growth.

Q. --blossoming personality?

A. Growth, yeah.

Q. If he was prone to relapse of his previously psychotic condition, would you expect such relapse to have occurred in the 12-month period when he was off the drug entirely?
A. Okay, if there was a relapse, it can come any time. And we know that from the, from the longitudinal studies that a relapse can even happen 25 years later after people stop the medication. That was last Finnish study I, I read.

Q. You had a number of years in 2016 and 2017 where his dose was very low indeed, I think?
A. Yes.

Q. In the order of 150--
A. Yes.

Q. --milligrams or less, and titrating down to I think at the end 25 milligrams?
A. Yeah.

Q. Which is, what, 5% of the dose that he was on approximately when he first began with you in 2012?
A. Yes.

Q. Did that slow reduction of the dose over a period of years give you some confidence that you were on the right track in reducing his dose whilst his--
A. Definitely.

Q. --functioning and personality appeared to improve over that period?
A. I stopped monitoring his clozapine level after the last level was 150 microgram per millilitre, because I knew that it was not sufficient for preventing or, or treating a relapse.

Q. If the clozapine showed a subtherapeutic level, which it did I think in April 2013, the serum clozapine level was 290 micrograms per litre - this is at page 262 - then you would expect that as the dose further reduced, the serum clozapine level would further reduce in a corresponding way, is that fair to say?
A. Definitely, and it would not be providing any protection for him. So, 160 microgram per litre was 3 June 2014.

Q. It's inevitable, is it not, that the serum clozapine level would have continued to reduce as you reduced the dosage of clozapine?
A. Very much.

Q. Does that follow inevitably?
A. It, it may not be in a linear form, but as in we taper down, it's more like parabolic form. So even though it's low dose, it could have given him - that's why we did it slowly, not to have rebound or, or, or some other withdrawal symptom.

Q. Was the absence of any relapse of any psychotic symptoms or any early

warning signs of a psychotic symptoms in that period--
A. No.

Q. --between 2016--
A. Not at all.

Q. --to 2018--
A. No.

Q. --did that reinforce the plan to cease clozapine eventually?
A. Yes. And this was his, his aim.

Q. His desire was--
A. His desire and--

Q. --to get off clozapine?
A. And I, I supported that, yes.

Q. Do you think it was a responsible psychiatric decision to undertake, bearing in mind his preference?
A. I think it was a responsible and, and - how to say that - respectful approach, and evidence-based, guidelines-based, and responsible and compassionate and all others, wholesome. Logical.

Q. Excuse me a moment. In November 2019 Mrs Cauchi, Joel's mother, informed your practice that she had some concerns, and I think on the following day after those concerns were relayed to RN3, you decided to issue a script for Abilify without even seeing--
A. Yes.

Q. --Joel, is that right?
A. Based on the mother's description and, and the finding what RN3 told me that there was a little bit of vagueness in his speech. You know, he was a bit of - not formal told this or that.

Q. You were suspicious--
A. Yes.

Q. --based on the mother's report--
A. Very much.

Q. --that he may have had early warning signs of relapse of psychosis?
A. What was described in the mother letter, and then the same day, and after then RN3 went and confirmed that it was not psychosis.

Q. We'll come to that.
A. Yes.

Q. But you've repeatedly agreed that Mrs Cauchi, Joel's mother, was in a good position to express an informed view about Joel's condition--

A. Yes.

Q. --from her lifelong contacts with him?
A. Yes.

Q. Is that right?
A. Yes. And I always responded promptly.

Q. You took her concerns seriously on every occasion?
A. Yes.

Q. But did her views or concerns operate as a substitute for exercising your own--
A. No.

Q. --professional judgment as a psychiatrist?
A. No, I am responsible to review the patient, not just guessing from collateral information. But I trusted the collateral information and I trusted my nurse examination on the same day and next day, but decided to give a prescription of 5 milligram Abilify because that was the last drug we, we, we'd withdrawn, in order to as an insurance policy. If it was an early warning signs of relapse, it wouldn't - would, would, would go back with the early invention of counselling. And finding the cause of the early warning signs of relapse and solving the problem.

Because that's the whole thing, is you always have to find what causing the early warning signs of relapse. It can be medical, physical, psychological, whatever. So if you intervene and, and do crisis intervention or, or resolving the problem, the early warning signs goes back. Even when you admit a patient with early warning signs of relapse, they don’t give medication straight away.

Q. In brief, once RN3 had personally assessed Joel after the mother's concerns were relayed to you and after you'd prescribed the Abilify, and you had assessed Joel once again, both you and RN3 concluded that there was no relapse of psychosis?
A. Yes.

Q. Is that correct?
A. I interviewed Joel seven days later, but in the intervening period, Joel was away in Brisbane or Sunshine Coast, and we had phone calls from mother through the aunty that he was taking a medication, which we confirmed it wasn't my prescription. It was--

Q. I understand that. But can you address my question--
A. Yeah.

Q. --more specifically, if you would please. You formed the view, along with RN3, when you assessed Joel shortly after--
A. Seven days after.

Q. --the concerns relayed by his mother--
A. Yeah.

Q. --that he was not suffering from psychosis. Is that right?
A. I was absolutely sure, and accepted his explanation.

Q. You were asked some questions about the minutes of meetings that took place between the staff at the practice by my learned friend, counsel assisting, Ms Dwyer. Have you been able to locate those minutes of meetings?
A. My experienced practice manager contacted the practice manager who was there at that time, and the answer was that it was until 2016 when the mental health nurse program finished and the PHN program started. And after that, there were no minutes. Every nurse, when we did the meeting, had to take the responsibility to document their patients - they document what was--

Q. I'm really just asking you about--
A. No. We couldn't - we--

Q. --have you been able--
A. To locate--

Q. --whilst you're in Sydney and your staff are in Brisbane, to--
A. No.

Q. --use your best endeavours to try and locate these records?
A. Did to the - I think that my current practice manager actually got the IT expert, so they went through everything, but they couldn't do - couldn't bring up anything else. Just what is already been in the notes. And, and my receptionist cross-reference everything.

Q. Were these meetings the sorts of things that you would include in a patient's file--
A. Not me. The nurse.

Q. --or were they more like morbidity/mortality meetings that occur in a hospital?
A. No. No. No mortality. It was clinical meeting about, about patients brought by the nurse, and we discussed them, and then the nurse had to, had to kind of put it in the file and, and register as a, as a, as a non-patient encounter 15 minutes for each, so that they - on our health. Before, the minutes just said that this was discussed, this was discussed, this patient was discussed.

Q. Did you think that they had to be included amongst the patient records for individual patients who might've been the subject of discussion?
A. They were always clinical. Like RN3 always a clinical meeting, we discussed that and that. But that is the whole thing. We couldn't locate that grey folder. I don't know. I had six other receptionists in between, and maybe it's been shredded.

Q. You were asked some questions also about the notes which Mrs Cauchi had apparently observed when Joel was staying around the house, and RN3 made some notes about conversations she had had with Mrs Cauchi?
A. Yeah.

Q. Did you understand that Mrs Cauchi had possession of those notes, or had merely read them, or observed them? Did you know whether they were available for perusal?
A. Yes. It, it was reported to me in her, in her letter, and that happened when they didn't live together. When Joel lived in the new home, and she observed that when she visited him. I don't know the content. It was just lots of notes left around. And I, I - the letter didn't contain the satanic stuff. It was, it was a new information after first RN3 talked with the mother and has put it in the notes. So I thought that RN3 would say more about that yesterday or before. And I, I really did not - I, I, I, I took it in the first say "This is psychosis under - it proves otherwise".

But I think later on, because, because I saw Joel, I knew that it was more - like I, I would say that the - maybe some suggestion that he was tormented by the ego alien and Christian alien and, and religion alien - not obsession, because it not obsession. Is a interest in porn, which was not - it was forbidden for this guy. Cultured early--

Q. You described yesterday, I think, the interest in pornography by people is not a negative sign indicative of possible early warning signs--
A. No.

Q. --of relapse, but a positive fondness for looking at the pornography?
A. At, at the time of the, of the prevalence of man that age interest in pornography was normal for me, so I did not feel that it was psychotically driven.

Q. You've been asked some questions too about the final referral letter to Dr Grundy, which I think makes reference to possible referral to a psychiatrist if required, but you also invited Dr Grundy to refer Joel back to yourself--
A. Yes. That was my primary--

Q. --if he chose to. What did you mean by the words "if required"?
A. Okay. It's a lot. It's a lot. It's giving the choice of the GP to follow him up based on the - based on the assessment when he recalls Joel. Makes an assessment, and it is the GP's skill set that making an assessment and discussing with him, "Okay. Do you want to keep seeing me, or do you want me to refer you to psychiatrist, or do you want to go back to Dr A?"

Q. If Joel and/or Dr Grundy wanted Joel to return to you, would there be any requirement to refer to another psychiatrist?
A. No. Actually, I wanted him to come back, and I was quite let down when I saw that he came back to Toowoomba 2022 and didn't come back to me. But I think there is a letter which explains why.

Q. You've been quizzed by my learned friend Ms Mathur about the phone call you recall having with Dr Grundy. Do you still have some recollection of having such a phone call?
A. Exactly. It's not the figment of my imagination. I did not recall when I wrote the first coroner report, because it wasn't - I was just sticking to the notes.

Q. Your first statement--
A. Statement. Just ticking--

Q. --basically summarised each of the consultations--
A. Yeah.

Q. --that took place--
A. Exactly.

Q. --with Joel in the period you were treating him based upon your examination of your notes. Is that the case?
A. Exactly. And it was my first coroner report, actually, in my life. So I was instructed to go through and write facts, and that is what I did.

Q. It came to you when you were answering the questions posed by those assisting the Coroner in your second report when you were specifically asked a question--
A. Yes.

Q. --about the role that you played in referring Joel back to Dr Grundy, that it occurred to you you had this phone conversation. Is that right?
A. And I know why, because it - I recalled it because I had a patient who, who I, I had a problem - a variance in the treatment and discharge, and automatically call the GP and discussed it. And then this is when it, it, it, it jumped into my memories - episodic memory. This is what it happens. Cue driven. So this is what I did with Joel, because that was I always do when it's - something not okay. So something is unusual, then I always talk with the GP.

Q. Have you ever given evidence before--
A. No.

Q. --in any legal proceeding, or coronial proceeding--
A. No.

Q. --or any court at all?
A. I always get - I always been exempted or didn't have to do.

Q. You understand your obligation to tell the truth to her Honour in your sworn evidence, do you not?
A. I sworn, and I am - I wouldn't, I wouldn't lie.

Q. Have you done your utmost to try and tell the truth?
A. In here, definitely. Definitely.

Q. You mentioned an email that Mrs Cauchi sent you I think in 2024 after this tragedy occurred. Have you located that email in the last 24 hours or so?
A. Yes. Yes I did, and, and I think it was part of the, the documentation I had - no, no, because it was after 2024. I think I did send it to my lawyer at that time, and my lawyer--

Q. You can assume that it's been passed on to--
A. Lawyer. Yes.

Q. --counsel assisting--
A. So it - and I, I asked that--

HER HONOUR

Q. Just one moment.

LYNCH: I invite counsel assisting to tender that letter, your Honour. It has some relevance both broadly and narrowly, in my respectful submission.

WITNESS: I was instructed not to contact the mother after that.

DWYER: I'll tender that when it's in a form that's acceptable, your Honour.

HER HONOUR: Thank you.

LYNCH: If your Honour please.

Q. You did your best to try and recall the telephone conversation you had with Dr Grundy, and you made some reference to him being the family GP, or the family's GP. Do you remember what he said, with any precision?
A. Definitely that - I remember that he was his GP. So the family--

Q. Joel's GP?
A. Joel's GP. The family - it's every GP can see the family. I, I know he said that he wasn't the family GP, he didn't see the family, but he also said this, he's very familiar with this case, and he's been the GP for a long, long time.

Q. Is it fair to say that you don't have a precise recollection of that conversation that occurred years ago?
A. It's fair, because the memory is fallible, but I know that he was the GP who referred him to me, and he was even the GP before he referred him to me, and the hospital was corresponding with him. So he knew - a family GP in this context, it was possibly my misunderstanding, but I know that he was over - very familiar with Joel's case from the beginning of the psychotic episode, throughout the illness.

LYNCH: They're the matters, if your Honour pleases.

HER HONOUR: Thank you, Mr Lynch.

LYNCH

Q. Thank you, doctor.
A. Thank you.

DWYER: Your Honour, might we have a short five minute break so that I can just get my notes together and--

HER HONOUR: Certainly.

DWYER: Thank you.

HER HONOUR: I'll just take five minutes.

LUNCHEON ADJOURNMENT

HER HONOUR: Dr Dwyer.

DWYER: Thank you.

<EXAMINATION BY DR DWYER

Q. I've just got two topics for you. Can I start with some clarification or comments that you made in response to the questions by Ms Chrysanthou. With respect to the events of 13 April 2024, you have reflected on your evidence yesterday. Is that right?
A. Yes.

Q. And you have withdrawn your comments about Joel being disorganised(as said) as at April 2024. You've withdrawn your conjecture about that, correct?
A. Yes.

Q. You accept that there was no evidence of violence when Joel was your patient, correct?
A. Correct.

Q. And you respect the opinions of your excellent practice nurses, RN2 and RN3, who you've described.
A. Yes.

Q. You understand RN3 described Joel as gentle, and that she was shocked and it's her view that if he remained medically well, he would not have been capable of the events of 13 April?
A. Of course he had to be unwell to do that, yeah.

Q. And you understand that it's the evidence of psychiatrists, including Dr Nordentoft, who you respect, Dr Heffernan and Dr Olav Nielssen, that Joel was psychotic at the time of the events on 13 April 2024?
A. Yeah. But they couldn't find direct evidence. There was no direct evidence. Based on indirect evidence, yes.

Q. And you defer to that opinion, that he--
A. Defer, defer to that opinion.

Q. And accept that he was likely to be psychotic at that time?
A. Yes.

Q. The last topic is this one. It relates to some questions asked by Ms Chrysanthou about the letter you sent, which is at page 240 of the medical records, and it's just to clarify this issue of first episode psychosis in the context of a chronic illness. And you'll recall that your barrister Mr Lynch clarified some questions around this?
A. Yes.

Q. Just to re-familiarise yourself--
A. Yep.

Q. --this is your letter to Dr Grundy, 2015. "Thank you for the referral"?
A. Mm-hmm.

Q. You note that Joel was started on clozapine for his first episode of schizophrenia at age 17?
A. (No verbal reply)

Q. Just have a look at that again.
A. Yes. Yes.

Q. You understand that Joel was an inpatient in 2001, and again in 2003 when his medication was changed?
A. Yes.

Q. And in 2003 he was still hearing voices, which were then dealt with by way of the clozapine, and the further medication?
A. Yes.

Q. And by the time then Joel came to you, he'd had 12 years of being managed in terms of that long-term mental illness, do you agree?
A. Yeah.

Q. Do you accept that schizophrenia is a genetically mediated disease?
A. Yes.

Q. And the fact that Joel's father has had schizophrenic disorder lends itself to it being a chronic disorder that Joel was suffering from?
A. There is evidence that if one parent has schizophrenia, there's 20% risk of that offspring to have schizophrenia--

Q. What you write in that--
A. --versus one person.

Q. --I'm sorry. What you write in that letter to Dr Grundy, and the third paragraph, last line, is "I do believe Joel needs antipsychotic, an antipsychotic for long-term relapse prevention"?
A. Yes.

Q. That was your view in 2015?
A. Yep.

Q. And that was your view for most of the period of time that you treated Joel?
A. Yes.

Q. It was always your view that Joel would need close follow-up?
A. Yes.

Q. Along the lines of the follow-up that you were delivering--
A. Yes.

Q. --at the practice with your nurses?
A. Forever, yes.

Q. So, is what you're trying to tell us is that Joel, in 2001, had experienced first episode psychosis in the context of a chronic illness, that is schizophrenia?
A. Yes. He was - he, he had schizophrenia with first episode psychosis between 2001, 2002, and 3, and then he's responded to clozapine.

Q. Your evidence is he needed close follow-up, such as what you could deliver at--
A. Yeah. Yes.

Q. --such as the type you could deliver at the practice, because there would always be a risk of relapse for Joel in certain circumstances?
A. Always for the lifetime, but there is 14% of people with first episode psychosis who never have one.

Q. But given the risk--
A. Yeah, risk was high--

Q. --of relapse--
A. Definitely.

Q. --it was important to have close follow-up?
A. Definitely. Definitely. Never, never stop.

Q. Thank you.

DWYER: Those are my questions, your Honour.

WITNESS: That's good.

LTS:DAT

HER HONOUR

Q. Thank you. That's the end of your evidence, doctor. Thank you very much. And you are now free to go.
A. Thank you very much.

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

<THE WITNESS WITHDREW

LTS:DAT

<NATHAN RUGE, AFFIRMED(2.10PM)

<EXAMINATION BY DR DWYER

Q. Could you please tell the Court your full name?
A. Nathan Michael Ruge.

Q. Where are you currently working?
A. Chermside, Queensland.

Q. You're a general practitioner, is that right?
A. That's correct.

Q. How long have you been at your current professional address?
A. Since January 2024.

Q. How long have you been a general practitioner?
A. Seven years, I think.

Q. Where did you do your training?
A. My vocational training for GP was in Brisbane.

Q. You've prepared a short statement for her Honour, which is dated 17 September 2024. It appears in volume 22 at tab 802, and it relates to a period where you came to be a general practitioner treating Mr Joel Cauchi when he lived in Brisbane. Your treatment for him was between May 2020, in the middle of COVID when you were delivering telehealth consultations, through to I think the last consultation was in April 2021, is that right?
A. That's right.

Q. Have you reviewed the records that are relevant to your treatment of Joel?
A. I have.

Q. Before I ask you about your treatment for Joel, you did your degree in Brisbane, you've been practising about seven years. As part of general practitioner training, is there a component relating to mental health?
A. Yes.

Q. How much of your initial degree is dealt with mental health?
A. The initial degree? It would be in the order of months. Dedicated time.

Q. Then after that period of time, is there any specific training that you're required to do by way of practical engagement?
A. There is, and the weight is determined I suppose by the speciality, or the vocational training.

Q. Is there any aspect to your vocational training that involves specific training in mental health?
A. Yes. Within the scope of general practice.

Q. Could you tell us what training you did?
A. It is a mixture of self-directed learning, or prescribed learning, reading. Structured or practice clinical encounters, lectures. And all administered by our regional training organisations for general practice.

Q. In 2020, had you had any experience in managing patients with schizophrenia?
A. Yes.

Q. It would be your experience that schizophrenia cuts across a significant range? There can be some people who have a relatively mild instance of the disease, is that right?
A. Yes. It's very diverse.

Q. And then other people who have to be managed for their entire lives on very strict medication regimes, like clozapine for a very serious form of the illness, correct?
A. Correct, yes.

Q. As at May 2020, had you had any experience of managing patients who were on clozapine medication for a serious form of schizophrenia?
A. Yes, and I still have some of those patients.

Q. With respect to those patients, is there always a psychiatrist involved in the management?
A. With respect to my patients, yes, they all have psychiatrists still involved in their treatment.

Q. Why is that?
A. For the opportunity for expert assessment of their condition, even if it appears on face value that they might be in remission. To ensure - especially with medications like clozapine where there are a number of opportunities for complications, to ensure they have the appropriate timely regular follow-up.

Q. With respect to the patients that you currently have who are on clozapine, are any of them managed in a multi-disciplinary environment, so that there is a mental health nurse as well as a GP as well as a psychiatrist involved?
A. Yes, with the majority of the input coming from the specialist and myself.

Q. How is that done? Are there any clinics with all of those persons in the one area, or is it spread across the different clinics?
A. It's quite diverse. For my patients in particular, they'll have a consultation with their psychiatrist a couple of times a year, depending on their stability. The remainder of the time, most of those interactions will occur between the patient and myself, often on a, on a monthly basis.

Q. So, it's important for you with respect to those patients on clozapine who've suffered a severe form of the illness to have very regular follow-up with a general practitioner?
A. Yes.

Q. And regular follow-up with a psychiatrist, and--
A. Yes, regular follow-up with a psychiatrist, their general practitioner, and with certain investigations done.

Q. The investigations relate to the blood, to blood investigations, is that right?
A. The most frequent ones are, yes.

Q. I referred to a multi-disciplinary approach for those patients. You've talked about yourself and the psychiatrists. Are there also mental health nurses and other disciplines involved in managing those patients?
A. I'm aware of services that provide that service. I'm not aware of any that my patients are actively involved with.

Q. What about psychologists? Would some of your patients who are on clozapine with severe forms of the illness be referred to psychologists as well, if necessary?
A. Only if necessary.

Q. From your perspective, the most important part of a team in managing patients on clozapine is a psychiatrist and the general practitioner?
A. Generally speaking, for a stable patient, yes.

Q. Would you expect then there to be close communication between the general practitioner and psychiatrist with respect to the patient and how they're being managed?
A. I'd expect there to be regular communication, the usual channel being mail, like written correspondence. And ideally a, say, telephone as well if there was any sort of emergent issue.

Q. For example, have some of those patients who you have treated experienced psychoses as part of their schizophrenia?
A. Yes.

Q. Have most of them who have ended up on clozapine experienced psychoses as part of it?
A. Yes.

Q. Is it very important then, if the psychiatrist became aware of any early warning signs of relapse, that that be communicated to the general practitioner?
A. Yes.

Q. In your practice with respect to patients who have, who are living with a severe form of schizophrenia who are now stabilised, if you have an engagement with a family member who is well informed about the mental illness, is it important to take seriously information they provide about their loved one?
A. Yes, it is.

Q. How would you do that? That is, do you have regular meetings, do you accept phone calls? How do you maintain that contact?
A. I can tell you how I have done it in the past.

Q. Please.
A. The most typical way it would be is for a family member to attend the practice in person or consult with me by telehealth to relay their concerns, usually accepting that there are limitations in what I can offer if I don't see any reason to break the patient's confidence or confidentiality.

Q. In respect to the confidentiality, you can always receive the evidence and take it into account in your treatment?
A. Absolutely.

Q. I'll come now to your consultations with Mr Cauchi. We've counted them up and there appear to be 13 consultations, seven of which related ultimately to mental health, and the first five of which were on telehealth. So, I'll just run you through those quickly. They appear at tab 803A of the brief of evidence. The first consultation was on 27 May 2020, and it was by telehealth. At this stage, just remind us where you were working?
A. I was at a Spring Hill based practice, which is very close to the Brisbane CBD.

Q. It was May 2020. Were you seeing any patients face to face or were they all by telehealth because of COVID?
A. The majority were by telehealth.

Q. How would a patient come to be in your practice for the first time?
A. At that point in time, as in face to face or--

Q. No, sorry, just telehealth. So how did Joel come to be a member of your, or be part of the practice as a patient?
A. He would have found us via, via an internet search, and either online or by making a phone call to our reception booked himself an appointment.

Q. In relation to this first appointment, Joel explained that he was requesting an STI check. He didn't have symptoms. He said that he'd had sex with a woman and the condom fell off and he didn't - he explained that there were no systemic systems, and neither was he notified by any STI contacts, but he wanted to be cautious, and he also complained of vomiting. There was nothing in that first consultation to indicate any mental health history, is that right?
A. That's correct.

Q. The second consult then, which appears at page 4, was on 2 June 2020. So just a short time later. It was again a telehealth consult. The reason for visit was STI screen and schizophrenia. He wasn't well, he reported no symptoms of STI, and then you write, "Incidentally, Joel discloses a poor history" - sorry, "a prior history of schizophrenia. Nil specialist follow-up since moving to Brisbane from Toowoomba". What do you mean by "incidentally"?

A. His initial presentation there was - well, his primary reason for presenting was for STI screening. I pressed him during that consultation for any significant medical history, given that there was nothing that I could corroborate, and I specified any mental health history. And it was on my questioning that he responded that he had a history of schizophrenia.

Q. Were you asking him - were you pressing him in relation to that because this was just a week after the first phone call where he was saying again that he was worried about having an STI but there was no apparent basis for his concerns?
A. There's no basis of concern illustrated in my notes, to be fair. I would have given him a referral for a repeat STI screen if it was indicated, but, yes.

Q. What I'm asking you is, did you pick up that this might be an indication of paranoia, the fact that you'd had a second phone call in such a close period of time?
A. I should clarify, this consultation was follow-up of the results ordered--

Q. I see.
A. --from the previous consultation. It was not for a request of an additional screen. I'm sorry.

Q. How did Joel come to make the disclosure, what were you pressing him on?
A. Just an examination of his previous medical history, as is prudent if you have continuity with any patient.

Q. I see. So, when he said he had a prior history of schizophrenia, he then said that he no specialist follow up since he'd moved from Brisbane to Toowoomba(as said). Did he tell you when he had moved?
A. Not that I can recall.

Q. He said he hadn’t been on medication for over 18 months. He felt well, he reported. He had no active perceptual disturbance or formal thought disorder. No suicidal ideation. Nil pervasive mood disturbance. So you asked him a series of questions and he gave you answers, is that right?
A. That is correct.

Q. That was a telehealth consultation. Did you recognise at that stage the potential limitations of telehealth in terms of picking up on any symptoms?
A. Very much so.

Q. You knew from your experience that by prior history of schizophrenia, it could be anything from a first episode which had abated to an ongoing illness which needed close monitoring, correct?
A. Correct.

Q. What did you do, if anything, to determine what he needed going forward with respect to his schizophrenia?
A. First of all, recognising the limitations of that assessment that I performed,

because of the telehealth consultation, you'll note that there's no comment on his appearance or his affect or any unusual movements or behaviours, things you can only glean by sitting in a room with someone. So what followed was - I mean what informed my questions was whether or not he had any active symptoms, and then within the limitations of the consult, the risk assessment. What followed was - and I don't see that it's actually recorded in my notes - but encouraging him to make a follow-up consultation with it being face to face to make a more detailed assessment and refer him for appropriate care.

Q. Indeed, that's what happened on 15 June, is that right, that you had a face to face visit?
A. I don't recall. It might have been a telehealth consultation.

Q. I see. So even if it says, "surgery consultation", it goes on to say telehealth consultation, meaning that it was a phone call?
A. That's right.

Q. That was because again the COVID restrictions, is that right?
A. I honestly don't recall.

Q. If you have a look then, that's page 5. You note there,

> "Well today, discussed schizophrenia further with me today. This first manifested for him age 17 with tactile hallucinations and disorder of thought. He reports it was closely related to excessive use of drugs at the time. He has been following up monthly with his previous psychiatrist in Toowoomba, Dr A, until recently. Given the distance between them now, this therapeutic relationship is no longer tenable. He is not taking any regular medications presently. He denies any active symptoms".

And Joel himself requested a referral to a private psychiatrist, Dr Rob Moyle, is that right?
A. Yes.

Q. Do you recall Joel now and these presentations, sitting there today?
A. The majority of them, yes.

Q. In relation to what information he gave you then, that it first manifested when he was aged 17, it manifested with tactile hallucinations and disorder of thought, he thought it was closely related to excessive use of drugs, but since that time he'd been followed up monthly with a previous psychiatrist.
A. Mm.

Q. So, he was by the time he saw you I think about 37 years old, so he was saying that for 20 years he had been monitored in terms of his schizophrenia?
A. Yes.

Q. Did you form a view as to how severe a form of schizophrenia he may have

been diagnosed with?
A. Outside the, like the length or duration of his symptoms, no. Because what I didn't have access to was his actual treatment history that would have better informed that assessment of his severity.'

Q. He nominated a doctor, Dr A, as the psychiatrist. Did you make any enquiries in relation to her, getting access to her notes?
A. I did not.

Q. When you look back on it, is that something you should have done?
A. Ideally, yes.

Q. What would best practice be in those circumstances when somebody tells you that they've been followed up by a psychiatrist for that length of time?
A. Best practice would have been to ensure that the patient had access to a service they were actually willing to engage with and to inform that service's assessment. For the sake of continuity obtain whatever records I could from his previous, previous service provider.

Q. Did you take some comfort from the fact that he was asking for a private psychiatrist himself and so agreeable then to be managed by a psychiatrist going forward?
A. Yes.

Q. With respect to that, you wrote him the referral letter. Did he nominate Dr Robert Moyle, or was that somebody you had proposed?
A. No, he nominated Dr Moyle. I recommended - I may have recommended with the previous consultation that he should have regular follow-up with someone he thinks he might develop a good rapport with.

Q. Did you have any relationship with Dr Moyle, did you know him at all?
A. Not that I can recall.

Q. The information that was provided by Joel on 15 June, was that information that it had first manifested at age 17 with tactile hallucinations and disorder of thought, there's nothing in there specifically about any admission to hospital, but do you recall discussing that with him?
A. No, I don't recall.

Q. Are you now aware of that fact that Joel had an admission into the public hospital system in 2001 and again in 2003 to manage a change in medication?
A. I'm aware that he had admissions, the specifics of which, no, I'm not across.

Q. Did you give consideration to accessing the Queensland public health portal to give you background information about the hospital admissions?
A. I did.

Q. Is that something that you did?
A. Not at the time.

Q. Could you have done that?
A. Yes.

Q. Can you tell us why you didn't do that?
A. Not being aware at the time that he'd had admissions under the public service, and that he'd been up until recently involved with a private service, I didn't expect there to be anything useful by the health provider, the HPP. The other reason being details of assessments, treatment admissions on the HPP are really scant, or at least they were, very scant at that point in time.

Q. Had you had information that Joel had been managed on two frontline antipsychotics for a couple of years in the public health system and then for nine years on clozapine in the public health system, would you have been much more interested in obtaining those records to understand the manifestation of that disease?
A. Yes.

Q. So, 20 July was a telehealth consultation, and that was where Joel was requesting an STI screen because he's had a new sexual partner since the last test in May. So that was a fairly standard and quick consultation that had nothing to do with his mental health, is that right?
A. That's correct.

Q. At that stage you still believed that he was going to make contact with a private psychiatrist who he had nominated?
A. Yes.

Q. Then on 17 August, so the next month, Joel returned. He was requesting a referral to a psychiatrist, not Robert Moyle. He needed someone who was bulk billing. I said he returned, but it was a telehealth consult again. There are pretty brief notes at that time. Do you recall anything else about that presentation?
A. Nothing, nothing unusual.

Q. Again, there are limitations of course in relation to telehealth. You didn't pick up, I take it, on any speech disorder, or anything that gave you an indication then of any psychotic influence on Joel?
A. No. Nothing.

Q. But you accept that it would have been difficult for you to do so over the telephone?
A. Very much so.

Q. And it was your belief, even not knowing that he was on clozapine, that he needed to seek a referral from a private psychiatrist?
A. That's right.

Q. And you believed that he would then do so in the public system?
A. In the private system, sorry.

Q. Sorry. In the private system, but someone who would bulk bill?
A. Yes.

Q. The next three consultations I won't take you to specifically, but on 4 September, 8 September and 14 September you have contact with Joel. I'll take you to them separately for this reason. 4 September, there's a telephone consultation again where there's a diagnosis of herpes and the request for an STI screen. On 8 September 2020 there's a note, "Surgery consultation. He presents with rash." So Joel obviously came in on that day?
A. On the 4th of the ninth?

Q. No. I'm sorry, the 8th of the ninth, and that appears at page 7 of the notes?
A. Yes he did. He was there as a face to face consultation.

Q. Was that because of the staph infection that needed a face to face review?
A. Yes.

Q. On 14 September it also appears to be a face to face interaction in relation to impetigo?
A. (No verbal reply)

Q. Do you see that?
A. I do see that.

Q. I'll come to the 21st shortly. Your notes on the 8th and the 14th don't include anything in relation to his presentation for mental health?
A. No.

Q. Was there a reason for that?
A. The pressing issue there was a presentation for erysipelas. It can be a potentially severe skin infection involving the face. You will note there was a referral made to the local emergency department on that basis. So that issue took precedence then.

Q. And I take it that in your mind, in any event, he was going to see a psychiatrist, so the mental health would be dealt with. Is that right?
A. That's right.

Q. 21 September 2020 if you would have a look at that. That's down the bottom of page 7. The reason for his visit on that occasion is impetigo and schizophrenia. The skin had significantly improved. He was requesting a referral to a new psychiatrist, and that was when you came to write the letter to Dr Sarkar?
A. Yes.

Q. Did you know Dr Sarkar?
A. No.

Q. How did the name Dr Sarkar come up?

A. I was searching for names in the directory I'd used for local referrals at the time. Those names at the top would usually correlate with sooner availability.

Q. Did he tell you at that stage anything more about why he wanted to see a psychiatrist?
A. Nothing new, or emergent, so, no. There'd no been - at that point there'd been no change in his mental state.

Q. You note there "GPMP performed". Could you tell us what that is?
A. The GP Management Plan is a device to set a - it's a framework to establish and structure some goals of treatment for a chronic disease.

Q. Which chronic disease were you referring to?
A. For him it was schizophrenia.

Q. What were your goals at that stage for him?
A. At that point, given again my assessment of him is that he was in remission. It was to the very least make sure he wasn't lost to follow-up. One of the most useful aspects of a GPMP, if generated digitally, is you can establish - the practitioner can establish a recall, an automated recall to the patient, at whatever time is appropriate, be it three, six or 12 monthly after formulation of the management plan. For him specifically, at that point in his treatment, the goal was just to ensure that he had follow-up with either me, or a psychiatrist.

There were two other - there were a couple of other goals that were stipulated there provisionally, given - acknowledging what he'd been - what had been used previously for treatment, safeguarding against things like, you know, blood disorders, agranulocytosis, or cardiomyopathy.

Q. Could you have a look please at page 11 of the notes. Is that the GP Management Plan that you're referring to?
A. That's page 1. Yes.

Q. Just before I get to the next plan. Some parts of that are filled out in relation to the medications, the Hydrocortisone. The first line is, "If the patient has a previous or existing care plan when was it prepared", and that's left blank. Was this supposed to be an ongoing document, or why is that blank?
A. That's blank because he had no pre-existing plan with myself.

Q. I see. If you'd been able to find out about a pre-existing plan that another doctor had arranged, you would have put that in there. Is that right?
A. That's correct.

Q. So ideally, you would have a handover from another general practitioner who'd be telling you what the plan was?
A. Yes.

Q. But there was none in this case?
A. Not in this case.

Q. I asked you a question about whether or not you'd made any inquiries of his treating psychiatric, because you nominated that name. Did Joel ever nominate the name of Dr Grundy?
A. No he did not.

Q. Did he nominate the name of any other treating general practitioner?
A. No names. No.

Q. Did you ever ask him is there a GP?
A. I did.

Q. And what did he tell you?
A. "There was a family GP. I had a psychiatrist in Toowoomba. I'm not involved with them anymore."

Q. So he didn't disclose--
A. Not their names.

Q. --the name of the GP?
A. No.

Q. I'll take you towards the end of your evidence to some information that you are missing, but do you agree that it would have been very helpful for you to have a handover letter from the general practitioner who had seen Joel previously in Toowoomba?
A. Yes. I agree.

Q. And who had been connecting him up with a psychiatrist, who he had seen for many years?
A. Yes.

Q. In relation to the second page of the GP Management Plan, that appears at page 12, "The goal is improve mental health; reduce the impact of schizophrenia on the function and daily life." Were you able at that stage to determine what impacts schizophrenia did have on Joel's function and daily life?
A. Not with great clarity or specificity. Only what I could glean based on my interpersonal interactions with him, and what limited social interactions he seemed to have over the year that he was seeing me.

Q. Do you understand that with respect to schizophrenia there can be positive symptoms and negative symptoms?
A. Yes.

Q. Would you also refer to a category of cognitive symptoms?
A. Yes.

Q. So taking each of those three, positive symptoms would include, for example, positive evidence that he had hallucinations, or suggestions that he

might be hearing voices, writing satanic notes, something like that?
A. As examples of positive symptoms?

Q. Yes. I'm not suggesting you were aware of any, but is that an example of a positive symptom?
A. Writing satanic notes is not necessarily a positive symptom.

Q. If it was indicative of hearing voices, hearing voices would be a positive symptom?
A. If it - if the writing was manifest of him perceiving voices and feeling compelled to do it, that would be an example of a positive symptom.

Q. What are other examples of positive symptoms you'd look out for?
A. Hallucination. That is a sensation that is elicited from internally, not from external stimuli. Seeing things, hearing things, feeling things that aren't actually there. Thought disorders. So severe preoccupations, obsessions. Those are some examples.

Q. What about being unkempt, or messy, so having poor self-care. Is that a positive symptom?
A. It's a - usually evidence speaks to neglect, like personal neglect. So in my approximation, more of a negative symptom. If there's a failure to recognise a need for hygiene, or to feed yourself, or to respond to cues like going to the bathroom or sleeping. Those are examples.

Q. So poor sleep, would you regard that as a negative or a positive symptom?
A. It's very - that's a very general term. It, it depends on what the sleep disturbance is.

Q. If it was insomnia related to a compulsion to use pornography?
A. Then the compulsion to use pornography - I mean it - clearly that is getting to the point of disordered. But if there's a compulsion to use pornography, that's not necessarily a symptom of schizophrenia.

Q. No. But if there was compulsive behaviour, regardless of what it was related to, it might be excessive hand washing, or excessive amounts of pornography, or excessive note taking, can that be a positive symptom of schizophrenia?
A. Yes.

Q. In relation to your interactions with Joel, and your noticing of the way that schizophrenia might impact on him, could you expand on that?
A. I'll address how I think it didn't impact on him actively. I didn't see any - I didn't observe anything unusual about the tone, or the content, or the timing of his speech. He didn't seem to be distracted by any external stimuli. He didn't show any signs in my interactions with him that would point me towards active symptoms of schizophrenia. The - scrutinising, I guess, his - the way he presented himself to maintain normal eye contact seemed to be work for him. He was--

Q. Seemed to be hard work for him, you mean?
A. Yes. Whilst the content of his speech was appropriate, it wasn't organic. He wasn't reticent, but he was very economical with his words. He struck me as someone who was very cautious about what he'd said, more with concern for embarrassment, or saying the wrong thing.

Q. Did you ask him about any psychosocial supports that he had? For example, did he appear to have any friends?
A. He did not, and I did ask him.

Q. And that's of concern, isn't it, in terms of wanting to help him live a happy life?
A. Yes. An isolation, if it's ongoing, is a significant risk factor for relapse.

Q. So included in what you write as the plan - let's have a look at page 12 - is:

> "Co-ordinate specialist referrals; specialist assessment and guidance of pharmacotherapy and psychotherapy as appropriate; clinical monitoring for mental health status; response; therapy; and co-ordinate review for potential sequela of antipsychotic therapy; ECG; biochemistry; electrolytes; FBC; for agra(as said)."

You tell us what that is?
A. Agranulocytosis.

Q. I'll just ask you to break that down, but what's clear from that is that by 21 September 2020 you knew that Joel needed a routine around him to make sure that there was no relapse in relation to the schizophrenia?
A. Or to intervene timely if there was one.

Q. And that's even before you had any idea that he had been on clozapine for a number of years?
A. Yes. That's right.

Q. On 23 November, which was the very next consultation after the GP Management Plan, there's a telehealth appointment that you have, and the reasons for the visit are "STI screen; medical certificate; and schizophrenia". You note that Joel is:

> "Well since last review. Still denies any active symptoms of previously diagnosed schizophrenia and no pervasive mood disturbance. Joel request today's consult for consideration of a medical certificate clearing him medically to hold a gun licence. Joel says he has an appointment with the psychiatrist I referred him to, Dr Sarkar, this Thursday. Advised that, given his request for a psychiatrist review and for concern for schizophrenia diagnosis impact on candidacy for holding a gun licence. Advised he discussed the matter with her."

Meaning Dr Sarkar. Is that right?

A. That's right.

Q. Had you ever had one of your patients, who was diagnosed as having suffered schizophrenia at any time, request to be medically cleared to hold a gun licence?
A. Not that I can recall.

Q. Did you do anything at that stage to investigate how a GP might go about giving somebody a medical certificate for that purpose?
A. No.

Q. Had you ever given anybody a medical certificate to hold a gun licence?
A. Yes.

Q. At that time, did that person ever have a history of suffering mental illness?
A. No.

Q. In these circumstances, can you recall to the best of your ability what Joel said to you about the gun licence?
A. He'd made an appeal for a medical clearance for a gun licence with his intent to use it for sports shooting.

Q. Did you ask him any more questions about that?
A. I would have probed as to his intent or what was his motivation to seeking a gun licence, what sort of guns he was looking at using, had he any experience or exclusion previously. And he maintained that yes, it was for sports shooting for the local shooting range.

Q. Your notes don't go into any details about that, do you accept that?
A. I accept that.

Q. Was there a reason for that?
A. That's a defect in my - deficiency in my notes.

Q. In any event, you yourself were not going to write him a medical certificate. You told him to talk to the psychiatrist about that, correct?
A. I told him specifically, no I wasn't willing to write him a medical certificate and then he was aware, or he was made aware in that consultation that if he was to be considered, he'd at very least need to have an assessment with a psychiatrist.

Q. Why were you not prepared to write him a medical certificate?
A. Given the stakes, given - that is it being a firearms licence, and given his mental health history, especially from what I could glean, this - the complexity of it, there was - I felt it was out of my scope of practice to comment on this medical condition and his candidacy to hold a licence.

Q. At this stage you still didn't have any of the background records in relation to Joel's mental health status or his background?
A. Mm.

Q. And this was a telehealth consult. Did you have any concerns generally about the fact that he was making the request?
A. Yes.

Q. What were they?
A. Again, just generally speaking, I find just the prospect of firearms a very confronting topic, and then considering the fact that I'm being asked to clear someone for use of said firearms knowing that they've got a mental health history, to me, it begs a certain due diligence, that being specifically a specialist assessment.

Q. In relation to Dr Sarkar who you referred Joel to, did you have any conversation with him?
A. No verbal conversation, no.

Q. You wrote him a letter which appears at page 37 of the documents. 36 I beg your pardon, I'm corrected. It's standard, isn't it, for when you're referring to a psychiatrist to write a letter containing as much detail as possible in relation to the patient?
A. Yes.

Q. Sorry, page 34, I've given you the wrong number. You write:

> "Thank you for seeing Joel Cauchi, age 37 for an opinion and management regarding schizophrenia. First manifested for him at age 17 with tactile hallucinations and disorder of thoughts. He reports it was closely related to excessive use of drugs at the time. He has been following up monthly with his previous psychiatrist in Toowoomba, Dr A, until recently given the distance between them now the therapeutic relationship is no longer tenable. He's not taking any regular medications presently. He denies active symptoms. Thank you for your care and assistance. I look forward to hearing the outcome of Joel's attendance".

So, you include information to him to the extent that you know it at that time, and then you receive a letter back which is at page 36. The doctor reports to you then:

> "Thanks for the referral. He says he's going well for his mental health. He says he wants a gun licence to use for sport and hence a report for that. He's been interested in shooting for six months and wants to go camping for shooting targets. He is not very clear about the whole plan. He will be doing a course to be able to do that. He has not visited the club yet and vaguely knows its location. Earlier he did hiking around Toowoomba. His family lives there. He lives with three housemates.
>
> He was put on medication for schizophrenia, clozapine 600 milligrams at age 17. He came off it in 2018, now on no medication for two years. He'd used marijuana before the onset. He has

> confusion as a symptom and struggles to tell about his other morbid experiences. He has poor eye contact and uses stock words. He may be guarded or have poverty of content of thought and speech. Affect is restricted. He does not seem to have hallucinatory behaviour. He took off well before I could finish my assessment".

I'll just pause there. At this time, there was very significant information provided to you by Dr Sarkar that he'd been able to get out of Joel, do you agree?
A. Yes.

Q. The information that he gave to you, that in fact, Joel had been on medication, clozapine, from the age of 17 right through until 2018, just a couple of years earlier, suggested a very serious form of schizophrenia that Joel had been managing, do you agree?
A. I agree.

Q. It also suggested, didn't it, that Joel was not entirely forthcoming with you about the extent of his illness. Did that concern you at the time?
A. Yes.

Q. And what Dr Sarkar also reports is that he had noticed some symptoms, not hallucinatory behaviour at that stage, but poor eye contact, stock words. I'll pause there. That was similar to what you've noticed, correct?
A. Yes.

Q. Guarded or he may have poverty of content of thought and speech. Had you also noticed that?
A. Yeah, emphasis on "may". I agree with that assessment given that he answered questions appropriately, you know, in conversation. It, it didn't - whilst he was, again, economical, I guess, with his words, it, it wasn't to the point of being terse or reticent.

Q. But his affect was restricted, he says, and he also says that he took off before Dr Sarkar could finish his assessment. He notes:

> "He's aware that I require his previous psychiatric reports to make any decision about future treatment or document towards getting gun licence for the first time. My general view is that he may be having autism spectrum disorder when he could have unusual psychiatric experiences and especially on illicit drugs. He does not come across as a typical patient with schizophrenia who is off psychotropic drugs".

What did you do in response to receiving that letter?
A. You'll see there were subsequent referrals made to other practitioners after that, given that Joel, when he followed up with me after that encounter, wasn't happy to go back and see Dr Sarkar. He was - but he was amenable to following up with somebody else.

Q. Did he tell you why - so in terms of when you next saw Joel, I think it was 1 February 2021, and he came to see you at that stage in relation to STI and stress?
A. Yes.

DWYER: That can come up on the screen if possible. Tab 803A, page 8.

Q. At that time, this is a telephone consult. So, you've already accepted the limitations of telephone consult. Did they remain, even when you'd seen a patient face to face?
A. The limitations?

Q. Yes. Was it still difficult to make an assessment of a patient by telephone, even if you'd had an experience of seeing them face to face?
A. Yeah, there are still limitations.

Q. There's only a very brief note here in relation to Joel's request for referral for STI screen and prescription for Valium, and the request for Valium comes in response to some stress Joel has been experiencing. Did you, at that stage, discuss with him the consultation that he had already had with Dr Sarkar?
A. At that point I had. It's not reflected in, in the notes, I have to accept, but yes, I had.

Q. What was your discussion?
A. I probed as to what the outcome was given I had that correspondence from Dr Sarkar already. He didn't express any confusion about what he - why he was there, just that he didn't have the outcome that he achieved. In response to - in the body of that letter, when it was raised that he got up and left, he offered to me that it - he thought the consultation was over. He didn't think it was unusual.

Q. But did that make you concerned in relation to Joel's behaviour, that he had perceived that the consultation was over, when in fact the perception of the psychiatrist was that he got up and left in the middle of it?
A. Yes.

Q. Joel was prescribed Valium for stress at that point. What was he stressed about?
A. Sorry, he was not prescribed Valium during that consultation.

Q. I see, I beg your pardon, I withdraw that. I'll start again. There was a request for Valium in response to some stress Joel has been experiencing. What was the stress that Joel described?
A. Again, I have to concede that it's not actually in my notes at that time. I suspect it had some - he had some stress in relation to, I guess, the recent fear, the health anxiety in relation to STI screening.

Q. Are you guessing that now, or do you have a memory of discussing that with Joel?

A. I don't have a precise memory.

Q. Can I suggest to you that Joel experiencing stress, whatever it was related to, was a concern on the back of what you had learned already about his mental health issues?
A. Yes.

Q. Because stress itself can be a trigger for psychosis in the context of a long history of schizophrenia?
A. Yes.

Q. I don't want to be overcritical of your notes, but you accept that that's not in accordance with the standard expected of general practitioners, taking notes about this serious condition?
A. I, I accept that.

Q. At that stage, given that he was refusing to go back to Dr Sarkar, what did you do?
A. I offered him the opportunity to have a consultation with another psychiatrist.

Q. Who was that?
A. One of them was Dr C who he did follow up with. I ended up giving him I think five different referrals on different occasions, trying to increase his, his chance of actually getting him with somebody sooner rather than later. I had--

Q. On this - sorry, please go on.
A. I hadn't actually had any conversations with any of these referred practitioners.

Q. I'll take you to the letter that is sent back to you by Dr C. You referred Joel to him at some stage prior to that visit on 1 February 2021, and his letter appears at page 37. Is that up on your screen?
A. Yes, I can see.

Q. That doctor writes back to you to say that he has seen Joel and:

> "Joel informs me that today's assessment was in order to attain a medical report certificate on his current mental state and risk so that he can provide it to the local gun range where he uses to practice target shooting under supervision once a week or once a fortnight".

I'll just pause there. Was it your intention to refer Joel to a psychiatrist so that he could get a gun licence?
A. No.

Q. What was your intention in relation to the referral to a psychiatrist?
A. To get him a specialist assessment with concern for his mental state, the, the chronic disease, schizophrenia.

Q. Do you agree that there appears to be a disconnect at stage in relation to what's in Joel's mind about what he might need?
A. Yes.

Q. Do you say that you had explained to Joel that he did need follow-up in relation to his psychiatrist?
A. Yes.

Q. In this letter back to you, there's further information again provided, can I suggest you in relation to Joel's background. It notes page 37,

> "Joel currently reports stable mental state and describes good stable mood, nil hallucinations or psychotic symptoms were reported. He denied problems with memory or functioning. A mild degree of twitching of the mouth was noted which Joel reported to be due to mildness, to nervousness".

Putting the gun to one side but I'll come back to it.

> "In relation to past psychiatric history, Joel admitted to this doctor that he had been an inpatient at a psychiatric unit in Toowoomba at the age of 17 for an episode of psychosis, secondary to a yearlong use of cannabis. He reports experiencing tactile hallucinations at that time and says that he commenced on clozapine as part of his treatment. After being on clozapine for two years, his treatment was changed to aripiprazole. More recently, Joel reports seeing Dr A at Toowoomba and reports being off Abilify for the past 18 months."

This information is slightly different to the last because it says clozapine for only two years before the treatment was changed to aripiprazole. So, at this stage, you've got conflicting information that's been given to Dr Sarkar as opposed to Dr C. Did you, at that stage, think that you really needed to clarify what the extent of Joel's treatment had been?
A. At that point, I think in that letter it refers to documentation obtained from his previous, the previous treatment service, so at that stage we had some clarification.

Q. Was it your view that the psychiatrist was going to be able to manage that hand over from the prior psychiatrist?
A. Yes.

Q. He says in terms of a plan:

> "I have advised him to have six monthly reviews to monitor mental state even though he's currently asymptomatic. This is in part due to him being on clozapine for many years and the possibility that his diagnosis could be schizophrenia rather than drug induced psychoses".

Yes?

A. Yes.

Q. Do you agree though that you did not in fact have an accurate picture at that time in relation to Joel's treatment in Toowoomba?
A. Yes.

Q. With respect to the gun issue, Dr C says that: "He doesn't hold a gun licence. He reports he will have access to guns that are owned and registered by the gun range for the duration of his practice". Did you have any conversation at this time, or any time afterwards, with Dr C?
A. No.

Q. Did you have an understanding at that stage about what Dr C was going to do with respect to the application for a gun licence so that he could go to the firearm range?
A. No, not that I can recall.

Q. Did you remain concerned with respect to his desire to obtain a gun licence, even if it was in the context of a fire range?
A. Yes.

Q. You had indicated that you would not have been prepared to write Joel any sort of medical certificate to say he was eligible for a gun licence. I take it that that is the same answer with respect to any licence to operate at a gun range?
A. That's right.

Q. There was a consult that you had with Joel on 24 March in relation to a rash. I don't need to take you there in any detail, but do you recall? It's the second last consult that you had with Joel. Do you recall anything specifically about it?
A. No.

Q. So, the final consult you had was on 30 April. It appears at page 10 of the notes. Is that a consultation in person?
A. Yes.

Q. Joel presented on that date in respect to wanting a driver's licence examination, and you say with respect also to his schizophrenia?
A. Yes.

Q. Do you agree there that under "Actions" is written "medical certificate given from 30 April 2021 until 30 April 2021". Is that a typo?
A. No. But - so, that looks like a generic medical certificate. That doesn't, that doesn't bear any relevance to a driver's licence medical certificate. For clarification, he presented that day for a medical certificate to be completed by me. That's a Transport/Main Roads Form, 3712.

Q. So, he wanted a medical certificate so that he could continue to drive, is that right?
A. Yes. So, he could drive with a conditional licence. The condition stating M

on his driver's licence.

Q. Did you understand what that M was supposed to infer or indicate?
A. Yes.

Q. What?
A. That this person, the person that held this medical certificate is allowed to drive for a prescribed period after medical review, provided they meet the conditions. In this particular case, it was subject to 12 monthly medical review.

Q. And in relation to Joel's driving, did you ask him any questions? At this stage, you knew that he'd suffered from schizophrenia for a lengthy period of time. Did you ask him about any impact on his driving?
A. I did.

Q. What did you ask him, and what did he say?
A. As far as - again, I performed a cursory screen for any active symptoms of schizophrenia, which he denied. The remaining - the, the content of the notes there is a reflection of the content of the Australian Fitness to Drive Guidelines at the time. It was..(not transcribable)..his actual condition, he met the eligibility criteria.

Q. Did you think at that point in time that he had a treating psychiatrist?
A. Yes.

Q. Who was that?
A. Dr C.

Q. In terms of what you knew about Joel's condition, you thought it was adequate that he see a psychiatrist at six monthly reviews, is that right?
A. Yes.

Q. Dr C in his letter back to you recommended that Joel be seen at six monthly intervals. He wasn't committing to seeing Joel himself at six monthly intervals. Is there anything that you did in relation to contact with Dr C by letter or otherwise to confirm the six monthly review?
A. No.

Q. Did you intend to do anything after that time?
A. To contact Dr C directly, do you mean?

Q. Yes. Or anything else to ensure review?
A. The two, the two devices that were in place by that time were, one, the automated text message or telehealth notification service generated by the Chronic Disease Management Plan. And two, granted it was outside of six months, but he would need a doctor's review again 12 months after me signing his driver's licence. So, they were the two frameworks in place.

Q. You said that you asked some questions of Joel in relation to his driving, is that right?

A. Yes.

Q. What did you ask him?
A. Again, it was a cursory mental state examination. Asking about perceptual disturbances, seeing things, hearing things in reference to his previous hallucinations.

Q. Do you have a memory of that now, or are you going on your standard practice?
A. I have a memory of it, though it's not precise.

Q. In relation to a mental state examination, do you agree that your notes are too scant. That is, there is no note in relation to any mental state examination that was conducted?
A. Yes, I accept that criticism.

Q. And there should be?
A. Yes.

Q. In fact, can I tell you now that on 10 October 2020 and on 6 November 2020, Joel was stopped by police in Brisbane because - for example, on 10 October, he was driving with his head down and braking erratically, such that they thought he might be affected by drugs or alcohol. And they tested him, and he was not. In November, he was stopped by police in Brisbane due to his erratic driving and changing lanes, and he again returned a negative breath test. You didn't have that information from police when you gave the medical certificate, correct?
A. That's correct.

Q. If you had had that information, might that have prompted you to ask more questions, or do something different?
A. Yes, it would have.

Q. In what respect? Can you explore that?
A. I would have explored that interaction and that event with Joel directly, and even if I - even I think in that context, had I received something approximating a reassuring answer from Joel, I'm not likely to have signed off on that medical certificate, and I would have relayed that information to his treating psychiatrist.

Q. It underscores, doesn't it, the limits of getting information from the patient themselves with respect to any symptoms that they experience?
A. It does.

Q. When Joel was pulled over for a third time, can I tell you at the end of 2021, after you had seen him, there's a third time when he's pulled over for the same sort of erratic driving, and when the police officer says, "Do you know why I've pulled you over?" Joel says that he doesn't know. He's not conscious himself of his erratic driving. Is that something that you would understand to be a symptom, potentially, of a return of symptoms of schizophrenia?
A. It speaks to a likely perceptual disturbance, cognitive disturbance, and lack

of insight which, yeah, are features of schizophrenia.

Q. I just want to finish by asking you about some information that you did not have, and whether or not it would have impacted on your treatment in any way. Firstly, at any time when you were treating Joel, were you aware that Joel's treating psychiatrist in Toowoomba, Dr A, understood that Joel's father also had schizophrenia? Were you aware of that?
A. No, I was not.

Q. That would have been something that was very relevant to you, in terms of assessing Joel's background?
A. Yes. Yeah, it would have been relevant.

Q. You were not aware that Joel had been managed on clozapine for a period of about nine years in the public health system, and then a further period of nearly a decade by his treating private psychiatrist?
A. That level of specificity, no.

Q. And that would have been helpful to you in terms of understanding the urgency--
A. Yes.

Q. --with respect to getting a review?
A. (No verbal reply)

Q. Is that correct?
A. As far as the urgency, I'm not too sure. There's clearly an indication for regular review. The urgent - what's more likely to dictate the urgency is I guess the presence of symptoms to suggest a relapse.

Q. I'll take you to those shortly. You were not given information in relation to the fact that the clozapine had been slowly titrated down by Dr A from 2012 through to 2018? You didn't have--
A. I was not aware of that.

Q. --that information?
A. No.

Q. And you didn't have information specifically as to when the Abilify or another period of antipsychotic that Joel was continued on was taken off?
A. I was not aware.

Q. And that would have been helpful for you, as a general practitioner, in terms of managing him to understand the doses he'd been on previously and the way they'd been titrated?
A. Yes.

DWYER: If I could have on the screen please p 240. It's a letter from 6 May 2015. It's tab 793.

Q. Do you see that third paragraph, last sentence, is Dr A in 2015 with a note that she believed at that stage that Joel needed an antipsychotic for long-term relapse prevention. Given your knowledge of people who suffer from a severe form of schizophrenia who are managed on Clopine or clozapine for a lengthy period of time, that fits with what you know about that..(not transcribable)..too, doesn't it? That in fact, people will usually need to be managed on some form of antipsychotic to prevent relapse prevention?
A. As far as I know, yeah.

Q. You did not at any time have information that Joel's previous treating psychiatrists, including Dr A, and a former psychiatrist, Dr Nicky Stephens, believed that Joel's mother was a very important source of information in relation to how Joel was functioning, and whether or not the psychosis had returned? That would have been helpful?
A. Yes.

Q. Because in fact, in your notes, you don't have any information about family members and who could be contacted, or who would be useful to giving you that information, correct?
A. I did not have that information.

Q. And you didn't have any information that indicated to you that between October 2019 through to February 2020, shortly before Joel stopped seeing Dr A, his mother had contacted her to report that she believed that he had had a decline in his mental health. You did not have that information?
A. I did not.

Q. If you had read emails or seen notes that suggested, for example, what was suggested in an email by mum on 20 November, that Joel wasn't doing very well off his Abilify? I withdraw that.

DWYER: That can come up on the screen. Page 141, tab 793.

Q. Do you see that email, if you can just take a moment to read it to yourself? So, this is about four months after Joel was taken off Abilify, and about a year and four months after he was taken off clozapine, and his mother, who is known to be a trusted source of information, says:

> "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 an effect, but I have noticed a gradual decline in his condition, and judging from notes on paper he has left around the place in the past week, I have a feeling he is now hearing voice, et cetera. He is very distracted, forgetful, and the OCD is getting out of hand with him going through half a cake of soap in one shower".

If you had that information when you are assessing Joel in 2020 and 2021 and trying to learn about him, that would have been very important information, do you agree?
A. I agree.

Q. That would have suggested that there was a level of urgency in making sure that he had psychiatric follow-up?
A. Yes. It would have better directed it as well.

Q. I'm sorry, could you say that--
A. It would have better directed it as well.

Q. Just explain what you mean by that?
A. Given these specific features, like the, like the OCD traits as well.

Q. Yes.
A. It may have, I may have even steered him towards - explored his concerns with not going back to Toowoomba. There was sort of a brick wall there as far as our progress, and like why, you know, why Brisbane, why not Toowoomba, given that's where he had continuity.

Q. Yes.
A. And in that space he was reticent. But, yes, as far as refining his diagnosis and therefore the treatment, that would have been really helpful.

Q. She goes on to say at paragraph 2,

> "I would hate to have to see him go back into hospital after 20 years of being stable while 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".

So, she's also giving information in that email that Joel may be reluctant to go back on medication because of the sedating side effects, correct?
A. Yes.

Q. Then the third paragraph she 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". So, the information from mum is also that Joel might be guarded in terms of disclosing the symptoms?
A. Yes.

Q. Before I ask my last question, I put to you this further information that was known to the practice where Dr A practiced out of. Following up from that email, there's a conversation in notes recorded from a nurse that says this: "Reports from those known to Joel of changes in behaviour". This is November 2019, and you see him the next year.

> "He's having extreme OCD with showering and washing himself, usually half a cake of soap, writing a lot of notes, plus, plus, plus, at home and leaving them about. Mother reads some notes with some content of under satanic control, of religious theme, a desire for porn, which conflicted with his religious beliefs. She had noticed a

> funny change in his gait. He's been observed that he bends his head a lot and has odd movements. Possibly hearing voices has been considered".

That's all very important information that's suggestive of an urgency or review that would have assisted you, do you agree?
A. I agree.

Q. I won't read all of the notes of her concerns, but right up until February, on 14 February 2020:

> "Joel's mother called to express her concerns about Joel's functioning at home and his probable move to Brisbane. She said his self-care is poor. She said he appears more isolated and irritable, and he is occasionally swearing".

This is just a couple of months before you saw Joel by telehealth in May 2020. If you had had information that came in mum's email about the possible hearing of voices and these further concerns, the notes that he was leaving around the house, the compulsive behaviour, the lack of self-care, the isolation, irritability, and swearing, you would have arranged for an urgent assessment from a psychiatrist, is that right?
A. That's right.

DWYER: Nothing further, thank you, your Honour.

Q. I'm sorry, just one thing in terms of her Honour's recommendation power. You're aware that as the coroner, her Honour can make recommendations to try and prevent tragedies such as the one that happened on 13 April?
A. Yes.

Q. If you can accept from me that we have some expert opinions that will be delivered shortly by general practitioners and then next week by psychiatrists. A general practitioner Dr Edwin Kruys says this in relation to a suggestion. "From Dr C's letter" - she's referring to the one that I put on the screen, sorry,

> "From Dr C's letter it is not clear who should perform the recommended six-monthly reviews, for example, the psychiatrist or the GP or both. He suggests", that is, Dr Kruys suggests, "that guidelines to support collaborative care between general practice and specialist mental health services, including role clarity and responsibilities for people living with a mental health condition would assist with longitudinal care provision across healthcare sectors".

Do you agree with that?
A. Yes.

Q. Thank you.

HER HONOUR

Q. Thank you. There may be some other questions.

CHRYSANTHOU: No questions, thank you, your Honour.

FERNANDEZ: No questions.

ROFF: No questions, your Honour.

FRECKELTON: No questions, thank you.

ROBB: No questions, thank you, your Honour.

LYNCH: No questions, your Honour.

HER HONOUR: Ms Mathur?

MATHUR: Yes, I just wanted to--

HER HONOUR: Sorry, I'll just check and make sure there's no-one in court 2. Any questions in court 2?

CALLAN: No questions, your Honour.

CHIU: No questions, your Honour

CASSELDEN: No questions, your Honour.

JORDAN: No questions, thank you.

<EXAMINATION BY MS MATHUR

Q. Dr Ruge, it's correct to say, isn't it, that a general practitioner cannot initiate antipsychotics? Or it wouldn't be the usual practice for a general practitioner to initiate antipsychotics, including clozapine?
A. Definitely not including clozapine, no.

Q. If we could just have on the screen again Dr C's letter back to you. A suggestion was made that Dr C was not committing to being the treating psychiatrist, but can I draw to your attention - it's page 38 - if we could go to the bottom of that page, just under "plan". Dr Ruge, could you just read to yourself what's written under "plan"? Have you read to the bottom of the page?
A. Yes.

Q. When you read that, were you left with the impression that Dr C or his clinic was taking on the continuing psychiatric management of Mr Cauchi?
A. Yes.

Q. So, you didn't read that as Dr C indicating to you that he wasn't committing

to ongoing care?
A. I'm sorry, could you say that again?

Q. A suggestion was put to you in questioning that Dr C was not committing to the six-monthly review. That's not how you read that passage, is that correct?
A. That's correct. Usually if there is a discharge from the clinic or a severance of care, usually that's stated explicitly in the management plan.

Q. You were given snapshots of a longitudinal history of Mr Cauchi primarily with respect to his care in Toowoomba in questioning just now. You recall that?
A. Yes.

Q. You were asked that if you had that information at hand, would that have changed your response, and you said that it would have led to an urgent assessment. Do we take it you used the word "urgent assessment", being an urgent referral to a psychiatrist?
A. Yes.

Q. Or do you also have the power to do a referral to a hospital?
A. I do.

Q. With respect to urgent referrals of assessments to a psychiatrist, if you can take your mind back to 2020 and 2021, what time period is optimistic with respect to being seen by a psychiatrist if it's an urgent assessment?
A. If it's an urgent assessment, my approach would likely have been different. What I'd likely to have done is actually referred him to a public health mental health service, referred to as acute care, and that would be immediately.

Q. If it's to a psychiatrist in clinical practice in the community, what was the time period back then?
A. In the private setting, if a patient was not known to that psychiatrist, the prospect of them taking on their care was dubious at best.

Q. The facts of the situation are that you in fact write four referral letters to four different psychiatrists in the period of time that Mr Cauchi was coming back to see you?
A. I think it was five.

Q. Sorry, I stand corrected, five, is that correct?
A. Yes.

Q. I understand that you did want to address the family and those that have been, who have lost loved ones or been harmed by this incident?
A. Thank you, yes. I wanted to offer my sincerest condolences to everyone affected, in particular the friends and family of the loss.

HER HONOUR: Is there anything arising?

DWYER: Nothing arising, your Honour.

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

<THE WITNESS WITHDREW

HER HONOUR: Mr Murphy.

MURPHY: Your Honour, the next witness is Dr Amitava Sarkar. His statement is at vol 22, tab 805.

LTS:DAT

<AMITAVA SARKAR, SWORN(3.25PM)

<EXAMINATION BY MR MURPHY

Q. Could you please state your full name?
A. Amitava Sarkar.

Q. What's your current occupation?
A. Psychiatrist.

Q. Where is that, where are you based?
A. I work at Ramsay Clinic, New Farm. Then Cornwall Street Medical Centre, Woolloongabba. And also at Bremer Specialist Centre in Booval.

Q. Bremer, was that?
A. Bremer Specialist Centre.

Q. You've given a statement in this matter dated 28 June 2024, is that right?
A. Mm-hmm, yes.

Q. At paragraph 2.2 of your statement you say that,

> "There was a single consultation with Mr Cauchi on Thursday 26 November 2020, and given the time that has passed since that consultation, I have no independent recollection. My statement is based on my records and usual practice.

Is that correct?
A. That's right.

Q. Subsequent to making that statement in June 2024, you haven't had any other specific recollections about the consultation with Mr Cauchi?
A. No, no.

Q. The statement is otherwise based on your notes and records?
A. That's right.

Q. You obtained a Doctor of Medicine in Belarus in 1994, is that correct?
A. That's right.

Q. You were registered to practice in Australia in 2002?
A. Mm-hmm.

Q. You became a fellow of the Royal Australian and New Zealand College of Psychiatrists in 2012, is that correct?
A. That's right.

Q. If you wouldn't mind just speaking up.
A. That's right.

Q. You first worked for Queensland Health as a psychiatrist, is that correct?
A. In Queensland I worked in Queensland Health, but before that I worked in Melbourne and Gosford.

Q. Were you working as a psychiatrist in Melbourne and in Gosford?
A. For a short while as a psychiatrist in Melbourne, and before that a senior registrar.

Q. Was it from around 2002 where you worked as a psychiatrist in Queensland?
A. No.

Q. When was that?
A. 2011 May.

Q. Whereabouts were you based in Queensland?
A. Mackay. Mackay Mental Health Services.

Q. Was that a full-time role?
A. Yes, initially.

Q. Did that role have any particular speciality or area of focus?
A. Adult mental health.

Q. Adult?
A. Adult mental health.

Q. Was there any particular specificity or specialisation in particular mental health conditions?
A. No.

Q. Your statement provides that since 2017 you've been in private practice, is that correct?
A. In full-time private practice. Before that, partial.

Q. You've already given evidence that that includes at Ramsay Clinic, Cornwall Street Medical Centre, and Bremer?
A. That's right.

Q. Are they all located in Brisbane?
A. Bremer is located in Ipswich. The other two are in Brisbane.

Q. During the relevant consultation with Mr Cauchi in November 2020, you were based at the Cornwall Street clinic for that consultation?
A. That's right.

Q. How often did you work there in 2020?
A. Thursday afternoon every week.

Q. And the balance of the week was spent at either the Ramsay Clinic or in

Bremer, or did Bremer come later?
A. Bremer around the same time. So Bremer one day a week and the rest Ramsay Clinic.

Q. In your private practice role, do you have any particular specialisation?
A. Adult mental health.

Q. And any specific conditions?
A. Not really.

Q. Do you have any particular experience or specialisation in the treatment of schizophrenia?
A. In, in Queensland Health I did treat a lot of patients with schizophrenia, but not so much in private practice.

Q. During the period up until 2017 you had involvement in treating patients with schizophrenia in the public system?
A. That's right.

Q. And from 2017 onwards you haven't dealt with the patients?
A. Very rare.

Q. What are those patients that you do deal with in private practice that are suffering from schizophrenia?
A. Depression, PTSD, anxiety, et cetera. But not really schizophrenia. Once in a while I do get referrals. Also I treat bipolar disorder.

Q. Turning to the consultation with Mr Cauchi on 26 November 2020, were you in court earlier when counsel assisting took Dr Ruge to the referral that was sent to you in relation to Mr Cauchi?
A. Mm-hmm.

Q. I won't repeat it, but I'll bring it up on the screen. It's tab 806 at page 3. This is in volume 22. Sitting here now, you don't recall reviewing that letter at the relevant time?
A. I didn't understand.

Q. Do you recall reading this letter in November 2020?
A. I would have. I, I don't recall that, but I would have.

Q. Looking at this document now, is this the standard sort of referral document you would receive from a general practitioner?
A. It's reasonably good. There are referrals I get two lines.

Q. And what makes you say that this is reasonably good?
A. I think he did - he gave a fair bit of information.

Q. In your experience you usually receive limited information?
A. That's right.

Q. And then it makes it your job to obtain that further information as you need to?
A. I would anyway have to get information, so it doesn't matter how much. But I think this is reasonably good.

Q. Would you read a referral in advance of a consultation?
A. No. I would accept a referral maybe a week before, and read it in more detail before the patient dials up.

Q. Would you ever, in your experience, contact a GP about a referral if you didn't understand what the referral related to, or if you needed any further information in advance of the consultation?
A. Generally a GP forwards as much information as is known to them, so I don't require to do that.

Q. Your recollection of the consult, as set out in your statement, is based on your subsequent letter sent to Dr Ruge. Is that right?
A. That's right.

Q. And that was again dealt with by counsel assisting in Dr Ruge's evidence. You were here for that evidence?
A. (No verbal reply)

Q. Was it your practice to prepare this report during the consultation, or afterwards?
A. What I generally do is write one or two words, and then I put that all into a full report when the patient leaves, or at the end of the work day.

Q. You state in that report that "Mr Cauchi wants a gun licence to use for sport and hence needs a report for that." Was there any other purpose that you understood for the consultation to be about?
A. So from the GP end, the reason for consultation was opinion and management regarding schizophrenia. From Mr Cauchi's end, it was about the gun licence.

Q. In your experience, is there very often, or is it unusual for there to be a disconnect, between what's set out in the referral letter, and what the patient, who attends the consultation, actually wants?
A. Yes, but not very frequently.

Q. So this was unusual for someone to be getting a general referral and then be very specific about wanting a gun licence?
A. I think this was a bit more extreme than other cases, because it's a gun licence.

Q. Why do you say it's more extreme?
A. Because someone with schizophrenia and asking for a gun licence, so that was extreme. Other cases are very different. It's about medical certificates and et cetera.

Q. Was it unusual for you to be asked to provide a report for a gun licence, or in support of an application for a gun licence?
A. I do get such requests. Not very frequently, but it is known to be in the practice of any psychiatrist.

Q. That's from people suffering from mental health conditions?
A. Either they have suffered mental health conditions, but I have known them before, or my own patient.

Q. Have you had any experience giving a certificate in support of an application for a gun licence for someone suffering from schizophrenia?
A. No.

Q. You've said that that was "extreme". Was it concerning that someone with schizophrenia was making an application to obtain a gun licence?
A. I needed more information about where it all comes from.

Q. I understand you needed more information--
A. Yes.

Q. --but based on your practice, do you find it concerning if someone who is suffering from schizophrenia had come to you seeking support for an application to obtain a gun licence?
A. As I said, that I would have to get more information about what brings this on. In this case, he had been taken off antipsychotics two years back, so it would be very difficult for me to say that this is utterly unusual, because it could be the fact that people - his, his previous practitioners would have said that "You are, you're clear of schizophrenia", or something like that.

So I had to get more lies - more, more information from at least the previous psychiatrist, and then I had to go over to the parents, because I think parents are most important in his, in his life, and, and then probably go over to the mental health services of Queensland to gather more information. What lies in the background of this request.

Q. To your knowledge, does treatment-resistant schizophrenia result in remission, or can result in remission as a result of treatment with antipsychotic medication?
A. Treatment-resistant schizophrenia is something that psychiatrists may differ whether one has a treatment-resistant. The other psychiatrist may not say that, whereas about schizophrenia everyone would agree that a person has it. So generally speaking, if a mental health service has seen a patient for a period of time not responding to two or more antipsychotics, one of them being a first generation antipsychotic, then they consider the next, next treatment should be clozapine.

Q. What's a first generation antipsychotic?
A. It's like Haloperidol, or otherwise known as Serenace. Just one of them. There are many others.

Q. So that is the first treatment that a person receives if they're diagnosed with schizophrenia, they'll be treated with a first generation--
A. Not really. So in the last 20, 25 years people are generally treated with the second generation atypical antipsychotics. But at the time that I was training, it was essential that someone also has trialled a first generation, having failed the second generation, to be considered treatment-resistant.

Q. At the time that Mr Cauchi attended in November 2020, were you aware of any guidelines that had been published for psychiatrists concerning schizophrenia and assessments of applications for gun licences, or access to firearms?
A. At the time I was not aware, but I think such came a bit later on, maybe two, three years later through the College.

Q. In your report to Dr Ruge you state that "Mr Cauchi took off well before I could finish my assessment". Was there any particular type of assessment that you were undertaking during that consultation?
A. My intention was to get more, more information towards the objective of opinion and management regarding schizophrenia, less so about the gun licence, because about the gun licence, he would probably have to see me three, four times to contact the people I just mentioned. I might have to take his case to a peer review or - and, and, and a forensic psychiatrist. So it is not an easy one.

Q. If Mr Cauchi had not left and had remained with you throughout the rest of the consultation and then attended upon you on further occasions, are you saying that that's what you would have done--
A. Yeah.

Q. --in order to satisfy yourself that it was appropriate to support an application for a gun licence?
A. As I said, on that day, it was not so much about the gun licence, because the gun licence issue can't - I won't be taking it as seriously on the first day. I would have to get reasonable history to carry over to the next day. I would have seen him three, four times, and then develop enough rapport so that he gives me permission to talk to his parents, and so forth.

So the rest of it. So, it needs some bit of rapport to get him into a good management plan, because even with the gun licence, one needs to be following up with psychiatrist and taking treatment, if there is need for it. I mean, if there's a big treatment needed, then probably not suitable for gun licence, so all - I'm coming from the standpoint of gun licence for depression, depressive illness, and so forth.

Q. Is it likely that you told Mr Cauchi that you would need to do those things before you could consider his application for a gun licence? It's not in--
A. I, I don't, I don't recall what I told him, but I generally - it says here that I did - he--

Q. Yes.

A. Yeah, he's aware that all his previous history would have to be known to me.

Q. Was it strange for a patient attending a consultation to leave halfway through?
A. It's like a - I think when he realised that that's the, that's the next step, without that step nothing goes ahead, he, he did - I don't recall, or it's not written there. If he had left with an incident, like slammed the door or something like that, I would've written it here. I don't think he has done anything like that, and neither do I have a memory of what he - he left, and that was important for me to write it down here, so, yeah.

Q. Do you have any other instances in your practice that you recall of patients leaving halfway through consults? Was this unusual?
A. Not really. It does happen. Generally in private practice they don't, but in the mental health services it does happen, because they are more unwell, or, or, or just being treated for the first few months, so they might leave.

Q. If Mr Cauchi had left and you had concerns about risks to harm to himself, or to others, is there anything that you could've done from your position as a private psychiatrist?
A. Yes. So I do - from time to time, if I'm very concerned about someone to have imminent risk, or, you know, then - or risk to self or to dependents, I generally refer immediately to the acute care team who follows them up within 24 hours.

Q. And that's in the public health system?
A. Yes. Because it is impossible to do it as a, as a psychiatrist in a GP clinic, and, and they're pretty good at picking up cases. Usually they would be known to them, so they would be known to them from previous history, so - and then they send them back to us later.

Q. Your evidence is that even if these are people who are known to the public health team, they will still go and collect them?
A. Yeah. Even if the patient is mine and they were known by public mental health, they will still pick them up for a period of two weeks, or, or a little more.

Q. In your report to Dr Ruge you state that:

> "My general view is that he may be having autism spectrum disorder when he could have unusual psychiatric experiences and especially on illicit drugs. He does not come across as a typical patient with schizophrenia who is off psychotropic drugs."

What is a typical patient with schizophrenia who is off psychotropic drugs look like to you?
A. So, I think there the psychotropic drug I meant was clozapine. So, clozapine is, as you understand, that's the, the most - I mean that’s given to patients who haven't responded to other medications. Now, in schizophrenia, once you give clozapine and then you withdraw it, generally I would, I would,

see, in my experience, if I had seen someone, they would relapse very quickly within three months and maximum six months to be brought into hospital, to be reinstated. Now, the history I had at that moment was that two years he was off or two years or a little less than that. He was off clozapine. Then he had a very, it's a low dose Abilify. Abilify is much weaker than clozapine.

Also, the fact that when we say two years off clozapine, there was a period of time when he was weaning off clozapine, so he was taking less and less and less. So, that's a bit unusual. I mean, I had to make sense of this case at that time to make sense of the symptoms that I mentioned here, cross-sectionally, that why is he appearing the way he's appearing. So, that's why I brought up the condition of autism spectrum disorder that is being - that is still continuing, and obviously there are psychotic experiences before, that's why he's on medication. He was on medication.

Q. When you talk of symptoms of relapse of schizophrenia, what are those symptoms and how do they manifest? What would you observe?
A. So, schizophrenia relapses exactly the same way as it happened in the first time. So, if someone were to record how they were brought in in the first episode, pretty much that repeats itself. But when someone is taken off clozapine and while they are actually not in full remission, full remission, then we expect quite a violent relapse. So, it won't take six months to come up to a full episode. It would happen very quickly.

Q. So, your evidence is that when you're treating a patient who has schizophrenia, you would look to the original symptoms or the original incidents?
A. That’s right.

Q. And that would inform your assessment of whether there was a risk of relapse?
A. That's one way of picking up early warning signs.

Q. Can we just bring up your statement, paragraph 2.9.

MURPHY: Just to assist the Court, that’s tab 805, page 4.

Q. At 2.9, you state that "I did not consider him a risk to himself or others"?
A. On that day.

Q. Then at paragraph 2.11, you also state in the final sentence, "There is nothing in those reports" - which I'll come to - "from Dr A that would have caused me to change my risk assessment". You accept that your report to Dr Nathan Ruge doesn't refer to anything about Mr Cauchi being a risk to himself. Is that right?
A. So, on that day, he did not present with the imminent risk to self or others. If that was so, I would not have, I would not have just asked Dr Ruge to do anything. I would probably refer him to acute care teams straight away.

Q. So, the fact that it's not referred to in your report suggests that it wasn't an

issue that you were concerned about?
A. It, it was not an issue on that date.

Q. After the consultation with--

MURPHY: If we could just bring up tab 806 again.

Q. After the consultation ended with Mr Cauchi, a request for medical records transfer was completed--
A. Yes.

Q. --in relation to Dr A? Did you complete that document?
A. No, it is done between Mr Cauchi and the admin staff. So, when he goes out of my consultation, that's where he did all this.

Q. During the consult where you informed him that he was aware--
A. Yes.

Q. --or you indicated that he was aware of the need for records?
A. That's right.

Q. He left the consult?
A. And he, he probably signed - I mean, I didn't come out, but given that it was signed on that day, it means that he would have done it as I told him to.

Q. And that would have been after the consult?
A. After the consult.

Q. Do you recall having any discussion with Mr Cauchi about what records you needed, was it all of the records or some of the records?
A. I think generally we ask for whatever records can be sent over from a private practice. I generally don't specify anything. I go, from my own practice, if someone asks me, even a, even a general practitioner, I send my whole file.

Q. Is that, in your experience, the common approach when asked for a request for records?
A. No, not a common approach. But I give my whole file, because otherwise I'll have to go through my file to see which to be given and which not to be given.

Q. Would you expect when you ask someone for a medical record transfer, that you would receive the whole file?
A. I leave it to their discretion, especially if a specialist, then I leave it to their discretion. Usually, they send reasonably good amount of information.

Q. At pages 18 through 21 of that document, if we can just scroll through, these are the records that were provided to your clinic in response to the request. Are you familiar with those documents?
A. Yes, I only got familiar with them last year. I could have read them before, but I don't recall having read them. They usually come in the inbox of best

practice. And I would cast my eyes and then put them into the file and wait for the patient to turn up. Then I would read them in detail. But when I read them last year, that's what I came up with, 2.11.

Q. Acknowledging in your statement that having reviewed these four GP letters, that would not have caused you to change your risk assessment, but would you have liked to have received more information if Mr Cauchi was to continue being a patient of yours?
A. Yeah, then I would probably receive more and more information, especially if I hear from the parents a different story, and, and if I get from the community, from the community mental health service or Queensland Health information that are critical, then I would like to line them up.

Q. Could you have gone back to Dr A and requested further information if Mr Cauchi was to continue as--
A. Yes.

Q. --your patient?
A. Yes, I would have, depending on, you know, what the goal is. Generally, if I could manage the patient for treatment, and I see whatever is - what the reports are, the parents report to me, then I can treat accordingly. I don't need a lot of information.

Q. Would it have been useful to have received, as part of that, if that had to have occurred, the clinical notes?
A. Well, clinical notes. I mean, I, I would need, I - what information would be helpful is more about when he stopped clozapine until he got discharged from the clinic.

Q. You spoke about speaking to the family of the patient. If Mr Cauchi's mother had raised concerns with the practice in which he was previously treated about him deteriorating in terms of his mental health and possibly suffering a relapse in the period of late 2019, late 2020, that is after he ceased all medication or treatment for his schizophrenia, is that something that you would have expected to have been provided to you in response to a request to a psychiatrist?
A. Certainly, if I got to know about his mother reporting all this, I would have had a professional reports from psychiatrists because that's, that’s the only doctor who had seen in that period.

Q. So it would have been helpful for that information to have been provided?
A. That's right. So, we need, we need a collateral information, that's from the mother, and we need objective information from the doctor and the nurse.

Q. Can I just ask, as part of your practice, are you able to access Queensland Police records?
A. No. They are offered to us when someone needs report. So, Queensland Police briefs are offered to us then. Otherwise, we can't get them.

Q. If you had been aware - if you were to continue to be Joel's treating

psychiatrist, would information about his interactions with Queensland Police would have been helpful to you as part of your treatment?
A. Knowing that he has been picked up by the police for any reason would have probably prompted treatment straight away. And then I can get more information out of, out of the patient. Only that I need to know where and when things happened.

Q. So, depending on what had occurred, that would influence your decisions that you make, but you need to get that information?
A. Whether, whether treatment can be done as an outpatient, or needs to be sent into hospital in this case, whether needs to go back on clozapine.

Q. Is there anything else that you recall about the events on 23 November 2020 about your consultation with Mr Cauchi that you'd like to provide to the Court?
A. No.

Q. Dr Olav Nielssen has given an expert report in this matter. One of the issues that he deals with is the assessment of a person suffering with schizophrenia to hold a firearm, and he says that given the susceptibility of those suffering from schizophrenia and the potential propensity or the high proportion in which those people are involved in homicides, that it should be that people suffering from that condition do not have access to firearms. Do you have any observations or comments you'd like to make in relation to that?
A. I guess that is the most logical thing to say. But at the same time, we need to engage patients in treatment who has come with a request for firearms licence. So, in this case probably it was an opportunity to engage. But if I, if I, if I were to take any patient, prototypical patient, through the process of, of investigating him for, for a gun licence, it is highly likely would not pass, would not be cleared.

Q. Mr Cauchi never returned to your practice?
A. No.

Q. That was an opportunity for him to have re-engaged with the mental health system, which wasn't taken up?
A. No.

MURPHY: Nothing further, your Honour.

WITNESS: Thank you.

HER HONOUR: There may be some other questions, Doctor. Ms Chrysanthou?

CHRYSANTHOU: No questions, thank you, your Honour.

FERNANDEZ: No questions.

ROFF: No questions.

FRECKELTON: No questions, thank you.

ROBB: No questions, thank you, your Honour.

<EXAMINATION BY MR LYNCH

Q. I act for Dr A, the private psychiatrist who sent you those four letters. Could I just ask you this, if the clinical file that Dr A had was this size comprising some 400 pages, would you expect to receive the 400 pages in response to a request for the record?
A. As I said, it's up to the discretion of the psychiatrist.

Q. You wouldn't have had any opportunity to read the 400 pages in the context of your consultations, would you?
A. If you were to see me over a bit of time, I, I, I have the habit of going through up to 1,500 pages, given I do medico-legal assessments--

Q. Then this wouldn't have been a challenge for you then
A. --so I know how to go through them quickly.

Q. Thank you.

MATHUR: Sorry, your Honour, I have no questions.

HER HONOUR: Anyone in court 2 with any questions for the doctor?

CALLAN: No questions, your Honour.

CHIU: No questions, your Honour.

CASSELDEN: No thank you, Thank you.

JORDAN: No questions, thank you.

HER HONOUR: Thank you. Mr Wilson?

WILSON: No questions, your Honour.

HER HONOUR

Q. Thanks very much doctor, you're excused.
A. Thank you.

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

<THE WITNESS WITHDREW

MURPHY: If convenient, we would propose that we start at 9.30 tomorrow. Dr Grundy, who is giving evidence via AVL, is based in the United Kingdom, and just for his timing, it would be appreciated if we could start at that time.

HER HONOUR: Yes.

MURPHY: Subject--

HER HONOUR: No-one has any problem with that? Good.

MURPHY: We can scrub that all from the record. 10am for tomorrow morning, your Honour.

HER HONOUR: We'll start at 10am tomorrow. Thanks very much, I'll adjourn.

AUDIO VISUAL LINK CONCLUDED AT 4.00PM

ADJOURNED PART HEARD TO THURSDAY 15 MAY 2025