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LTS:DAT

IN THE NEW SOUTH WALES STATE CORONER'S COURT

STATE CORONER O'SULLIVAN

THURSDAY 15 MAY 2025

2024/00139002 - BONDI JUNCTION INQUEST

PART HEARD

AUDIO VISUAL LINK COMMENCED AT 10.01AM

AUDIO VISUAL LINK TO LONDON COMMENCED AT 10.01AM

HER HONOUR: Good morning.

DWYER: Good morning, your Honour.

HER HONOUR: Dr Dwyer.

DWYER: On the screen we have Dr Richard Grundy, and I call Dr Grundy.

LTS:DAT

<DR RICHARD GRUNDY, SWORN(10.01AM)

HER HONOUR

Q. Thank you, Dr Grundy. And thank you very much for making yourself available. I know it's very late for you where you are.

DWYER: Very early, your Honour. I think it's 1am.

HER HONOUR: 1am. Late or early.

<EXAMINATION BY DR DWYER

Q. Can you please tell us your full name?
A. Richard John Grundy.

Q. Where are you physically located to be giving evidence today?
A. London.

Q. Where is your place of employment normally?
A. Toowoomba.

Q. You're practicing as a general practitioner in Toowoomba currently, is that right?
A. I actually retired as a general practitioner towards the end of last year, and I currently work - I do sessions in a public hospital. So, I continue to work as a general practitioner, but not in my private practice.

Q. Are you connected with the Platinum Health Group still?
A. Yes, yes. All my email contact and my mail still goes through there.

Q. We've got two statements from you to assist the Coroner in her inquest, and one is dated 24 May 2024, the other one is 15 April 2025. Have you read those statements recently?
A. No, not recently.

Q. When you signed them, I take it that you were careful to make sure that they were true and correct to the best of your ability?
A. That's correct.

Q. Do I understand that sitting there now in London where you're located, you don’t have your statements in front of you?
A. That's correct, yes.

Q. I will be taking you to aspects in your records and your statements, so I'll read them to you. We'll put them up on the screen and hope you can see them, but otherwise I'll just pinpoint what the reference is so that everybody in the courtroom can follow it.
A. Okay.

Q. Your experienced legal senior counsel will let me know if I get anything wrong in terms of those records, and we can correct it. Can I ask you firstly, before I ask about your treatment of Joel Cauchi, about your background in general practice. When did you first start as a general practitioner?
A. About 40 years ago. I'm not completely sure of the exact date. I graduated from medicine. I did three years in a hospital, we travelled for a year, and then I came back and started work as a, as a doctor in Toowoomba.

Q. Have you worked--
A. So, I'm--

Q. Sorry, please go on.
A. I'm 70 now, so, yeah, 40 years ago.

Q. Have you worked your whole life in general practice in Toowoomba?
A. No, no. What my - initially when I came back to Toowoomba, I worked as a, as a psych registrar, and I did that for three years. And psychiatry wasn't really for me, so I moved into general practice, and my general practice was varied. I always did at least a day surgical assisting, which you wouldn't call that general practice, and I always maintained some sessional work in, in the hospital.

Q. Apart from--
A. So, I--

Q. Sorry, please go.
A. No, no you're right.

Q. Apart from - so do I take it that you did that work as a surgical registrar sometime in your 20s, very early on in your career?
A. No, a psych registrar.

Q. Sorry, I beg your pardon. I meant to say psych registrar. Was that very early on in your career?
A. Yes, that was my first job after we came back from our travels. So, it would have been - I'd have been four years out of uni.

Q. Approximately what timeframe are we talking, what years are we talking?
A. Are you talking dates or my age?

Q. Either will do.
A. Probably 28, 29, 30.

Q. We understand, or her Honour understands, that general practitioners assist members of the public with both their physical health and their mental health, but of course there are some specialists where general practitioners refer their patients to. Apart from those three years very early on in your career, have you specialised in any aspect of psychiatry or mental health?
A. No.

Q. Did you, in the course of your work as a general practitioner, assist a number of patients with respect to their mental health issues?
A. Yes.

Q. Did you manage a number of patients other than Joel who were suffering from chronic schizophrenia?
A. Not many. Perhaps three, maybe four, over the 40 years.

Q. Can I just come directly to Joel Cauchi then. In your statement - at tab 785 for my learned friends - you refer to your treatment of Joel from 2001 or thereabouts when he was - or you set out Joel's treatment and treatment plan from 2001 when Joel was 18 years old through to 2019 when he was 36 years of age, and that was the last time you saw him. Were you involved over the entirety of that period in Joel's general practice care?
A. Mostly. I don't have his record in front of me, but I think there was a period of time, perhaps three or four years, where he or his family chose to attend another GP.

Q. I see. In roughly what period what was that, what timeframe? For example, was it the period when he was seeing Dr A from 2012, or prior to that?
A. I think it might have been prior to that.

Q. I'll just take you through some--
A. But--

Q. Sorry, please go, Doctor.
A. But for the rest of the time in that period, he came to see me.

Q. Is it fair to say that you got to know Joel reasonably well in the course of treating him for over 15 years?
A. Yes.

Q. I'm just going to take you to some of the key documents. I'll be mentioning volume numbers or tab numbers. I won't trouble you with those unless there's an obvious need to, but for the benefit of my friends, at tab 788 we find a volume of documents which appear to relate to your care. They're the complete record from the Platinum Health Group. Can you just tell us what the Platinum Health Group is?
A. It's a, it's - Platinum Health Group is just a name. It's a group of GP practices. There's two practices - two separate practices in St Andrew's Hospital. One's called St Andrew's Medical Centre, that's where I work, and one is called Platinum on North - interesting name, but it's basically upstairs. There's another practice at Highfields, which is sort of like an outlying suburb. So, there's three practices. There was a fourth, but it - it's closed. So, in total, there's probably 20 plus GPs involved in Platinum Health Group.

Q. Where were you based, which--
A. I was at St Andrew's Medical Centre, and it's, it's on the ground floor of one of the buildings on the St Andrew's Hospital campus.

Q. Is that where Joel would come to see you?
A. Yes.

Q. Did you also, in the course of treating Joel, meet his parents, his mother Michele and his father Andrew?
A. I don't, I didn't - I don't think I've met his mum, but I certainly knew his father, yes.

Q. At some point in time, were you the treating practitioner for his dad Andrew?
A. Yes, yes.

Q. Over what years?
A. I'm not sure.

Q. Are you able to just give us a rough estimate?
A. It was probably for about ten years.

Q. Was that--
A. And, and--

Q. I'm sorry, Doctor, I keep interrupting.
A. And I - no, that's - and I, and I continued to see him after Joel left the practice.

Q. When was the last time roughly that you will have seen Mr Cauchi senior?
A. Probably 22.

Q. Was it for the decade leading up to 2022?
A. That's an estimate, yes.

Q. Can I come back to Joel. In relation to Joel, there's a letter that we have at page 148 of that volume, 788.

DWYER: I don't think that needs to come on the screen for the moment so that we can see the doctor, and I'll just read it.

Q. That's a letter to you. It's from Dr Nicky Stephens on 14 August 2002. She notes that she reviewed Joel that day:

> "He continues to suffer acute positive symptoms of schizophrenia at present. He complained of auditory hallucinations, distorted perceptions of his body, poor concentration and thought disorder".

She tells you that "At the moment we're gradually changing his medication from olanzapine to risperidone. Unfortunately, he had a poor response to olanzapine." She tells you what he's prescribed. She says at the end of that, "I spoke to mum today during the interview. She continues to be very involved in his care and is taking a proactive approach to learning all she can about

schizophrenia". So, there's a couple of things I just wanted to draw out from that. You understood that Joel had been admitted to the Toowoomba Hospital for his mental health following a first psychotic episode in 2001, and then he was managed in the public health system until 2012. You were engaged as his GP for most of that time, is that right?
A. Yeah, that's correct.

Q. This letter told you, didn't it, that he was still experiencing the symptoms of schizophrenia in 2002, and you understood that an experienced psychiatrist was involved in trying to work out the right medication and dosage for him?
A. That's correct.

Q. You would have appreciated from your experience and training that it is quite common, when you're dealing with persons suffering from schizophrenia, for there to be a period of time to identify what the right dose and medication is?
A. That's correct.

Q. The letter also told you that mum was going to be involved, a good source of support for Joel going forward?
A. Yes.

Q. At that time, I take it that given that he was managed in the public health system and had an experienced psychiatrist, you were happy to defer to them in relation to any diagnosis for Joel and the appropriate medication regime?
A. Yes, that, that would - that's their expertise. Yes, I would definitely have done that.

Q. And in terms of Joel's complexity at that stage, did you appreciate that he was somebody who was suffering from a very serious illness that required management from a specialist?
A. Yes.

Q. I'm obviously not going to take you to every single document, you'll be relieved to know, in your notes, but I just note that in 2003, for example, you received a letter saying that:

> "Joel was currently taking clozapine 500 milligrams at night. That had been gradually increased by Dr Stephens. He felt he had some improvement. He still had positive symptoms, auditory hallucinations. He was hearing frequent spirit voices in 2003 which were making some derogatory comments. And also negative symptoms, and it was very difficult to motivate him".

So, this was now a period of two plus years that Joel had been experiencing schizophrenia where the psychiatrists were trying to manage his symptoms. In terms of the patients that you manage with mental health issues, was Joel the most complex?
A. I don't know whether you'd say he's the most complex. He was complex.

Q. And I take it, again, he was someone who certainly required expert psychiatric management at that stage?
A. Definitely, yes.

Q. In your period as a psychiatric registrar, had you managed people with complex or serious schizophrenic illness?
A. Yes.

Q. You understood--
A. Yes, that, that, that would have been in a hospital setting with a, a, a consultant in charge of the patient. Registrars work under a consultant. And they obviously get to make some decisions, but all their decisions are reviewed.

Q. Do you understand what's meant by that terminology "treatment-resistant schizophrenia"?
A. Not really. That's - I would think that that - they're talking to an illness that's not responding to the treatment of it.

Q. We've heard some evidence about positive and negative symptoms of schizophrenia. Is that terminology you're familiar with?
A. Yes.

Q. When you were seeing Joel in between his psychiatric appointments, you saw him when he was in the public system and then you saw him after he moved to the private system in 2012, is that right?
A. Yes.

Q. And fair to say that you were responsible for managing his physical health needs in the same way that you would be for any member of the public? Coughs and colds and rashes--
A. That's--

Q. --and whatever he was presenting with?
A. Yeah, that's correct.

Q. What was your role - let's start with when he was in the public sector until 2012, what was your role in relation to managing his mental health?
A. I, I would have made note of any dramatic changes that were occurring, and perhaps, if I was concerned, contacted his treating psychiatrist. If, if he was reasonably stable, and happy, and compliant with his medication, I would be pretty happy with that.

Q. We understand that in order to get a referral to a psychiatrist, the general practitioner's role is to make that referral? To write a letter referring someone to a psychiatrist?
A. That's, that's, that's correct.

Q. So, by the--
A. It, it would depend on how urgent things were, and often the patient had

some input into who they wanted to see--

Q. Sure--
A. --because at, at - you might provide the referral, but the patient might take the referral from the rooms and organise their own appointment. So, it's - yeah.

Q. Let me stay on this first phase of treatment that Joel had when he was in the public health system. Starting from - your involvement was at least from 2002, and you saw him until the time that he was discharged from the public system and went to the private system, although there were some years when he went to a different general practitioner. During that period of time that you were seeing him as his GP, would you expect to have regular updates from the psychiatrist in the public health system?
A. Yes. I, I would have expected to have some form of correspondence from the specialist every single time they saw them - they saw the patient.

Q. That's regardless of whether they're in the public or the private sector, is that right?
A. Correct.

Q. In terms of determining what is the appropriate medication regime and at what doses, you would rely on the psychiatrist, obviously?
A. Yes.

Q. But when you were seeing Joel on a routine basis for any general health needs, if you noticed something different, you would be reporting that back to the psychiatrist, correct?
A. Yes.

Q. And alternatively, if the psychiatrist noticed any change in Joel, or if he became non-compliant, or if there was anything significant to report, you'd expect a letter back or a phone call to you, is that right?
A. Yes.

Q. Just taking the public sector consultation again. At tab 788, page 159, we can see in our records a letter to you, on this occasion from Dr Ursula O'Sullivan, who was a locum consultant psychiatrist, and Dr O'Sullivan says to you that the diagnosis is schizophrenia with features of OCD. The medication at that time was clozapine 600 milligrams at night, aripiprazole 10 milligrams in the morning, and he was also taking some vitamins. Had you, at any time prior to this, managed a patient who was taking clozapine for treatment of their schizophrenia?
A. Not privately. Perhaps when I was working as - no, I don't think, I don't think clozapine was available 40 years ago when I was a registrar. So, no.

Q. In terms of your private practice, did you manage any other patients other than Joel who were on clozapine?
A. It's - some of the patients at, at the hospital where I do sessions, they were on clozapine.

Q. What about in your general practice?
A. No. Joel was the only patient I had any experience of with clozapine.

Q. And were you--
A. In the, in the general practice.

Q. --were you responsible for monitoring Joel's blood levels, the plasma levels, after he started on clozapine, either when he was in the public or private sector?
A. No.

Q. Did you understand that for a patient to be put on clozapine, the first line of psychotropics of antipsychotics must not have worked?
A. Can you repeat that?

Q. Sure. I'll ask it slightly differently. Did you understand that for a patient to be put on clozapine, they must be suffering a serious form of the illness schizophrenia that did not respond to--
A. Yes.

Q. --first line antipsychotics?
A. Yes, I think. Yes.

Q. Dr O'Sullivan in this letter says - reminding you again, this is March 2008 - she reviewed Joel at the clozapine clinic. She also had the opportunity to speak with his mother. By Joel's account, he is doing relatively well. He continued to live with his parents, and he was doing one paper of his arts degree per year. She says that:

> "He has occasional auditory hallucinations, which he describes as 'thoughts', and ongoing difficulties with obsessive compulsive symptoms. At present, his OCD focus is needing to complete a ritualised prayer in response to certain thoughts that come into his head. By his account, this was taking up less than an hour per day".

And she goes on to talk about managing the side effects. So, it would have been evident to you - this is 2008, seven years after he started his treatment, and there were still some positive symptoms of Joel's illness that he was grappling with that were being managed?
A. That's correct.

Q. So, it was evident to you that this was a serious, long-lasting form of the illness schizophrenia?
A. That's correct.

Q. Appropriately described as a chronic illness for Joel?
A. Yes.

Q. I'll just read, in your notes around that same place, there's a letter from Michele Cauchi. It says, "Hi, Dr Grundy. Joel is a bit concerned that he will forget to ask you some questions, so I have written you this note". And she goes on to write a number of things about his physical conditions. And at the end--
A. Yeah.

Q. --she says, "Please note that if he does have any antibiotics, et cetera, that he is on clozapine. Also, you might want to add to his file that he has now developed obsessive compulsive disorder". I'll just pause there. Was it evident to you from a very early stage that Joel's mother Michele was very engaged in his treatment plan?
A. Only, only from the two letters that you've talked about. I, I, I don't - I didn't have any contact with his mum to sort of make that sort of appraisal, I would think.

Q. When Joel came to the GP practice to see you, he came independently, is that right? Did he bring himself, or did he come with his dad?
A. No, no, no. Joel - I, I considered Joel to be a pretty bright guy. And he made his own appointments, and he usually kept them. He was punctual. He - even though he was a quiet, reserved guy, he still could talk fairly freely about whatever problem or concern he had. He was - he accepted investigations. Usually followed through and had them, followed, followed up the results. And he was compliant with treatment, antibiotics and that kind of thing. So, I think he was independent in his making the appointment, keeping the appointment, and I think he, he did that reasonably regularly. If he had any concerns, I think Joel usually sought out someone to talk to about it.

Q. I think the last time you saw Joel was in August 2019, according to your notes. Does that accord with your understanding?
A. Yes.

Q. So, in your first statement, you say, "Joel was always polite and compliant with all treatment offered". Are you referring there to the entire time that you saw him, from when he was in the public sector and through to the private sector in August 2019?
A. Yes. Mostly for the entire time I, I, I knew Joel, he was compliant with treatment offered.

Q. I think then, given that you saw him in August 2019, but for the last two months, for the entire time that you saw Joel, he was medicated on some form of antipsychotic?
A. That's correct.

Q. I'm going to turn now to the period there Joel was managed in the private sector. In your records at page 220, if you'll take it from me - and if you need to see any of these documents, please let us know and we'll try to put them on the screen--
A. Okay.

Q. --at tab 788 page 220, there's a referral letter dated 20 February 2012. It's written to Dr A, and it says:

> "Thank you for seeing this 28 year old patient for treatment and management. Joel has been attending the clozapine Clinic for the past eight years. He's reasonably well and compliant with treatment. Please assess and treat as appropriate".

And Joel's condition, as described by you then, is "schizophrenia and obsessive compulsive disorder". I just want to get a snapshot of Joel's condition as at that time. I take it that you were basing that diagnosis on the information you'd received from experienced psychiatrists over many years, by this stage?
A. That's correct.

Q. Is it fair to say this - please correct me if I'm wrong in any of this - that Joel had a chronic condition, that is schizophrenia and obsessive compulsive disorder, and that he had experienced a first episode psychosis in 2001? Am I right so far?
A. Yes.

Q. He had continued to experience some positive symptoms of the schizophrenia, for example in 2003 and 2008?
A. Yes. That's correct.

Q. Did he continue to experience any negative symptoms of the diagnosis of schizophrenia as at around 2012?
A. I think you'd have to put that question to the psychiatrist.

Q. I'll defer to the psychiatrist--
A. I, I, I don't know, is the honest answer.

Q. You understood that he needed ongoing management by a specialist psychiatrist after he was discharged from the public sector?
A. That's correct.

Q. Did you know Dr A in 2012?
A. No. Not really.

Q. Do you know how it was that Joel came to be referred to her?
A. No.

Q. At page 221, there's another letter to you from Michele Cauchi, Joel's mum. She says:

> "Dear Dr Grundy, Joel has been a client of the clozapine clinic at the hospital for a number of years now and at his last monthly visit, he was given the option of seeing a private psychiatrist, Dr A, from The practice in Street."

And then she's asking for a referral from you, which you attended to?
A. Okay.

Q. You got a letter back from Dr A, and she confirms the diagnosis. She writes, "Chronic paranoid and disorganised schizophrenia, in control on Clopine", and she sets out her plan in that letter. That was a standard follow-up letter that you would expect to receive from someone who's taken on his care?
A. Yeah. That's correct.

Q. She also says in that letter that she will "continue his Clopine and Abilify and explore possible adjuncts". She said she believed "he will need some CBT for his OCD to address his low social confidence and avoidance behaviours". Are those types of characteristics - low social confidence and avoidant behaviours - are they appropriately described as negative features of schizophrenia?
A. Yes. Yes.

Q. And she says that she would refer him to Dr Paul McQueen, a psychologist. He was his case manager at the mental health service. Did you know Paul McQueen?
A. No.

Q. At that time, in terms of Joel being taken over by the private sector, did you think that it was going to be a good system where he would have a psychiatrist, a psychologist and mental health nurses involved in a holistic care team, with you as the general practitioner managing the physical health?
A. Yes.

Q. I won't put all these letters on the screen, but if you could take it from me that from that time on, there are fairly regular letters going to you to indicate that Joel--

HER HONOUR: Just one moment.

DWYER: Sorry.

HER HONOUR: Dr Dwyer, we'll just make sure we haven't lost Dr Grundy. Still connected?

Q. Can you still hear us?
A. I can still, I can still see you. I can still hear you, and see you.

Q. All right. We've just lost your image for the moment.
A. Yeah the, the image - yeah, the image is sort of - people's faces are jumping around a bit, but everybody's there.

Q. Okay. Well as long as you can still see and hear us, we might just continue for now.

DWYER: In that case, I might just put this on the screen if we're not seeing the doctor. Just by way of example, page 253, tab 788.

Q. Can you tell us, Dr Grundy, if we put this letter on the screen, is it something that you can see?
A. Yes. Yes. I was going to say you disappeared, but no, the letter's there now.

Q. Excellent. Terrific. Do you see that that's a letter to you from Dr A? She outlines what the medication is, and she says:

> "Just a brief note to let you know that Joel has been doing extremely well despite a slow reduction regime of his Clopine in order to find the optimum dose for himself that prevents relapse. Currently, he is on 375 milligrams at night and from tonight he'll go down to 350 milligrams. Will do more intensive monitoring and social skills training. His mother is closely involved in his care and monitoring."

Just pausing for you to reflect on that.
A. Okay.

Q. Am I right to say that that letter would give you comfort: that there's a qualified psychiatrist who's engaged in his care, she's working on finding the optimum dose of Clopine, and Joel's mum was closely involved in his care and monitoring him?
A. Yes. I would've been confident that things were going along well.

Q. So in terms of what your obligation is as a general practitioner, is it fair to say that you can focus on any of Joel's physical needs and doing anything practical, like writing the referral letters, but his mental health is firmly in hand, in terms of psychiatric care?
A. That's - yeah, that's correct.

Q. And you're being informed there from his psychiatrist that mum is involved in the monitoring practice as well?
A. Yes.

Q. It's comforting, also, that Joel has good supports from his family and that family members are in touch with the private psychiatrist?
A. Yes.

Q. If you could take it from me that there are further letters sent to you in 2014 and 2015 about Dr A reducing the Clopine - and just for the benefit of my friends following it, they're at page 260. There's a letter from 8 May; a letter from 30 July at 268; 17 December 2014, 271; 14 January 2015 which appears at page 281. So there's a fairly regular stream of letters going from Dr A to you reassuring you that titrating the dose down is going well?
A. Yes.

Q. And I take it that you just deferred to her expertise in that regard?

A. Yes.

Q. Was it your practice to have telephone conversations with Dr A, or to rely on the letters generally?
A. Rely on the - yeah, generally rely on the letters.

Q. When would you have expected to receive a phone call, if at all?
A. If, if perhaps she'd written a letter and wanted to amend it, or something, you might get a call from a specialist then. But generally not.

Q. If the specialist had any concerns about a patient, would you expect to get a phone call from them, if there was anything urgent?
A. I think if in her meeting with Joel she thought he had some physical illness that needed prompt assessment and care, I, I'd expect a phone call.

Q. Would you expect a phone call if there was any significant deterioration in his mental health that she was concerned about?
A. I would, I would hope that if she was assessing Joel and things were changing, that you'd get a more detailed letter, not a phone call.

Q. In relation to specialists contacting you, was it your practice to make a note yourself in your records if you ever got a phone call from a specialist?
A. Yes. Always.

Q. Can I just come to one change in 2015, and I'll put this on the screen again. It's page 287 of tab 788. Dr Grundy, can you see that on your screen?
A. I can see it, but I don't think I can read it.

Q. No. It's blurry that one, isn't it? I'll just read to you--
A. Yeah.

Q. --the main sections of it. It says, "Dear Richard" - that's you, Dr Grundy:

> "Thank you for the re-referral. Joel's been well for some time, despite a gradual reduction of his Clopine which was reduced from 600 milligrams at night to 275 milligrams at night with continuation of Abilify 5 milligrams in the morning."

She sets out some of the history, and then she says:

> "With the advent of Nicky" - that's Dr Nicky Stephens - "coming to private practice, I've approached her to give a second opinion regarding Clopine. What would be his optimum dose? Could we switch him to another medication, for example, optimum dose of Abilify? I do believe Joel needs an antipsychotic for a long-term relapse prevention. Both Joel and his mother consented to me asking for a second opinion from Nicky, and Nicky's agreed to see Joel."

So your role in that was to write a referral letter to Dr Nicky Stephens

requesting a second opinion. Is that right?
A. I--

Q. Just before you answer that--
A. I would--

Q. Sorry, Doctor, just pause for a second, if you will. Before you answer that, can I ask you to have a look at page 288, just in fairness, because you don't have the documents there.
A. Yeah.

Q. You then write Dr Nicky a referral letter as requested?
A. Okay. Yeah. I, I got the impression from the first letter that Dr A was going to do the referral letter. Specialists can do referral letters to each other, it's, it's just a little bit time-based. Whereas a GP referral letter lasts a bit longer.

Q. I see. You do exactly what was requested of you in writing this letter to Dr Nicky. I just wanted to point out some features of the letter written to you. It was clear from the letter that what you were being asked to do was to write a second opinion in relation to finding the optimum dose and the best medication for Joel, but his psychiatrist at that stage indicated that she believed Joel did need an antipsychotic for long-term relapse prevention?
A. Yes.

Q. Did you form a view of that yourself? That is, did that accord with your view, or would you then just defer to the specialist?
A. I would've deferred to the specialist.

Q. Was it part of your understanding, in terms of an appreciation of the complexity of his mental health, that he would be likely to continue to need an antipsychotic in the long term?
A. Yes.

Q. You then have, in your records, the letter that came back from Nicky Stephens. That's at page 289 of your records. Can you read that one okay, Doctor?
A. It's a bit better. Yes.

Q. Just so that everybody following can understand it as well, this comes back to you from Dr Stephens, and we looked at this yesterday and the day before with Dr A, but what it says is: "Thank you for referring Mr Cauchi for a second opinion regarding his clozapine medication and his treatment of schizophrenia." She sets out some of the history, and she makes a note in that second paragraph that "his psychotic symptoms did not resolve with risperidone or olanzapine medication, and he was readmitted to be established on clozapine."
A. Okay.

Q. At the end of page 1 going onto page 2 of that letter she says:

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

And then this is the paragraph I want to ask you to reflect on. She says:

> "I have discussed with Joel and his mother today the potential risks and benefits of stopping clozapine medication, the risks of relapse of positive symptoms and also potential exacerbation of negative symptoms, and the attendant impairment in functioning and disruption to his ongoing study and lifestyle. The benefits of a trial off clozapine would be to reduce the ongoing risk and positive side effects such as neutropenia, et cetera, and to determine whether his illness is manageable on a less complex antipsychotic medication such as aripiprazole for the longer term".

I'll just pause before we finish with that letter. Was it your practice to read the letters that came in from specialists such as Dr Stephens?
A. Always.

Q. So, you will have read that and digested what Dr Stephens was saying in terms of Joel's ongoing care?
A. Yes, yes.

Q. It would have been evident to you that there were risks in what was proposed in terms of reducing the clozapine and that they had been explained to Joel and his mother?
A. Yes.

Q. And that they were also then going to be clearly understood by the psychiatrist who was treating Joel, Dr A?
A. Yes.

Q. Was it your view that they would then be carefully monitored going forward to determine if Joel did exhibit any risk factors?
A. Yes.

Q. What Dr Stephens goes on to say is that:

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

Would you agree with a proposition--

A. Yes.

Q. --that Joel's - I withdraw that. I appreciate that you were relying on the experts, but that would have made sense to you as his general practitioner, that Joel himself didn't have much recall about when he became acutely unwell, and there was a need to place an emphasis on what the family said in that regard?
A. I'm not going to - I'm not sure; I think that's - it's fair enough. I think Joel certainly could express when he had - when he did have the positive symptoms, he could verbalise about them, he could tell you about them.

Q. You would defer to the opinion of Dr Stephens, wouldn't you, in relation to whether or not Joel had much memory of his positive psychotic symptoms?
A. Yes.

Q. If you had been told that Joel's mother had concerns about his risk of relapse or his positive symptoms, would that have been something you placed weight on?
A. Yeah, I, I'd have to - I, I would put - yes, I would place some weight on that. I think if Joel's mother had ever called me and, and was concerned, you'd have to be very sympathetic and deal, deal with that, with her distress and try and formulate some plan.

Q. In terms of, I think I'll take you to some symptoms that Joel experienced that were not passed on to you. We covered off earlier that in the period that you saw Joel, which is up from about 2002 until August 2019, Joel was medicated for that entire time but for the last two months, or but for the last month, I think, is that correct?
A. That, that seems to be correct, yes.

Q. For that period of time, you did not notice any positive symptoms of schizophrenia in Joel, while he was medicated?
A. Only - I, I sort of can reflect and remember looking back over the notes. I think I made some notes very, very early in his illness that - when he was talking about some of his positive symptoms, but apart from that, no, he was reasonably symptom-free.

Q. Joel's positive symptoms when he had the first acute episode of psychoses included aggression and hearing spirit voices, that is auditory and hallucinations, correct?
A. I, I remember the auditory hallucinations. I don’t - I, I didn't have any experience of Joel being aggressive.

Q. No, I understand that, but I'll just say - I'll ask it in a slightly different way. If you can accept from me that when Joel was first admitted as an inpatient in 2001, his positive symptoms of the psychoses included acts of aggression, hearing spirit voices, and so there were auditory and visual hallucinations, if any of those positive symptoms had been reported to you during the period that you were seeing Joel, you would have been concerned, wouldn't you, about the risk of relapse?

A. Yes.

Q. You understood after receiving this letter from Dr Nicky Stephens that Joel was still to be managed on antipsychotic medication going forward?
A. Yes.

Q. And that he would be carefully monitored for signs of a risk of relapse, correct?
A. Yes.

Q. And that his family would be involved as part of that monitoring process?
A. Yes.

DWYER: That can come off the screen now,

Q. We'll see if we can see you again. No, we can't for the moment. Yes, we can. Some other members of the family have come in to see you, so I'll just note again. This is Dr Richard Grundy. You're coming to us from London, and you have given evidence at the beginning of the day that you've retired as a general practitioner, but you're still working in the hospital system in Toowoomba, is that right?
A. That's correct.

Q. I'll jump forward after 2015, and if you can accept from me that there are further letters in the brief of evidence from Dr A to you after that second opinion was obtained. They are 21 October 2015, that's page 291; 13 January 2016, page 308; 6 April 2016, page 314; 29 June 2016, page 320; 21 September 2016, page 328; 14 December 2016, page 340. And they all refer to Joel doing well in circumstances where his Clopine dose was being titrated down. In 2014, the letter that you wrote for a second opinion was about reducing Clopine and investigating what the best dose of antipsychotic medication was in circumstances where Joel was going to remain on antipsychotics long-term. Can I show you this document at page 340? It's a consultation record sent to you from the Clopine clinic. That might be difficult for you to read. It's dated the 14th--
A. Yes, it is.

Q. I'll just read it to you. It's dated 14 December 2016.

> "The impression that Dr A has is that schizophrenia is sustained full remission on treatment. Plan: continue with clozapine discontinuation. Cut the dose down."

At some point, the goal for Joel shifted to taking away Clopine or clozapine altogether. Still appears that he was going to be on some form of medication. Was that discussed with you specifically in any way other than receiving this letter?
A. No.

Q. And fair to say that you would defer to the expert psychiatrists who were

involved in that?
A. Yes.

Q. It appears there there's a suggestion of ceasing Clopine, but there's no suggestion of ceasing all medication altogether. Do you agree with that?
A. Yes, yes.

Q. So again, if you can take from me rather than putting all these up on the screen, there are further letters from Dr A. 8 March 2017, there's a letter from Dr B, and other psychiatrists, that's page 344. 27 July 2017, page 356. 19 October 2017, page 371. 11 January 2018, 384. 24 January 2018, page 385. All these letters that were being sent to you indicating a slight reduction in medication levels would have suggested to you that Joel was being carefully monitored by the psychiatrist and the team of nurses at The practice. Is that right?
A. Yep, that's correct.

Q. During that period when Joel was on medication, you didn't notice anything unusual when he was coming in to see you for various things, coughs or colds or rashes or whatever general issue might be?
A. No, no, his - he, he, he remained pretty much as usual.

DWYER: Can I just have on this screen a letter from 24 January 2018, that's page 385.

Q. That's a letter to you. You'll see I'm just trying to give a snapshot of Joel's presentation over the years?
A. Yes.

Q. Dr A writes to you, "Seen with mum", that is that she's seen Joel with his mum.

> "Mentally excellent but physically tired, fatigued. It's been an ongoing problem not getting better with Clopine discontinuation but maybe worse. Chronic fatigue is always aggravated by cold or flu, talks about him fainting".

And the plan at that stage is "Continue with Clopine at night, Abilify in the morning, ask to see Dr Grundy re chronic fatigue"?
A. Yes.

Q. At that time, the impression given to you by the psychiatrist is that he's mentally excellent and there's a plan at that stage to continue with some form of antipsychotic medication. Correct?
A. Yes.

Q. The impression given by that letter is that the The practice psychiatrist was paying careful regard to Joel and that his mum was still involved in his treatment. Is that fair?
A. Yes.

Q. You see Joel in March 2019 and that appears in your documents at page 4 on that same tab. This is a couple of months after the report in relation to fainting, and the notation there is "Dr Richard Grundy, request plan" - this is Joel - "Request plan to access psychology to get some counselling. Checking out options, will think about this".

MATHUR: Sorry, I think there's some confusion there. That's jumped forward to a consultation note a year later.

DWYER: I beg your pardon.

MATHUR: There is, in fact, a corresponding consultation note that follows the letter that Dr Grundy was just shown and that consultation note is on p 18, and it's dated 2 February 2018.

HER HONOUR: Thank you.

DWYER: Not p 18.

MATHUR: Sorry, I'm working from tab 788A. There's two tabs, your Honour, with respect to the consultation notes of Dr Grundy. There's an incomplete record behind tab 788, and then there is a complete record behind tab 788A.

HER HONOUR: Thank you.

MATHUR: So, in capital A, it's p 18.

HER HONOUR: Thank you.

DWYER: Can you get that on the screen?

Q. Can you see that note?
A. I - you're scrolling up and down through various notes. I'm, I'm not sure which one you're talking about the moment.

Q. I'll just read it to you. On 2 February 2018, Joel came to see you. "He reported fatigue, low energy levels, can't maintain activity. Recent bloods were okay, and he had no joint pain". So, you saw him after the letter came through from Dr A in relation to his fainting?
A. Yes, and all those tests sort of looking for inflammatory problems or viral illness.

Q. Were you able to identify anything specific that was the cause of the fatigue?
A. No.

Q. It's fair to say that for the most part while Joel was seeing you, he slept well?
A. Yes.

Q. Did you understand that whether or not a patient in his condition was getting good sleep was a relevant factor in terms of risk of relapse?
A. I think you'd have to ask the psychiatrists.

Q. All right.
A. Whether it was a relevant risk. I think everybody needs to have reasonably good sleep.

Q. Sure.
A. Or, you know, uncomfortable things can happen.

Q. In terms of you seeing Joel day to day for any physical health issues, what signs or symptoms would you be looking out for, or what would worry you in relation to a relapse?
A. I would think his demeanour, his dress, his speech, how he presented in the room, if he had unusual behaviours or was agitated or aggressive. I don't think I saw anything like that with Joel. Or if he was distracted and appeared to be perhaps, you know, hearing voices and, and not communicating with you when he was sitting in the room.

Q. If he had--
A. Things like that.

Q. If he had a strange gait or held himself in a particularly strange way, would that be a warning sign?
A. I don't think so.

Q. You would have expected the psychiatrist to raise with you any concerns that she had if she thought that sleep or stress might impact on his mental health?
A. Yes.

Q. Can I just come back then to the presentation of Joel in 2019, if I can jump to that last year. On 14 March 2019, Joel comes to see you, and he asks for, or there's a reference to a request to see a psychologist. Do you recall that presentation now?
A. No.

Q. Do you recall any change in Joel's presentation to you in 2019?
A. No.

Q. Joel was weaned off clozapine by July 2018. Did Dr A ever contact you, by phone or otherwise, to discuss any risks or warning signs of coming off clozapine?
A. No.

Q. Joel was then removed from any antipsychotic medication altogether by July 2019. Did Dr A ever contact you around that time by letter or phone or otherwise to discuss any risks--

A. No.

Q. --to look out for?
A. No.

Q. There are only a couple more entries that I want to take you to from your records. I'm still going to work off tab 788 - someone can suggest the 788A reference if necessary - but it's page 5 of that document. December 3, 2018 - so this is while Joel is still on some form of Abilify - there's a note from you that he continues to see a psychiatrist and he's on a small amount of medication. Above that it says, "varication of illness". Is that just a typographical error, or does that mean something, the "varication of illness"?
A. No, it doesn't mean anything to me.

Q. Okay.

HER HONOUR

Q. You see it's a Centrelink form requirement, I think.
A. Yes, the line above. "Needs Centrelink form".

DWYER

Q. Yes. It says--
A. For--

Q. --"varification" - should it be--
A. Verification of illness. So, it must have been - I must have been doing a Centrelink form for him to access a disability pension. I can't recall really.

Q. Okay. You'll see I took you earlier to the note from March that he requests a plan to access psychology to get some counselling. You can't refer to anything specific in March 2019 that suggested a change in Joel?
A. No.

Q. Joel was weaned entirely off all medication by July 2019. You've told us earlier that Dr A did not contact you in relation to any possible risks to look out for, or side effects. You were never asked to write a referral letter for a second opinion in relation to removing him from all medication, is that right?
A. That's correct.

Q. Have you reviewed your notes in relation to the times that you saw Joel after July 2019 when he was taken off all medication?
A. Yes.

Q. Excuse me one moment, Doctor. I think I'm right then that you saw Joel for the last time in August 2019, that's correct?
A. That's correct.

Q. Joel was seen by some of your colleagues after that time. Is there a

reason why you didn't see him after August 2019?
A. Well, Joel was always able to make his own appointments, so I would think - and when I saw him in August 19, I thought he was reasonably well and stable. So, he was directing his own appointments. So, I don't know whether - what reason there was that I didn't see him after that, other than he chose to go somewhere else.

Q. He saw one of your--
A. He, he--

Q. --colleagues - sorry, Doctor, I spoke over the top of you.
A. No, he, he was, he was - patients and Joel are always free to select the doctor they want to see. Joel, when he rang the, the clinic, if I wasn't available, I would think the receptionist would have offered him an appointment with one of the other GPs. And certainly Joel accepted those appointments on numerous occasions and saw lots of the GPs in the practice. So, I don't think Joel was particularly dependent on me, like if he didn't - couldn't get an appointment with me he wouldn't see someone else. So, he went and saw other doctors, yes.

Q. As far as you were concerned, when you last saw him in August 2019, there was nothing to worry about in terms of his mental health?
A. I thought he was reasonably stable and well, yes.

Q. You also would have thought that he was being closely managed at The practice as he had been since 2012, is that right?
A. Yes, yes, he was still having regular follow up in 2019.

Q. Did you regard yourself as Joel's treating general practitioner?
A. Yes.

Q. So in spite of the fact that Joel could make an appointment with anybody at your Platinum Health Group GP practice, you were his primary GP?
A. Yes.

Q. If he'd seen another general practitioner and they had noticed anything particularly concerning, would you have expected that to be drawn to your attention?
A. Yes.

HER HONOUR

Q. Just to be clear, it looks like you saw him, Doctor, twice in August. I think it was 16 August 2019 and then 22 August 2019?
A. You'd have to pop that up on the, on the screen for me.

Q. That's what it looks like from the records, yes.

DWYER: That's right.

Q. And that was for, just for viral infections, I think.
A. Okay.

HER HONOUR

Q. But you would have made a note if you thought that there was something seriously wrong?
A. Definitely.

DWYER

Q. After that time, we've got a note from your colleague, Dr Susan Dragone. Do you recall that general practitioner?
A. Yes.

Q. Had you seen Joel after - there's a particular note from 21 November that may be relevant, and 25 November - had you seen Joel after that time, would you have reviewed any notes taken by your colleagues to--
A. Yes.

Q. --see whether or not they were relevant to Joel's healthcare?
A. Yes.

Q. I'll come back to those shortly then, but I want to take you to a notation that you may or may not have received in relation to Joel's discharge. Joel was discharged from the practice on 19 March 2020.
A. Discharged from which practice?

Q. Sorry, Joel was discharged from Dr A's practice in March 2020.
A. Okay.

Q. And you've written about this in your supplementary statement?
A. Yes.

Q. Do you recall now sitting there being informed in any way in relation to Joel being discharged from Dr A's practice?
A. No.

Q. Do you recall when you found out that Joel had moved from Toowoomba to Brisbane?
A. Ask that again, please?

Q. Do you recall when you found out that Joel had moved from Toowoomba to Brisbane?
A. I think I found out when that, that discharge note came to the practice.

HER HONOUR: Can we get that up on the screen?

DWYER: Yes, we're doing that now. Tab 788A, p 48. It also appears in The practice documents at 136.

Q. Can you see that, Doctor?
A. Yes.

Q. If we could just scroll up, we can see the date of the letter, 19 March 2020?
A. Yep.

Q. Addressed to you?
A. Yes.

Q.

> Dear Richard, I've received advice from Medicare regarding the parameters of the Skype eligibility. Unfortunately, Joel has now moved - has moved recently and currently resides in an ineligible Skype area, and as such I'm no longer able to offer Skype appointments. My receptionist has contacted Joel to advise of this change. Joel has indicated that he will be unable to attend face to face appointments with me due to the distance to travel for the appointments. I'm therefore discharging Joel back into his and your kind ongoing care. Please recall Joel to discuss his options and referral to an alternative psychiatrist if required. In the future, should Joel move into a Skype eligible area, or wishes to see me for face-to-face appointments, I will be happy to, however I will need a new referral for that".

There's a stamped box at the bottom of that page?
A. Yes.

Q. Can you tell us what that is?
A. It's a stamp the receptionist puts on all the correspondence that comes in, and I acknowledge that I've read it by that little squiggle signature, and I tick "scan" to make sure that the document or letter is placed in Joel's file, or the patient's file.

Q. Does it have a date there to indicate when you read it?
A. No, I don’t think so.

Q. All right. Just thinking about--
A. I, I would get those letters at, at the end of every day.

Q. Just thinking about your practice, was it your practice to read those letters at the end of every day when they came in?
A. Yes.

Q. By this stage - this is March 2020 - Australia's just grappling with the COVID virus, you hadn't seen Joel since August 2019, and you understood that he'd been taken off all medication a month earlier. Did you have any concerns for him at that stage in terms of the risk of relapse?
A. No. When I saw him in August 19, I thought he was well, and I, I wasn't

concerned. I didn't have any evidence to be concerned that anything untoward was happening.

Q. I took you earlier to a letter from 2015 that had come back from Dr Nicky Stephens, where Dr Stephens referred to the risk of relapse in the event that there was titrating down of his dose of Clopine. Was that in your mind at any stage at that time?
A. No.

Q. I'll come back to that shortly. But you were aware, aren't you, that Dr A has given evidence that she had a phone call with you after this letter? Before I come to that, looking at the letter itself, was there anything in that letter that gave you any indication that Joel might not be doing well, in terms of his mental health?
A. No.

Q. Was there anything in that letter that gave you the indication that Joel would definitely need ongoing psychiatric review?
A. No.

Q. Was there anything in that letter that raised any concern about the urgency of ensuring follow-up for Joel?
A. No.

Q. Was there anything in that letter that gave you the view that, even if it wasn't urgent, Joel would need follow-up from a psychiatrist at some stage in the future?
A. I think the - she said "referral to a psychiatrist if required".

Q. In what circumstances would you have thought it was required?
A. If Joel reported symptoms, if he had concerns about himself or his health. He'd have to present.

Q. You would appreciate, wouldn't you, that if a patient is becoming unwell, they might not be able to recognise themselves what the symptoms are?
A. That's correct.

Q. Dr A gave evidence that she telephoned you after sending this letter, and I'll just read to you some of the evidence that she's given over the last couple of days. She says - this is for my friends - at transcript 972.6 from Monday. She said:

> "Dr Grundy is a very, very good mental health professional too. He looked after Baillie Henderson Hospital, so he knows about mental health. And that's why I talked with him on the phone and said he would recall him. He would discuss it with him. And that's why I felt totally, totally relieved".

She said:

> "I said in that phone call, unfortunately I wanted to follow him up, but there was no rebate, and he totally understood it. And he said, 'Can I send it back to you? I will send it back to you'. And he said, 'Yes, I'm the family GP. I know him very well, and I will do my best'".

She said, "I called him on the phone, and we had a chat". That's transcript 1018. At transcript 1024 she said this:

> "I always call the GP. And then it 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, it was - or it the receptionist who organised the phone call, it happened and I clearly remember. 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 received my letter".

So, I want to break down that evidence a little bit. Firstly, would you regard yourself as a "very good mental health professional"?
A. No. I'm a GP.

Q. Is it fair to say that you looked after the Baillie Henderson Hospital so you know about mental health?
A. No, that's not accurate. My sessions at the Baillie Henderson Hospital, I look after a ward of elderly, intellectually disabled men and women, aged between 60 and 80.

Q. So, nothing to do with managing complex patients who suffer from chronic schizophrenia? Is that fair?
A. That's correct.

Q. The doctor says that she remembers this phone call, and during the phone call, you said, "I'm the family GP. I know him very well. And I will recall, and I will do my best". Was there any such phone call?
A. No.

Q. Why are you so clear about that?
A. If a specialist had a phone consult with me, I would have opened the patient's file, and made note of their concerns, and there's no record of that phone call in the file.

Q. Did you regard yourself as the family GP for the Cauchis?
A. I looked after Joel and his father. I don't know whether that - I, I don't know why she's using the word "family GP". I think, all GP's are family GPs. We look after families.

Q. Would you have described yourself to her as the family GP?
A. No.

Q. And if you had said to her, "I know him very well. And I will recall, and I will do my best", would you have then recalled Joel?
A. Just ask that again. I'm not sure what that means.

Q. What Dr A suggests is this. That you said to her on the phone, "Yes, I can take Joel back. I am the family GP. I know him very well. And I will recall, and I will do my best". If you had held that out and made that promise, would you have done it?
A. Yeah, that statement doesn't make sense to me, really.

Q. Why's that?
A. I - certainly, I suppose in an ideal situation, if Joel was living in a different city and he became unwell, and he recognised that he was becoming unwell and he came back to his family, and he, he made an appointment, I'd certainly see him and assess him, and make whatever referrals were required.

Q. Just finally in respect to what Dr A said, she said at transcript 1024:

> "I remember very clearly that Dr Grundy said, 'I'm his family GP and 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 to him about refer to another psychiatrist".

Does that refresh your memory, or did that not happen?
A. That - no. That did not happen.

Q. Dr A said, at transcript 1024, "There were many times when he had a physical problem I rang him" - so, she's saying "There were many times when Joel had a physical problem I rang Dr Grundy, and he made an appointment to see him with a medical problem". Can you remember any occasion when Dr A telephoned you?
A. No.

Q. I've asked you some questions already - I'm coming to the end of my examination, Doctor. I've asked you some questions already about the role that Michele Cauchi played in assisting her son over the years. I've referred you to two letters she sent you. Mum is referred to by Dr Nicky Stephens as someone who is well placed - or that, sorry, the family are well placed to advise the doctors about whether or not he's experiencing the symptoms of relapse. And Dr A sent you letters in which she referred to mum, and mum's role in monitoring Joel. Can I ask you to consider this scenario. I'm not suggesting this happened, but can I ask you to consider what you would have done in this scenario.

If you had been told by Dr A in a letter or phone call that from October 2019 through to February 2020, Joel's mother had contacted The practice and expressed her concerns that Joel's mental health was declining after he was weaned off medication. Would that have been something you would have paid attention to?
A. Yes.

Q. If you had been told that in November 2019, a couple of months after Joel was taken off all antipsychotic medication, the reports from his family that Joel had changes in his behaviour, extreme OCD, writing a lot of notes at home and leaving them about with content of satanic control, of religious themes, of desire for porn, that there was a change in his gait, and that he was possibly hearing voices, would that be something that would have made you very concerned about a decline in Joel's mental health?
A. Yes.

Q. If you'd been told that on 14 February, Joel's mother contacted the clinic again and said that she thought he was hearing voices, he had poor self-care, and he had increased aggression, would you have been concerned that these were symptoms of a relapse into his psychotic condition?
A. Yes.

Q. If you had been told, or if you knew then that in fact Dr A had only seen Joel once after that, on 17 February by Skype, would you have been concerned to make sure that Joel did have a psychiatrist going forward? That is, that there was another referral?
A. Yes.

DWYER: Those are my questions, thank you, your Honour.

HER HONOUR: Can I just get the letter back up on the screen, the discharge letter of 19 March 2020?

Q. You see that letter, Doctor?
A. Yes. I can, yes.

Q. You'll see there that the last paragraph where Dr A said, "I'm therefore discharging Joel back into his and your kind ongoing care"?
A. Yes.

Q. "Please recall Joel to discuss his options and referral to an alternative psychiatrist if required"?
A. Yes.

Q. Are you able to say why you did not recall Joel, when you received the letter?
A. At, at the time, I thought Joel was well. I thought he was - he'd taken himself to live in a different city, which was his right to do. He could return to the practice any time he liked. I don't think, when I think back over my years of practice, I've ever recalled or chased someone up who was living in a different city to get them to come back and see me.

So, I'm not sure exactly what Dr A expected of me there. Joel had always been a person who made his own appointments if he had concerns about any of his health issues. I would think whichever city he was living in, he would have contacted a GP and - for assessment, and if referral was required, they'd

make that referral. So, unless there were sort of outstanding pending results, or I had some other information that his mental state had deteriorated, I didn't have any information - all those things that were discussed for some reason or other never came to me. All those phone calls from his mother, from his family, I had nothing of that, other than my memories of Joel when I saw him in 19 and he was well.

Q. You saw him in August 2019, and you thought he was well?
A. Yes.

Q. Did you think to let Dr A know that you were not going to recall him, for the reasons you've just outlined?
A. No.

Q. Okay. Thank you Doctor. We might take the morning adjournment and resume at 12.

SHORT ADJOURNMENT

HER HONOUR

Q. Doctor, I take it you'd prefer to keep going. I note that it's--
A. Yes. And if you're happy with that, that's lovely. Thank you.

Q. Yes. Okay. Thank you.

HER HONOUR: All right. Any questions?

HARRIS-ROXAS: Your Honour, I think I just have a few questions.

HER HONOUR: Certainly.

<EXAMINATION BY MS HARRIS-ROXAS

Q. Dr Grundy, my name is Tanya Harris-Roxas, and I act for the families of Dawn Singleton, Jade Young and Ashlee Good, and I've just got a couple of questions for you.

HARRIS-ROXAS: If Dr Grundy could please be shown p 24 of tab 788A. If you could please scroll down.

Q. There's an entry there dated 5 February. Dr Grundy, that entry says, "Recall edited, blood test. Reassigned from Dr Susan Dragone to Dr Richard Grundy." Can you please tell the Court what that means?
A. I would think that's perhaps a blood test that Dr Dragone ordered and she saw the result and wanted me to look at the result. I can't tell you what the blood test was.

Q. Yes. Thank you.

HARRIS-ROXAS: If now Dr Grundy can be taken to p 49 of tab 788A.

Q. Can you please tell us, that letter is dated 11 May 2020. Is that the kind of letter that you would expect to go out because of that earlier entry on 5 February 2020?
A. Yeah. If, if, if Joel had an outstanding blood test result that needed to be discussed, I would, I would think that's the sort of letter we would've sent. Yeah. I, I--

Q. Did these kind of letters go out at your specific behest, or was this part of the automatic practice management system that happened in your practice?
A. I, I would, I would think that's Dr Dragone using the automatic system.

HARRIS-ROXAS: If Dr Grundy can be shown p 48.

Q. This is the letter that you were taken to by her Honour earlier, and this letter, as you've previously given evidence and seen, it does contain a recall. This kind of recall, however, is not subject to any kind of automated system in your practice, is that right? Is this a different kind of recall?
A. Are you referring to the stamp here, or the--

Q. No. Where it says "please recall Joel to discuss his options". Now, the other recall letter, it seems, went out as something automatic in the practice that you're working in. This kind of recall is something that you would've made a conscious decision about, is it? It's not something that somebody else in the practice--
A. No. That's correct.

HARRIS-ROXAS: Thank you. Those are my questions.

HER HONOUR: Thank you.

FERNANDEZ: No questions.

ROFF: No questions.

FRECKELTON: No questions.

ROBB: No questions.

WILSON: No questions.

HER HONOUR: Mr Lynch?

LYNCH: Yes, I do, your Honour. I had a recollection yesterday that Dr A qualified the evidence that she gave in chief about the content of the phone call that she recalled having with Dr Grundy, and I think it appears somewhere around - I've just got the transcript - somewhere around p 1026 where I think she wasn't clear about the content of the phone call, but remembered having a phone call with Dr Grundy sometime after the discharge letter had been sent.

I'll try and find the evidence, but I'll be brief with Dr Grundy.

<EXAMINATION BY MR LYNCH

Q. Dr Grundy, I act for Dr A, the psychiatrist. Is her Honour to understand that the reason why you have not only no recollection, but say there was no phone call, because of the content of the phone call that my learned friend Ms Dwyer read out to you as Dr A originally claimed?
A. I'm a little confused. If, if--

Q. Understandably. My question was a bit confusing--
A. If, if a specialist, if a specialist had had a lengthy conversation with me about a patient, I would have opened the patient's file and tried to make some notes about the salient points in the conversation.

Q. You've said that your usual practice was to open the file and make a note if there was a extensive conversation of the kind that was suggested to you. Would you--
A. That's correct.

Q. Would you always open a file if there was some conversation, but not necessarily a comprehensive discussion, about a patient?
A. I would try to. Yes.

Q. Is the reason why you say there was no conversation because there's no entry in your notes to that effect?
A. Yes.

Q. Is that the only reason?
A. And the fact that I have no recollection of a long conversation with Dr A.

Q. Do you have a recollection of any conversation with Dr A?
A. No.

Q. Initially, you had no recollection of receiving the letter in March 2020 from Dr A, is that correct? But subsequently you saw the stamp and conceded that you had seen the letter. Is that right?

MATHUR: Sorry, I object to that question. I don't think that was the tenor of his evidence. Is that a reference to his evidence during questioning with counsel assisting?

LYNCH: No.

HER HONOUR: No. I think it's in his statement.

LYNCH

Q. Is that the fact, Doctor? Originally you had no recollection of receiving the discharge letter from Dr A in March 2020, but subsequently you realised that

you had received it because your mark was on the stamp?
A. Repeat the question?

Q. Is it the fact that initially you had no recollection of receiving the letter of March 2020 from Dr A, but later, after your attention was drawn to the stamp and your mark on the stamp of the letter, you accepted that you had received the letter. Is that true?
A. I can't tie that together. I don't understand that. No.

Q. Let me break it down a bit. Initially, you had no recollection of receiving the discharge letter. Is that true?
A. Yes.

Q. Subsequently, you realised that you had received the letter because you observed your mark on the stamp on the letter. Is that true?
A. That's correct.

Q. Your recollection in the first place was imperfect, was it not?
A. Correct.

Q. And can I suggest to you that there was a phone call - leaving aside its content - that occurred sometime after you received the discharge letter from Dr A to you, or from you to her?
A. There's no record of that conversation in Joel's chart, so I would say that conversation never occurred.

Q. That's based upon the absence of a record of it in your notes. Is that true?
A. Correct.

LYNCH: Nothing further, your Honour.

HER HONOUR: I'm just going to check with court 2. Are there any questions there, please?

CALLAN: No questions. Thank you, your Honour.

CHIU: No questions, your Honour.

CASSELDEN: No thank you, your Honour.

JORDAN: We have no questions. Thank you.

HER HONOUR: Thank you. Ms Mathur?

<EXAMINATION BY MS MATHUR

Q. Dr Grundy, if a specialist, be it psychiatrist or other, sends correspondence that you understand is instructing you to recall a patient, would you recall that patient?
A. It's very general.

Q. If it's directing you. If you understand that the nature of the correspondence is asking you to recall that patient, would you follow the directions of the specialist?
A. Not necessarily. No.

Q. In what circumstances would you not follow it?
A. If I thought the patient was well, and I had no reason - and, and the specialist hadn't given me any information as to why I should recall a patient, I, I wouldn't recall them. If the patient was well, and was able to make their own appointments with whatever doctor they chose to go to, I don't think I've ever recalled a patient. I recall patients when there's a specific concern.

Q. And is it your experience that a specialist will outline the specific concern, which is the foundation for their direction to you to recall the patient?
A. Always.

MATHUR: Nothing further, your Honour.

HER HONOUR: Anything arising, Dr Dwyer?

<EXAMINATION BY DR DWYER

Q. Just to try and clarify. Doctor, in relation to that letter, there may be some ambiguity in the sentence that was shown to you. Can I ask that that just come back on the screen now. Can you just read that last paragraph to yourself again.
A. Yes.

Q. I'm reluctant to read it out, because I don't want to put any emphasis on it. That last paragraph, the second sentence that begins, "Please recall", how did you understand that, in terms of what was being requested by you of the psychiatrist?
A. I'm not sure. "Please recall" doesn't really translate into sort of any sort of imperative to me. I think if Joel was living in a different city and was attending other doctors, and my last experience of him was that he was well and I had no evidence of any other changes in Joel, I wouldn't recall him.

Q. Do you agree with me that there's two ways to read this sentence. You can read it as, "Please recall Joel to discuss his options and referral to an alternative psychiatrist if required", or, "Please recall Joel to discuss his options and referral to an alternative psychiatrist if that is required"? You don't know now how you read it at the time?
A. No.

Q. In any event, if you had been told of any of those issues that I put to you with respect to his mother's concerns about his deteriorating mental health, would you have recalled him?
A. I would've made an attempt to contact him. I, I, I don't know whether you can make someone come from a different city to come and see you, if that's

what "recall" means.

Q. If you had been told about those issues in relation to a deterioration of Joel's mental health, would that have been something that you would have wanted to discuss with his treating psychiatrist?
A. Yes.

DWYER: I don't have anything further, your Honour.

HER HONOUR

Q. Thank you very much, doctor, for making yourself available at this most inconvenient hour. You're excused.
A. Thank you for your patience. Good night - good morning.

Q. Thank you for yours. Good morning.

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

AUDIO VISUAL LINK TO LONDON CONCLUDED AT 11.47AM

HER HONOUR: We might take the morning adjournment. We'll resume at 12.20.

SHORT ADJOURNMENT

HER HONOUR: Ms Sullivan.

SULLIVAN: Thank you, your Honour. The next witness is Dr C. Before we commence his evidence, can I just attend to the tender of some material that will be relevant. The first document I would seek to tender is a booklet, "Health and Weapons and Information" booklet from Queensland Government Health. That is to be tendered as an addition to vol 23, tab 835A that has been circulated to the parties.

HER HONOUR: Thank you.

SULLIVAN: The second document is "Professional Practice Guideline 23, Firearm Risk Assessments" from the Royal Australian and New Zealand College of Psychiatrists. That's at tab 1618A, vol 49. I provide your Honour with a copy of those documents.

HER HONOUR: Thank you.

SULLIVAN: Your Honour, I call Dr C, who is on the screen in Japan.

LTS:DAT

AUDIO VISUAL LINK TO JAPAN COMMENCED 12.22PM

HER HONOUR: Hello, Dr C. Can you see and hear us?

DR C: Yes, Madam Coroner, I can.

HER HONOUR: Thank you. Thanks for making yourself available. You'll just hear from the court officer now.

LTS:DAT

<DR C, AFFIRMED(12.23PM)

<EXAMINATION BY MS SULLIVAN

Q. Can you state your full name please?
A. My full name is Dr C.

Q. And your occupation?
A. I am a psychiatrist.

Q. Where are you currently employed?

[redacted]

Q. Before we proceed further with your evidence, I understand there was something you wanted to say, Dr C?
A. Yes. I would like to express my sincere and heartfelt condolences to the families who have lost their loved ones. I can't even begin to fathom the pain and the loss that this tragedy has brought upon them. I do also acknowledge the trauma and suffering experienced by the survivors and their families. And I hope that through the process of this coronial inquest and its recommendations, we are able to come up with measures in which we can stop or significantly minimise such tragedies from happening or taking place in the future.

Q. Thank you, Dr C. You provided a statement for the purposes of this inquest that is dated 16 July 2024. You have a copy of that statement?
A. Yes, I do.

Q. And you've read it recently?
A. Yeah. Yes, I have.

Q. Any corrections you wish to make?
A. Not necessarily corrections, but I do - I did realise that in a couple of the statements over there, I had mentioned that I did not feel it necessary for Mr Cauchi to have a follow up appointment at the time that I saw him, even though I did recommend that he have six monthly appointments. I just wish to sort of elaborate on that, that when I said that he did not--

Q. That's a--
A. I'm sorry.

Q. --clarification that we'll come to in your evidence, if you're content to proceed that way?
A. Yes.

SULLIVAN: Your Honour, that's at tab 807 of vol 22.

HER HONOUR: Thank you.

SULLIVAN

Q. I want to start first please by going to your background, in short form. You set this out in your statement at paragraphs 3 to 6. But in summary, you obtained your medical degree from [redacted], correct?
A. That is correct.

Q. In 2004 you moved to the United Kingdom and commenced formal training in psychiatry?
A. That is correct, yes.

Q. In 2010 you obtained a diploma in clinical psychiatry from the [redacted]
A. That is right, yes.

Q. And in 2013, you emigrated to Australia and began employment at Princess Alexandra Hospital in Brisbane, that's right?
A. That is correct, yes.

Q. In 2015 you joined the Royal Australian and New Zealand College of Psychiatry training program?
A. Yes, I did.

Q. And you completed that program and obtained your Fellowship in 2019, that's right?
A. That is correct, yes, that is correct.

Q. Then between November 2020 and July 2022, you worked as a private psychiatrist at Dr C's practice in [redacted], Brisbane, is that right?
A. Yes, that is right.

Q. How often were you working there during that period?
A. I used to work three days a week over there.

Q. What was the nature of the patients that you would see when you were working there?
A. It was a mixed sort of range of presentations, but I think this was just around the time where we had started seeing an increase in referrals from GPs for people with ADHD assessments. Those formed the bulk of the referrals we received. However, in between those, we did get referrals for people with depression, anxiety, OCD, bipolar disorder, and occasionally we would get referrals for somebody for - with schizophrenia management.

Q. That was a rarer patient cohort, is that correct?
A. Yes, that, that, that is correct, yes.

Q. Is it accurate to state that you have extensive experience with schizophrenia patients based on your experience in the psychiatry profession

since 2010?
A. Yes. That would be a fair statement.

Q. Indeed, at paragraph 5 of your statement, you refer to over 50% of patients that you see in the wards or in the community for continuity of care having schizophrenia or some other form of psychosis?
A. Yes, that is right.

Q. Coming now to your involvement with Joel Cauchi. At paragraph 7 of your statement you say you don't have an independent recollection of the assessment of him that we know occurred on 18 January 2021. That's what you wrote in your statement in July 2024. You recall that?
A. Yes, I have.

Q. Does that remain the position? That is, you haven't had any recollection of that assessment since that time?
A. Yes, that is correct. It remains the same situation.

Q. You've relied upon the medical records that were provided by Dr C's practice for the purposes of preparing that statement from July 2024, is that right?
A. That is right, yes.

Q. That consultation on 18 January 2021, was that a one hour consultation with Mr Cauchi?
A. Yes. The standard one hour assessment.

Q. That was in the middle of COVID when a lot of the medical consultations went to telehealth. Do you recall if that consultation was in person or a telehealth consult?
A. No, this was in person.

SULLIVAN: Could we go please to tab 803A of vol 22, p 35.

Q. This is the referral letter. With any luck, it will come up on the screen.
A. Yep.

Q. Are you able to see that letter?
A. Yes.

Q. So, this is a letter dated 21 September 2020 to Dr Jon Paul Teo from Dr Nathan Ruge. Do you see that?
A. Yes, I have.

Q. And this is: "In relation to Joel Cauchi aged 37 years for an opinion and management". And you see the presenting problem, "the opinion and management relates to schizophrenia". Do you see that?
A. Yes, I can.

Q. And it goes on to refer to some background:

"This first manifested for him aged 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."

This referral letter came to you. Is that the position?
A. Yes. That is right. So it came to the clinic, and I was able to view that before I saw him.

Q. What's the significance of it being addressed to Dr Teo and not yourself?
A. Personally, I don't think there was any specific significance. Normally GPs send a letter to any psychiatrist in the clinic, and if that particular psychiatrist has a longer waiting list, or they're not taking on new patients, then the other practitioners in the clinic get asked if they would like to see this person.

Q. That's the referral letter that came to you, and we know that you saw Joel Cauchi on 18 January 2021. We'll now go to your consult note.
A. Yes.

SULLIVAN: That's at tab 808, volume 22, at page 1 please. We might need to zoom - thank you.

Q. Can you see that, Dr C?
A. Yes. I can.

Q. Do you see that the consult is stated to be at 3.34pm--
A. Yes.

Q. --on 18 January. Do you see above that, the consult note includes the following in italics--
A. Yes.

Q. "Created by Dr C on 28 January 2021 at 12.37pm. Last edited by Dr C on 28 January 2021 at 12.37pm." When was this note created?
A. So that would have been created on the day that I saw him. And probably finalised a couple of days later once I would have received the correspondence from The practice.

Q. What's your usual practice in relation to taking consultation notes? Do you do them contemporaneously with your assessment of the patient, or do you generally do them after the assessment has concluded?
A. So I usually write down salient points as we go along during the review, and that was taken in a notebook at that time. And eventually that was transcribed onto the electronic record system that we had.

Q. When would you transcribe the notes onto the electronic system?

A. Preferably on the same day.

Q. Is it possible that they weren't transcribed until 28 January?
A. No. I, I don't think that would have been the case. In this situation, we also had a change in software, so when the previous - when the data from the previous software was migrated to the new software, I don't know if that is the one that has created that new timestamp over that.

Q. If we go to the content of the note, under the heading "Field. Record of the session." There's reference to:

> "37 year old single man. Currently living in shared accommodation at Kangaroo Point. Was living in a private rental unit in Toowoomba until his move to Brisbane in April 2020. Move was due to him pursuing options for gainful employment and studies to teach English."

Pausing there, this is all information that Mr Cauchi has provided you?
A. That's correct. All this information was provided by Mr Cauchi.

Q. It goes on, "Today's review for the purpose of medical fitness so that he can visit a gun range and practice target shooting." And further, "Does not own guns. Last time he went to a range was when he was 25 years old. Does not have a gun licence. No friends or family members own firearms." Again, this is information that Mr Cauchi had provided you?
A. That's correct. Yes.

Q. He indicated to you that the purpose of the assessment was so that he could visit a gun range and practice target shooting. Did he have some documentation to confirm that that was the proposal?
A. Not, not that I can recall. I don't think he provided any forms. We later received a letter from one of the police sergeants requesting a report for that purpose.

Q. You don't recall him having any documentation with him in relation to that purpose?
A. Not at that stage. No.

Q. The information about him not owning guns, firearms, was that something that you were able to independently check, for example, by contacting police?
A. I did not check at that stage. I just - this was based on information that was provided to(as said) him, and I thought if he did have access to firearms, it would have been mentioned in the records with his previous treating psychiatrist, or their team.

Q. It goes on:

> "Currently reports stable mental state. Good stable mood. Nil hallucinations or psychotic symptoms. Denied problems with memory or functioning. Currently studying to become an English

> teacher. Does not work. In receipt of disability support pension" - that's what we understand "DSP" to mean - "after being diagnosed with schizophrenia at the time of his initial admission in 2000."

Pausing there. That suggested that he had been diagnosed with schizophrenia some two decades prior?
A. Approximately, yes. So that would have been about 20 odd years before I saw him.

Q. He was eating regularly. "No problems with appetite. No problems reported with sleep. Denied thoughts of self-harm, suicidal ideation or thoughts to harm others." You elicited that information by asking questions. Is that the position?
A. That's correct. Yes.

Q. Continues on, "Some twitching of the mouth noted, which Joel reported to be due to nervousness." I take it that you have no recollection now as to what that nervousness might have related to?
A. No. Not that I'm able to recall, and I did ask him about the twitch. Initially, my suspicion was it may be related to a medication, or its side effects, which sometimes linger after medication has been ceased. However, he said that it was due to nervousness, and that was what was documented in my notes.

Q.

> "Had been seeing Dr A at Toowoomba privately for monthly follow-up sessions. Reports that he has had psychotic episode at the age of 17 years. Experienced tactile hallucinations then after smoking cannabis for over a year. Admitted to TMBA Toowoomba adolescent ward. States that he was started on clozapine, and then after a couple of years was transitioned to aripiprazole, which he continued for approximately 16 years. Been off Abilify for the past 18 months. No relapse in psychotic symptoms noted."

Taking all of that information, that was provided by Mr Cauchi?
A. Yes. That's correct.

Q. What did that subset of information indicate to you about the nature of the schizophrenia that you had been referred to assess?
A. My, my understanding was that, you know, if he had been consistent with his medication and treatment plan for that duration of time, that would have been a crucial factor in him maintaining remission. Alternatively, the other hypothesis would have been that the initial episode of schizophrenia, or even psychosis at that point, was significantly related to the preceding use of cannabis. Nonetheless, I think, given the duration of treatment that he had been on, and thereafter after ceasing medication, the duration of time that he had been - continued to be in remission and without symptoms, it indicated a good prognosis for him. That was my impression at that point.

Q. You say "no relapse in psychotic symptoms noted". Was that Mr Cauchi

telling you he'd had no relapse?
A. No. That was also based on my mental state assessment.

Q. What did that involve?
A. That would have involved assessing for any residual signs of psychosis, which could be thought disorder; disorder of form of thought; presence of hallucinations in any modality; any unusual or desire sort of thought processes, or thought content; delusional beliefs; and sometimes even signs of personal neglect. So things like inadequate personal care, grimy fingernails, or general loss of social functioning. Anything that could be similar markers.

Q. And those were all things that you were assessing at the same time as eliciting information from Joel. Is that right?
A. That's correct. Yes.

Q. You asked him about his forensic history, and he denied any?
A. Yes. That's what's documented in the notes.

Q. Yes. And you asked him about recent or current drug use, and he denied that?
A. Yes. He did.

Q. It states, "Last drug use was prior to hospital admission". That's right?
A. Yes. That, that was the case. Yes.

Q. He then indicates, "No acute medical problems." It goes on, "Parents live in Toowoomba. Has an older sister with her family in another area. Reports no known family history of schizophrenia." Do you see that?
A. Yes. That - yes.

Q. Did you accept that on face value?
A. Yes. I did accept it on face value at that point.

Q. Continues on, "Currently not on medication." This is on page 2.
A. Yes.

Q. And then you set out under the heading, "Impression. Presents with stable mental state. No acute psychotic symptoms." And you go on to state this: "Unsure why he was seeing a psychiatrist monthly for the past 18 months if he was not on medication." So firstly, in terms of your impression, what were the factors that led you to that view, that is, that he presented with a stable mental state?
A. So if - when we say somebody presents with a stable mental state, we are looking at a few different factors here. Firstly, signs or symptoms of an affective component, which could be like a mood disorder. So that would include signs or symptoms of a depressive episode of illness; signs or symptoms of hypermania, mania. There could be signs or symptoms of OCD, such as repetitive rituals or obsessive thoughts. Then we also - sorry?

Q. Sorry. Continue on?

A. Sorry. And then we look at markers of psychotic illnesses as well, which I have explained earlier. Then we look at general appearance and behaviour, whether they're dressed appropriately, not appropriately, and anything that stands out. We generally tend to note that down. So when I mentioned that he presented with stable mental state, my inference was that he had stable mood. He was euthymic. His affect was confident with his presentation. He didn't present in any dysphoric sort of manner, or with any bizarre behaviour that would raise any sort of flags, or concerns, from my part at that stage of the assessment.

Q. Is there a limitation, in a one hour assessment like this, of a patient who you understand to have longstanding schizophrenia, namely that you don't have a baseline? You haven't seen him before, so you're not in a good position to compare and contrast how he might have been on other occasions?
A. That is true. Yes. We, we don't have a frame of reference over there, so we don't know if there are any changes in their usual baseline presentation or not. And at times it does happen that people sometimes mask some of these symptoms, or, you know, they try to be - I would say..(not transcribable)..with the truth at times, and this is one of the reasons why we generally like to get collateral information from other people as well.

Q. And they might particularly mask their symptoms if they wanted access to a firearm?
A. They can. Yes. But a lot of the times - I think in my experience, it's very, very difficult for somebody who is unwell to keep up that masking for a period of an hour. Maybe a few minutes. But to do it for an hour is very, very difficult.

Q. Can I ask you to explain this comment, "Unsure why he was seeing a psychiatrist monthly for the past 18 months if he was not on medication." What did you mean by that?
A. It's very unusual - not unusual, but it's very uncommon, especially in private practice, for somebody to see a specialist if they're not on treatment and in remission on a monthly basis. Three monthly to six monthly is usually the accepted practice, and a lot of the times this is because of the financial burden that's placed upon the person. However, if there is an understanding between the person in question and their treating specialist that they would like to catch up every month for a review, then there's nothing unusual about it. It's just because of the financial burden that it places that on there.

Q. Have you had that scenario, where you're seeing psychiatric patients who are not medicated on a monthly basis?
A. Not monthly. My usual practice was about three months. If I have stopped somebody - if I've stopped somebody's medication quite recently, then, yes, I'll probably catch up with them every two to four weeks for the first three odd months, and then I'll probably start seeing them - space it out a little bit.

Q. Just in terms of Mr Cauchi's medication, you understood that he had been on clozapine at a point in time. Correct?
A. Yes.

Q. And that the clozapine had been ceased and he had been transitioned to Abilify. That's right?
A. That was my understanding at that point. Subsequently, after reading the new material that was available during the process of this inquest, he had done so - that he was on a combination of clozapine and the Abilify, and then eventually the clozapine was ceased and he was only on Abilify, which was then ceased later.

Q. Have you, in your psychiatric career, had a scenario where you had patients on clozapine who were then transitioned to another antipsychotic medication, but then stopped medication entirely. That is, a patient with a diagnosis of schizophrenia?
A. Yes, there are plenty of times where we get these situations. A lot of people do tend to cease clozapine because - mostly because of the requirements that clozapine has with regular blood tests for monitoring, monthly appointments at the clinic, and also because of the various side effects that the person can potentially experience under them.

Q. Pausing there. Not uncommon to cease clozapine because of the side effects, that's what you're saying?
A. That's correct, yes.

Q. Then in that case, are patients in the ordinary course transitioned onto other antipsychotic medication?
A. Yes, that's correct.

Q. Have you ever had a patient who has come off clozapine and then transitioned onto other antipsychotic medication and then come off that antipsychotic medication entirely? That is, a schizophrenic patient?
A. Just one case.

Q. Where was that?
A. This was when I was still at the Princess Alexandra Hospital so it would be about 2014, 2015 I think.

Q. What was the monitoring regime that you instituted in relation to that patient?
A. So, at that time, we requested her to continue attending the clinic once every three months and because she was still within the care of the public sector, she had a care coordinator sort of allocated to her who would see her roughly once every four weeks.

Q. That was in relation to a longstanding diagnosis of schizophrenia, was it, to be clear?
A. She had a diagnosis of schizophrenia, but over a period of time, we had other evidence sort of come up that made us revise that diagnosis.

Q. The fact that Joel Cauchi had been on clozapine, did that indicate to you that he had suffered treatment-resistant schizophrenia?
A. Usually, yes, that would be the case because clozapine is not our go-to

choice in terms of first choice antipsychotic. We normally will start somebody with a second generation antipsychotic and due consideration is to be given in terms of not just the dosage of the medication that is initiated, but also the duration for which they are tried on that particular medication. And if they do not respond to treatment with at least two different antipsychotics, then it is considered to be treatment-resistant schizophrenia.

Q. Did you understand from the information that Mr Cauchi had conveyed to you, and the information you obtained from his treating psychiatrist a day or so later, did you understand him to have treatment-resistant schizophrenia?
A. The information that I obtained from The practice did not comment upon his presenting symptoms at the time of his admission to Toowoomba Hospital given the number of years prior to that. But I also did not have a copy of the discharge summary from Toowoomba Hospital. So, I don't think I'm in any position to comment on what his treatment and his presentation was at that point. But just considering the fact or knowing the fact that he wasn't on clozapine, I'd take it on face value that they would have, you know, had justified reasons to commence that.

Q. Just in terms of access to the discharge summary, are you aware of an information repository called the Queensland Health portal?
A. Yes, I am aware of it.

Q. Did you consider accessing, or did you try and access the Queensland Health portal in relation to Joel Cauchi to obtain collateral information, for example, the discharge summary from the public health hospital in 2012?
A. We did not have access to that portal at that point, and my understanding was that it was accessible only to GP clinics.

Q. Might you be mistaken in that understanding?
A. Yes, it's quite possible that I was not fully aware of the process to access it for private practitioners at that stage.

Q. Did Joel Cauchi at any point advert to or indicate that he also had a diagnosis of OCD?
A. No, he did not mention that to me. Otherwise, I would have documented that in my notes.

Q. Your plan, as set out in your notes, is to--

SULLIVAN: If we could bring those back up, please. That's at 808, vol 22, this is at p 2.

Q. Your plan is to "keep referral open in case he requires further follow-up reviews and then seek collateral information from TMBA Toowoomba". Do you see that?
A. Yes, I see that.

Q. What did you mean by "keep the referral open in case he requires further

follow-up reviews"?
A. So, I suggested to him that it would be appropriate for him to have at least six monthly reviews, even if he wasn't on medication or currently experiencing any relapses or symptoms, and our usual practice is, as the patient leaves the consulting room, we ask them to make an appointment at the front desk before they leave. Now, some of them make an appointment, then and there itself, some of them call the clinic later on.

Q. You envisaged that Joel Cauchi would make an appointment with you for a further follow-up review in six months. Is that right?
A. Yes, yes.

Q. Do you have a clear recollection of advising him of that?
A. Yes, otherwise I would not have written that in my note.

Q. Well, we'll come to what goes into your letter to Dr Ruge, but you don't put in your clinical note what you put in your letter to Dr Ruge, I'll read it to you, and we'll come to it. But "I have advised him to have six monthly reviews to monitor for mental state, even though he's currently asymptomatic"?
A. Yes.

Q. That's what you told Dr Ruge, but that's not in your clinical note. Are you sure that you told him--
A. Yes.

Q. --to have six monthly reviews?
A. Yeah. Because if I hadn't told him, and if my plan was to discharge him from the clinic, I would have made that explicitly clear as well, that he was to be discharged.

Q. And six monthly reviews are consistent, aren't they, with what Dr Teo, that the referral to Dr Teo, I withdraw that. The referral from Dr Ruge that was addressed to Dr Teo, that in fact you received, referred to ongoing management of schizophrenia, didn't it?
A. Yeah, yeah.

Q. You telling him that he should undergo six monthly reviews is consistent with what was being asked of you in the referral, is that right?
A. That's correct, yes.

Q. But is it fair to say there was a disconnect between what Joel Cauchi understood you were doing, namely an assessment for access to firearms, as opposed to what was being asked of you in the referral letter?
A. No, I think that was Mr Cauchi's expectation. So when he attended, that was his initial statement, that he would like an assessment and a certificate for him to apply - to have a gun licence to practice shooting at a target range. I did mention to him that this was what the GP had mentioned, and he took that on board.

Q. In terms of your plan, the other aspect of the plan was to "seek collateral

information from Toowoomba". Why were you doing that, although it might be an obvious answer?
A. Just to clarify that he was actually in fact off his medication, and any of the information that he gave me was consistent with what was the clinical opinion and what their medical records stated as well. As I mentioned earlier, there are people sometimes who are not entirely truthful when they come into our offices, especially when they're seeing a new practitioner, and they may withhold some important information. So, I just wanted to make it 100% clear that he was in fact on medication, which was ceased under medical supervision, because we do often get a lot of people who cease medication off their own accord.

Q. Did you contemplate seeking collateral information from Mr Cauchi's family?
A. In the consent form that he had provided to us, he had very specifically mentioned not to contact family unless there was some sort of clinical emergency.

Q. Let's break that down. The consent form he'd provided. We have no copy of a consent form in the documentation that is in the coronial brief. Have you recently seen a copy of the consent form?
A. I think it should be where the patient registration form is at Dr C's practice. There's a little section at the bottom where he says, "Disclosure level: none. This person should only be contacted in case of emergency."

Q. Do you have access to a document that perhaps we don't have access to? Can you just read the title of that document?
A. So, the document is - this is from Dr C's practice and basically this is his patient registration form, and this is part of the documents that were sent by Dr C's practice to me, and I think a copy of this should have gone on to the solicitors too. So, the title of that collection of documents is "Dr C's Complete Records".

Q. Over the lunch break, we'll do a compare and contrast and look at those records if you don't mind. If you could provide them to your solicitors again?
A. Sure.

Q. Thank you very much.
A. Yeah.

Q. I'm now going to take you to the letter that you sent to Dr Ruge. This is at tab 808, volume 22, page 4.

SULLIVAN: If we could bring that up, please.

Q. This letter is dated on Monday 18 January 2021. But we know that it refers to, on page 2, correspondence from Dr A's office being received, and we know that that happened on 19 January 2021. Do we take it that, although the letter is dated 18 January, it was sent after you received that correspondence?
A. That's correct, yes.

Q. Going through the letter, you thank Dr Ruge for the referral and note that you have assessed Mr Cauchi in the clinic today.

> "Joel informs me that today's assessment was in order to obtain a medical report certificate on his current mental state and risk so that he can provide it to the local gun range where he wishes to practice target shooting under supervision once a week or once a fortnight".

That information is not contained in that format in your clinical notes. That is that Mr Cauchi wished to practice target shooting under supervision once a week or once a fortnight?
A. Yep.

Q. Was that information that subsequently was told to you, or how does it come to being in the letter, but it's not in your clinical notes?
A. No, that was what he'd told me at that point.

Q. You set out the information in relation to Joel reporting that he doesn't own a gun or have hold a gun licence et cetera. You summarise the assessment in terms that we've covered in your clinical notes. In the final paragraph of that letter, you referred to:

> "Joel currently reporting stable mental state and describing good, stable mood, nil hallucinations or psychotic symptoms being reported. He's denying problems with memory or functioning".

It goes on, consistent with your clinical notes. Then there's a section under the heading "Past psychiatric history" and some of this appears to accord with what is in your clinical notes, but we'll go through it.

> "Joel reports being admitted to a psychiatric unit in Toowoomba at the age of 17 years for an episode of psychosis secondary to yearlong use of cannabis. He reports experiencing tactile hallucinations at that time and states that he was commenced on clozapine as part of his treatment. After being on clozapine for two years, his treatment was changed to aripiprazole."

Pausing there, the reference to clozapine for two years, is that a typographical error?
A. No, that is based on what Mr Cauchi told me at that point.

Q. He told you two years?
A. That's right.

Q. It was your understanding that he had only been on clozapine for two years after being in the clinic at age 17 and then his treatment had transitioned to aripiprazole. Is that the position?
A. Based on the information he provided me, yes.

Q. If you go down to the bottom of that page under the heading "Plan", you say this. "I've advised him to have six monthly reviews to monitor for mental state, even though he's currently asymptomatic. This is in part due to him being on clozapine for many years". Do you see that?
A. Yes.

Q. Two years is not many years?
A. No.

Q. Can you explain the inconsistency?
A. So, the earlier paragraph is what Mr Cauchi reported, so that is based on the information that he provided me. But as for the "many years", that was based on the information obtained from The practice.

Q. You did understand that he had been on clozapine for a lengthy period in the order of some 15 plus years?
A. That's correct.

Q. Was it of concern to you that Mr Cauchi had told you he'd only been on clozapine for two years and yet through obtaining collateral information, you established this was not correct?
A. It did flag it up as a little bit unusual, that, you know, he had minimised the duration of clozapine that he had been on, because occasionally people might get a year or perhaps two years off the timeframe, but to sort of minimise it from 15 to 17 years of being on clozapine to just two years of being on clozapine, yes, that is very unusual.

Q. Very unusual and a red flag, I suggest?
A. Yes.

SULLIVAN: Your Honour, it might be an appropriate time.

HER HONOUR: Yes, we'll take the lunch adjournment and resume at 2.

LUNCHEON ADJOURNMENT

SULLIVAN: Thank you, your Honour.

Q. In the break, you've provided a document from Dr C's practice entitled, "Psychiatric consent - an informed financial consent form", to your solicitors, is that right?
A. That's correct, yes.

SULLIVAN: Your Honour, can I provide a copy of that document to the Court?

HER HONOUR: Yes, thank you.

SULLIVAN: I will seek to tender it once we've briefly adverted to its contents.

Q. This is a document that Mr Cauchi signed on 18 January 2021, is that

correct?
A. The date stamp will be on the document, so sometimes people sign it before they attend the clinic, and sometimes they sign it on the date. So, I'll have to check what the date is on it.

Q. This document on page 2 is dated 18 January 2021. And Mr Cauchi has ticked a number of boxes, including that he has read and understood the policy relating to the exchange of information. That is on page 1, do you see that?
A. Yes, yes, I saw that.

Q. This is the document that you were referring to earlier in your evidence?
A. That's correct.

SULLIVAN: Your Honour, I tender this document.

EXHIBIT #5 PSYCHIATRIC CONSENT FORM SIGNED BY JOEL CAUCHI ON 18/01/21 TENDERED, ADMITTED WITHOUT OBJECTION

Q. We were going through your letter to Dr Ruge of 18 January 2021. That's at tab 808, volume 22, page 4. In fact, we're on page 5 under the heading, "Past psychiatric history". And we'd just touched on the inconsistency as between Mr Cauchi's report to you of being on clozapine for two years and then the information that you had obtained from Dr A's office to corroborate his psychiatric history. You recall that?
A. Yes.

Q. We'll go now to the documents that you obtained from that clinic. Could we turn please to tab 793, volume 20, page 111. Do you there see The practice cover sheet addressed to Dr C's practice dated 19 January 2021 with eight pages of correspondence - referring to eight pages of correspondence?
A. Yes.

Q. The message is, "Following on from your phone call this morning, please see following collateral information, being copies of letters to his previous GP". Do you see that?
A. Yes.

Q. Do you recall having a conversation with Practice Manager, the practice manager at The practice?
A. I don't remember who it was that answered the call, except that I know it was somebody from the clinic.

Q. Do you recall speaking with the psychiatrist at this clinic, that is, Dr A?
A. No, she wasn't on the phone at that time, so I couldn't speak with her.

Q. Did you speak with her at any time in relation to Mr Cauchi's care?
A. No, I wasn't able to.

Q. When you say you weren't able to, did you try to speak to her?
A. Not multiple times, no. So that initial phone call, I don't recall exactly

whether I have called specifically to speak with Dr A or just to contact the clinic to obtain the copies of the letters.

Q. Is that your usual practice, to speak to a treating psychiatrist, or is your usual practice to obtain documentation and then form a view about whether to speak to the treating psychiatrist?
A. Usually, it would be to obtain information in the form of documents, whether it's letters or any other clinical assessments or forms that they may have, and if there are any specific concerns, then it would be usual practice then is to speak with that doctor in question.

Q. Thank you. So, we see if we scroll through, or if we move through that facsimile that's been sent through, you'll see the first document that you receive is at page 113. That is a copy of a discharge letter dated 19 March 2020 to Dr Richard Grundy from Dr A. Do you see that?
A. Yes.

Q. Do you recall reading that letter?
A. Yes, I do.

Q. You do recall reading it. What did it suggest to you about the status of Mr Cauchi's mental health?
A. Well, the indication or the interpretation that I had from reading those letters was that Mr Cauchi was indeed being treated by Dr A and that she had seen him for a number of years, and it confirmed parts of the information that Mr Cauchi gave, such as him being on clozapine which was then ceased under medical supervision. And subsequently after that he was ceased off the Abilify as well, which was approximately about a year and a half before I saw him, and that Dr A continued to see him thereafter, and at the point where she was no longer able to see him face to face or via telehealth, she was happy to discharge him under Dr Grundy's care.

Q. Yes.
A. Or alternatively if - sorry.

Q. No, no, keep going. I'm sorry.
A. I was just going to mention that, and if there were any signs of potential relapse at some stage, then he could be re-referred to any psychiatrist or if - sorry, if Medicare permitted assessments via Skype, then she was happy to see him again.

Q. You understood though that Mr Cauchi had not seen a psychiatrist between 19 March 2020 - the date of this discharge letter - and seeing you, is that right?
A. That's right, yes.

Q. You didn’t have visibility about what his mental health had been like during that period?
A. Not during that period, no. Only at the time of my assessment.

Q. These letters revealed to you, didn't they, that in fact rather than the two year period, Joel Cauchi had been on Clopine for a number of years, that is, in the order of 15, 16 years?
A. That's right, yes.

Q. That's the matter that we were referring to as being a red flag, you agree?
A. Yes, that's right.

Q. If you had understood from this discharge letter that Joel Cauchi's mother was concerned about a deterioration in his condition during the period October 2019 to February 2020, what would you have done if that information had been referred to in this letter?
A. If I had that information, I probably would have contacted Mr Cauchi's mum to find out what exactly was the nature of those concerns and what sort of changes she had noticed. Further to that I would have also - sorry, further to that I would have also contacted The practice again to find out if they had been made aware of it, or if the GP had any additional information about that.

Q. Would you have--

HER HONOUR: Can I just interrupt? Sorry, Ms Sullivan.

SULLIVAN: I'm sorry.

HER HONOUR

Q. I'm just wondering, with the consent form, it specifically says that his mother, Joel's mother, is not to be contacted. Would you still have been able to contact her?
A. If I needed additional information. I mean generally when people don't give us consent to share information with anyone, we generally don't give them information about the person's treatment or clinical conditions. But if we have specific concerns, or if there are concerns regarding risk of any sort, then we do have, what shall we say, the capacity to breach that confidentiality to obtain information from them.

Q. Thank you.

SULLIVAN: Your Honour pre-empted my question.

HER HONOUR: Sorry.

SULLIVAN: That's all right.

Q. If that information had been included in the discharge letter, as well as Dr A's view that Mr Cauchi was otherwise mentally stable, do you think that you would still have taken that step?
A. I probably would have, because I would have needed to be satisfied myself that I'm not missing out on any essential information.

Q. Before we move on from the correspondence that we see provided there, and just for the record, there's a letter from The practice dated - there's the discharge letter I've referred to, there's a letter dated 12 June 2019 to Dr Grundy, again from Dr A, about the stopping of Abilify?
A. Yes.

Q. Then there's a letter dated 3 May 2018 in relation to the ceasing of - or continuing with Clopine, 12 milligrams?
A. Yes.

Q. That's at page 116. Then there's a letter dated 5 April 2018 which refers to "best I have seen him", but still refers to the Clopine medication, although it notes, "finding it difficult to terminate Clopine". That's at page 117?
A. Yes, I've got that.

Q. Then a further letter dated 24 January 2018, again continuing with Clopine is the plan. Do you see that, page 118?
A. Yes, I have.

Q. And the final letter is dated 11 January 2018, again referring to cutting the dose of Clopine from 50 to 25 milligrams. Do you see that?
A. Yes, I do.

Q. That was important background information to inform your risk assessment of Mr Cauchi's request in relation to the medical certificate for access to firearms, is that right?
A. I would say, yes, it definitely corroborated some of the information that he provided.

Q. All right. Can we go now please to the medical certificate that you provide on 20 January. This is back at your records, tab 808, volume 22, page 7.
A. Yes.

Q. We'll bring that up on the screen. This is a medical certificate dated 20 January 2021 and addressed, "To whom it may concern". So, this is two days after you've seen Joel Cauchi with the benefit of the collateral information from The practice, correct?
A. Correct.

Q. You say, "I've reviewed Joel Cauchi on 18 January 2021 at the clinic for an hour-long assessment. I have also had the opportunity to talk to his previous psychiatrist". Pausing there, that's not correct?
A. Not talk to. I think that's a semantic error on my part on there. It should have meant contacted his clinic or gotten in contact with the treating clinic as such.

Q. You're clear about that?
A. Yes.

Q. At no point did you speak to - all right.

A. No, I did not have.

Q. "It's provided information on his progress over the past few years". Do you see that?
A. Yes.

Q. It goes on,

> "Mr Cauchi has had a history of psychotic episode in his late teens that required inpatient admission. At that time, he was commenced on clozapine, which was later changed to aripiprazole, and this was subsequently adjusted for dosage and eventually weaned off".

You see that?
A. Yes, yes.

Q. There's no reference there, is there, to the inconsistency in Mr Cauchi's report regarding the clozapine?
A. No, there isn't.

Q. And I suggest there should have been? Do you agree?
A. Yes.

Q. "His mental state at present is stable and he's in remission without any active symptoms of mental illness". And you go on to say, "He does not pose an imminent risk to himself or others at this stage". Do you see that?
A. Yes.

Q. That language of "imminent risk to himself or others", where have you drawn that from, that phrase?
A. I think it's usual clinical practice, and I suppose it's become a habit after treating in psychiatry and working in psychiatry for a number of years. So generally, when we talk or comment about risk, we talk about immediate or short-term risk and long-term risk. And it's become sort of a habit of nature to comment on imminent risk. So, if there was any imminent risk, then I suppose the treating provisions within the Mental Health Act would be considered as well.

Q. You go on to say, "He's currently not on psychotropic medication, and has been in remission in the absence of treatment for the past 18 months". Pausing there. Were you in a position to form that view, based on the fact that you knew that Mr Cauchi had ceased treatment with Dr A in March 2020, correct?
A. Correct.

Q. And you weren't aware that he'd seen any other psychiatrist in the intervening period until he'd seen you on 18 January 2021, that's right?
A. That's correct, yes.

Q. You obviously hadn't seen him during that period. Were you in a position

to say that he was in remission in the absence of treatment for the past 18 months?
A. Well, given the fact that when I saw him he was in stable mental state, and there were no signs of emerging symptoms or any of the signs of relapse, I thought it was a fair statement to make that he was in remission for the entirety of that duration.

Q. Looking back on this medical certificate, do you think you should have qualified the certificate in this way: that is, by indicating that "Today he appears to be stable and may be in remission. However, I am not his regular treating psychiatrist, and I note he was last seen in March 2020"? Do you agree?
A. Yes, definitely. Yes, I agree.

Q. Can I suggest another problem with this medical certificate is that it does not qualify itself in the terms that Mr Cauchi indicated to you, namely that he wanted a fitness assessment for the purposes of target shooting at a range, under supervision, once a week or once a fortnight. That's what he told you?
A. That's what he told me, yes.

Q. And you don't put that in this medical certificate, do you?
A. No, I didn't.

Q. And you should have done?
A. I probably should have done. I think it depends upon what Mr Cauchi intended to do with them medical certificate. Normally when patients request us of certificates, we generally give a brief synopsis of the assessment that we have done, and a general impression of where they are with any - we don't generally include recommendations either. Because those certificates could be for people seeking employment, those certificates could be for people to submit to universities in case they need extra time with their courses or curricular. It, it wasn't very clear as to why he needed that certificate.

Q. Well, it was clear though wasn't it? That's what he told you during the assessment. We can go back to your clinical notes. We go back--
A. I think that was--

Q. If we go back to your clinical notes. Page 1--
A. Yep.

Q. --"Today's review, for the purpose of medical fitness so that he can visit a gun range and practice target shooting"?
A. Yeah. But I did not think that that was sufficient enough for him to submit in order to get that access to the gun range.

Q. Right. Then we can go to your letter to Dr Ruge on 18 January. This is what you say:

> "Joel informs me that today's assessment was in order to obtain a medical report certificate on his current mental state and risk so that

he can provide it to the local gun range where he wishes to practice target shooting under supervision once a week or once a fortnight"?

A. Probably, yeah. Well--

Q. So, that's what he told you, isn't it?
A. That's right. Yes.

Q. And that's what you should have put in the medical certificate I suggest?
A. Yes.

Q. So, we're talking about the period 18 to 20 January when you write this certificate. Had you ever come across a request for a firearms risk assessment like this before at that point in your career?
A. Not before that. We, we - I've had occasions where I had to submit a weapons notification report with Queensland Police to sort of remove access to firearms from some individuals that we had seen during the course of our work at the public community health teams in hospital. But never a request like this where somebody could apply for a licence.

Q. All right. And as we've canvassed, there was at least one red flag, in that the past psychiatric history that Mr Cauchi was giving you didn't accord with the collateral information that you obtained, that's right?
A. Yes.

Q. Did you seek any advice or guidance from any colleagues in relation to whether you should write such a medical certificate?
A. I had spoken with one of the colleagues who was part of our peer group review. So, but it wasn't during the formal peer group session, but just an informal sort of discussion as to what are the things that I need to be looking at, and what are the steps that I should be taking before we proceed with giving him the approval or declining him the approval.

Q. Did you do that before 20 January 2021, or did you do that at a subsequent point - and we'll come to it - when you receive a letter from the Queensland Police Service asking you for a firm recommendation about whether or not Mr Cauchi was a fit and proper person for a weapons licence? Did you do it at that point?
A. I don't exactly recall when that happened. But it would have been a few days after the assessment, so I suspect it may be after 20 January.

Q. And in fairness to you, there are now, from the Royal Australian and New Zealand College of Psychiatrists firearm risk assessment guidelines that came out in September 2023. You're aware of that?
A. Yes, I am.

Q. You didn't have the benefit of any such guidelines at the time in making--
A. No, I didn't.

Q. --in forming this risk assessment?

A. No, there were none.

Q. Moving forward, we know that in response to your medical certificate, you were then sent a letter from Queensland Police from Acting Sergeant Larfield. If we go to that at tab 835 volume 23, page 1, please?
A. Yes.

Q. This is a copy of a letter dated 8 February 2021. It refers to your letter of 20 January 2021, which of course is the medical certificate, advising the result of an examination of Joel Andrew Cauchi. And it says:

> "Before any further consideration can be given to the Statement of Eligibility application, it's requested that a firm recommendation be provided by yourself to this office as to whether you consider the abovementioned to be a fit and proper person to be issued with a weapons licence authorising the possession and use of firearms, given the need to ensure public and individual safety".

Pausing there, what did you understand the reference to "Statement of Eligibility application" to be?
A. That there would be a certain set of criteria within the Queensland Police legislative framework or within the State legislative framework in order to - for people with a background history of either mental illness or any other illnesses, that would impact upon their use of such firearms.

Q. You didn't understand that to refer to a particular provision in the Weapons Act 1990?
A. I don't think I understand the specific reference over here.

Q. There's reference to some case law and to a tribunal decision to the effect that "The tribunal has to be satisfied there's virtually no risk in giving a person access to a firearm". Do you see that?
A. Yes, I saw that at the bottom, where it says that there has to be virtually no risk.

Q. Yes. Did you consider obtaining legal advice in connection with this letter from Sergeant Larfield?
A. No, unfortunately, at that time I did not seek legal advice.

Q. Had you ever received a letter along these lines before?
A. No. This was the first time.

Q. Did you consider whether you needed to review Mr Cauchi again, in light of the matters raised in the letter?
A. I could have. Although having said that, I don't think there would have been much change in his presentation or mental state. But yes, I definitely could have seen him again to challenge him on certain aspects of these things.

Q. Do you recall whether you accessed any of the links that are referred to, for example, "I refer you to the Health and Weapons Information available" at a

particular link. Do you see that?
A. Yes. That's, that's the link I checked.

Q. That's the link you checked. And can I suggest that, if one goes through a process of going first through Queensland Police, one then ultimately ends up at tab 835A, volume 23, Health and Weapons and Information booklet. Do you see that document?
A. Yep.

Q. That's the document that you accessed upon receipt of this letter?
A. No, there was a different website that it took me to. And then, eventually I think there's a booklet on that somewhere on that web page.

Q. Is this the booklet?
A. Yes, it looked similar to that, yes.

Q. Do you recall reading through the booklet?
A. Yes, I did look at some of the provisions that were laid down, and I think there's a flowchart at the end of it.

Q. And did the flowchart inform your assessment of whether or not you should form a view about Mr Cauchi accessing firearms?
A. It was a useful flowchart, yes.

Q. Do you recall looking at any of the risks associated with firearms on page 5?
A. Page 5.

Q. If you don't recall whether or not you accessed that information, it would be understandable--
A. I don't recall exactly reading all of that. But a lot of the points that were made here were part of the assessment that I did with him in the clinic.

Q. Which were the points that informed your assessment?
A. So, particularly whether he had access to a firearm, whether he had ownership to a firearm, and the answers to which he said, "No". If he had had said yes, then I would have checked, "Where was it stored? Who else had access to it? Was the ammunition stored separately?" and other sort of associated questions.

Q. What about protective factors? Did you give consideration to whether there were protective factors in relation to Joel Cauchi?
A. He did have a lot of protective factors. I mean, I'm assuming that we're talking about clinical protective factors, yeah?

Q. Well, the protective factors that are referred to in the booklet. You will see under "Risk of aggression, violence and--
A. Yeah.

Q. --risks associated with firearms. Also note the presence of protective

factors and supports". Do you see that?
A. Yes, I saw that line.

Q. And did you give consideration to protective factors in that context?
A. I only gave - how should we say - due cause for protective factors in terms of a wider context, which would have been his support networks, his clinical presentation, his state of mind at that time, and basically whether he was willing to sort of adhere to the procedures that were there in place, and access to help if he needed them.

Q. When you say "he was willing to adhere to the procedures that were in place", what do you mean?
A. The legal requirements of - for him to access the firearm.

Q. So, did you understand that you were in effect conducting an assessment as to whether or not Joel Cauchi was a fit and proper person to be issued with a weapons licence authorising the possession and use of firearms, and in order to form that view, you needed to be satisfied that there was virtually no risk by virtue of the decision that was cited in the letter from Sergeant Larfield?
A. Yes, that was mentioned in the letter, yes.

Q. But is that what you understood your threshold was? That you needed to form the view that there was virtually no risk associated with providing this medical report?
A. Yes. That's the wording in the letter, and my understanding was that that is what they required.

Q. And did you consider that you were in a position to attest to whether or not Mr Cauchi was a fit and proper person?
A. Given the assessment that I had, given the information that I had access to and my own assessment, I was of the opinion that he was somebody who posed, like, very low risk to himself and others at that point. He also did not have any previous history of aggression or violence. And these are some of the risk predictors that we take into account. It is very difficult for us in clinical practice to predict on future risk, because it's a very dynamic sort of situation. And clinically, we are never in any position to say or comment that somebody's of virtually no risk, and can be of virtually no risk in the future.

Q. But when you say that he "had no history of aggression or violence", was that your evidence?
A. Yes. That was partly from part of the assessment.

Q. That was based on--
A. And--

Q. Sorry?
A. Sorry, I was just going to say that, past history of violence and aggression is one of the most significant predictors of future risk of aggression and violence.

Q. That was based on information that Mr Cauchi had reported to you? That's right?
A. Yes. Yeah. And there was no mention of any past incidents of aggression or violence in the documents that I received from the clinic as well.

Q. That was only a very limited subset of documents, wasn't it?
A. That's correct. Yes.

Q. So you were otherwise reliant on Mr Cauchi's information?
A. That's correct.

Q. And you knew that he'd been an inaccurate historian, at least in relation to the period of time he was on clozapine?
A. That's correct. Yes.

Q. So I suggest that you should have been very cautious about whether or not you could rely on him telling you that there was no forensic history, or history of violence or aggression. Do you agree?
A. Yes. I agree.

Q. Can we go now please to your medical report. This is the report in response to the letter of 8 February 2021 from QPS. Your letter is at tab 836, volume 23, page 1, on 19 February 2021. It's addressed to Acting Sergeant Larfield. You thank him for the letter regarding a recommendation for holding a weapon's licence, "I saw Mr Cauchi at Dr C's practice on 18 January 2021 for this assessment, details of which are outlined below." You don't there indicate, do you, the limitation we talked about before, in terms of noting that you are not his treating psychiatrist, this is the first time you've seen him?
A. Yes.

Q. And that should have been noted?
A. I think so. Yes.

Q.

> "Joel informed me that the assessment was in order to obtain a medical report certificate on his current mental state and risk so he can provide it to the local gun range where he wishes to practice target shooting under supervision once a week, or once a fortnight."

You include that detail in this medical report, and I suggest that's appropriate. Do you agree?
A. Yes.

Q. You go on then to include a lot of details that have come, it appears, from your clinical notes, fairly directly--
A. Yes.

Q. --almost in the nature of a cut and paste. Correct?
A. That's correct. Yes.

Q. And then, ultimately, on page 2 under the heading "Impression", you indicate, "He presents with stable mental state. No acute psychotic symptoms at this stage." And you say, "His level of risk to himself and others is low." Pausing there--
A. That's correct.

Q. --what were the factors, in summary, that informed your assessment that the level of risk to himself and others was low?
A. Well firstly, it would be a response to direct questioning and assessment of whether he had any thoughts of wanting to hurt himself; whether he had any suicidal thoughts; any intent; any thoughts of wanting to hurt others; the previous history of any incidents of aggression or violence towards other people, and any mention of such instances; or any forensic history that could have been included in collateral information received from the GP or his previous treating psychiatrist.

Then the second half of it would be formed by the mental state assessment to assess for any disorder of thought form; content; any delusional beliefs; any other unusual beliefs or suspicions that he might be harbouring; or any other signs of an active mental illness, or signs of relapse.

Q. Those were the matters that informed that view?
A. Yes.

Q. In that reference to your opinion that "Mr Cauchi is a fit and proper" - we're missing the word "person" - "to be issued with a weapon's licence at this stage", you've picked up directly from the language in the letter to you from Sergeant Larfield. Is that right?
A. That's right. Yes.

Q. And then you've set out the plan below, "I've advised him to have six monthly reviews to monitor for mental state, even though he is currently asymptomatic. He does not require any psychotropic medication at present." Do you see that?
A. Yes. I do.

Q. The guidelines that I referred to that came into effect in September 2023, have you had an opportunity to review those?
A. Yes. I have.

Q. Do you think that they're a helpful publication?
A. I'd say they're a very helpful publication. Yes.

Q. Can I just pause in relation to that topic. Do you think that you likely consulted a peer, or a colleague, in relation to providing this medical report, prior to providing this medical report on 19 February 2021. Is that your best recollection?
A. Yes. Definitely before that.

Q. What was the nature of that discussion?
A. It would be around things such as what are the things we need to consider for these things. So it would be around the clinical assessment, the clinical impression at that stage, obtaining collateral from previous treating doctors. It would have been around, or looking at, whatever guidelines were available, and basically on the website that was linked onto Sergeant Larfield's letter regarding Queensland - the firearms licensing web page.

Q. Can I suggest that consulting with a colleague in that manner was a diligent step to take. Do you agree?
A. I would say, yes, I think it just would have also highlighted if I'm missing out any important information, or steps, towards having access to that information, then that would have been flagged up as well. So it would have helped me do better.

Q. I'm going back to the guidelines now, and I don't suggest that, of course, you had access to these. They were not extant at the time of your assessment. But a point that is made in the guidelines at paragraph 5.6 is this:

> "It's possible for a mentally healthy person to experience a rapid deterioration of their mental health if exposed to trauma, adverse life events, or after developing problems with substance use. Applicants also have a vested interest in having their application approved. Some applicants may be reluctant to reveal information they feel may jeopardise their application."

Do you agree with that?
A. Yes. I do agree.

Q. And you knew that Mr Cauchi had told you false information regarding the length of time he was on Clopine?
A. That's right.

Q. I suggest, given that circumstance, you ought not to have provided a medical report in support of Mr Cauchi's application for access to firearms. Do you agree?
A. Yes. I acknowledge.

Q. Can I go now please to some of the expert evidence that I understand you've had an opportunity to familiarise yourself with. Dr Olav Nielssen has provided an expert report. Paragraphs 33, 156 and 157, in effect, set out the view that because of the risks associated with a person who suffers from schizophrenia, having access to firearms that that ought not be permitted. That is the effect of those paragraphs that I've referred to. You're aware of those paragraphs?
A. Yes. I have read them.

Q. Do you have a view, given your extensive experience in psychiatry?
A. Well in, in my experience there is an associated increase of risk of violence towards other people, especially when it comes to the perpetrators who have

had a history of mental illness, especially something as significant and severe as schizophrenia. And I think when we take into account some of these things there usually are policies and guidelines and measures to safeguard, shall we say, the general public at large, but we also have guidelines and safeguards in place for an individual's autonomy and things like that.

I think it's, it's probably not, for me as an individual, to have a say in what it needs. I think we need a wider collaboration, not just between clinical specialists, but also between law enforcement agencies and perhaps the state legislative frameworks in order to come up with, you know, more robust and tighter frameworks and thing - which - I don't know whether - there would be some who might advocate for a blanket ban on permission of access to firearms for anyone who has had a history of mental illness, and there will be people who might oppose that view and they might do it on a case by case, and an individual basis. I think, professionally, I would be inclined to sort of review each case on merit based on whatever the associated risks are, and where each person is in the trajectory of their recovery and progress.

Q. Dr Ed Heffernan has also provided a report, and at paragraph 6.2 he indicates that in terms of Joel Cauchi's attendance on you--
A. Yeah.

Q. --there's a reference to it being unclear as to the plan to support the proposed reviews of Joel Cauchi. That's at paragraph 6.2. You're aware of that reference by Dr Heffernan?
A. Let me just quickly pull up that report. I have read his report.

Q. I can read it for you, if that's quicker. At paragraph 6.2 he says this:

> "Dr C's report addressed to Weapons Licensing Queensland Police notes that he advised JC to have six monthly reviews of his mental state (presumably by a psychiatrist). This did not happen, and it was unclear from the report if there was a plan to support this to happen."

Do you see that?
A. Yes. Yeah I saw that.

Q. What do you say to that comment?
A. That was the plan. So as we discussed earlier, Mr Cauchi was advised to book an appointment in about six months' time, and unfortunately that didn't happen.

Q. Dr Heffernan also says at 7.2.3 that "this was an opportunity for you to re-engage Mr Cauchi in treatment and care in a pro-active manner". Do you agree?
A. Yes.

Q. Do you think you did that?
A. Well I, I did recommend that he make an appointment. Unfortunately, he

wasn't at that stage where we could enforce treatment on him.

Q. Dr Edwin Kruys, an expert GP, comments along these lines at paragraphs 37 to 40. In effect, he says:

> "A more recent review by psychiatrist Dr C led to a recommendation for Mr Cauchi, communicated to Dr Ruge in a letter dated 18 January 2021, to have six monthly reviews to monitor for mental state, even though he's currently asymptomatic."

Paragraph 38, "From Dr C's letter it is, however, not clear who should perform the recommended six monthly reviews." And he goes on at paragraph 39 to suggest:

> "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 that would assist with longitudinal care provision across health care sectors."

That's his recommendation as to some potential systemic reform. Do you agree?
A. Absolutely agree with that.

Q. Why's that?
A. Because I've worked across public sector and private sector, and there's a lot of, what shall we say, opportunities where we could improve the system, and we could improve, improve on collaborative care. Not just between specialists and primary care professionals, but also other allied health professionals, such as psychologist, OTs, and even social worker input. I mean, there is - the number of people that get access to continued public health care is very, very limited, and a lot of it is based on the nature of the acuity of their symptoms, or when they present in crisis, or when somebody needs mandatory treatment under the Mental Health Act.

Once people get better and they are in better control of their symptoms and either are on treatment, or not on treatment, they often get discharged to the GP's care, and the GP has to manage them by themselves, and a lot of the time they don't have access to that collaboration from specialists, whether they be from private rooms, or whether as part of the public mental health systems. And not all of these patients can afford the fees that are charged by the private health practitioners, and this is also a big barrier to them accessing specialist care once they get discharged from the public mental health system.

Q. You understand the circumstance being that Mr Cauchi, in effect, was lost to follow-up after this appointment with you. There was one further GP appointment in November 2023, but, in effect, that was the end of his mental health assessment, or treatment. You understand that circumstance?
A. Yes. I do.

Q. Do you have any other reflections, or comments, for the State Coroner?
A. I think in hindsight I, I would have, you know, done things a lot differently. I probably would have been more insistent on him coming to see me again before I provided that certificate. I probably would have consulted a legal member, as per your indication - suggestion as well. And perhaps, you know, been a little bit more diligent in ensuring that he continued with treatment, either with us at Dr C's practice, or whether he wanted to continue see his GP.

Q. Thank you for those reflections. That's appreciated. How might you have been more diligent, do you think? How could you have effected that?
A. Probably personally calling him and finding out if he's booked an appointment and if he's coming back again, where is he living, how is he going, you know, doing certain things like that and if there were any other issues, I mean, I know we don't have permission to give information to his mother but maybe I could have asked her to see if she had heard anything from him and if there were any concerns on her part in whether the, there was enough cause over there to flag it up with acute mental health services in the district that he was living in at that point.

Q. Those are all things that you have done with other patients, is that right?
A. Not always, it's only when there is somebody with a history of quite significant deterioration or where they posed a risk to themselves or others.

Q. Thank you.
A. Thank you.,

HER HONOUR: There may be some other questions.

HARRIS-ROXAS: No questions from me, your Honour.

HER HONOUR: Yes, Mr Fernandez.

<EXAMINATION BY MR FERNANDEZ

Q. My name is Lester Fernandez.
A. Hello.

Q. I act for the family of Faraz Tahir. He was the security guard who was killed on 13 April last year. I'm going to try as much as I can not to go over the same things that you've just been asked.
A. Sure.

Q. But to touch upon the evidence that you've given.
A. Yes.

Q. The referral letter from Dr Ruge was addressed to you for the purpose of an opinion and management of Mr Cauchi's schizophrenia. You understand that, don't you?
A. Yes, I do.

Q. As can be seen from your clinical notes, is it fairly soon after you sat him down in your practice and started talking to him that he made clear to you that he wanted an assessment of his medical fitness so that he could visit a gun range and practice target shooting. Is that correct?
A. That's right, that’s correct, yes.

Q. Is that something that surprised you that the referral from the GP was about something entirely different to what Mr Cauchi was speaking to you about?
A. That's correct.

Q. The referral from the GP could have led to ongoing treatment. Do you agree with that? That referral for--
A. Yes, I do.

Q. --opinion and management of schizophrenia?
A. Yes.

Q. Whereas what Mr Cauchi was asking you about was more in the nature of a one off consultation, an assessment, or so a short period of consultations with a very specific purpose?
A. Yes.

Q. Was that something you thought about?
A. Yes, I did.

Q. Did you raise that with him while you were speaking to him?
A. Yes, I did.

Q. What did he say? I'm sorry I'll say it again. What did you say to him about that?
A. Well, I would have informed him that the referral was basically for management and treatment of schizophrenia and based on the notes that I have document because I can't really recall the exact conversation that we had. I believe his response would have been along the likes of I've been doing well, I've been off medication, I just need a certificate for X, Y, Z.

Q. As you went on to describe, he gave you a number of details which at first you took at face value. Is that correct?
A. Yes.

Q. When he said to you, "I've been doing well, I'm all right", did you say anything about "Why did you go and see Dr Ruge? Did you go and see Dr Ruge about an opinion and management of your schizophrenia?" Did you raise that with him?
A. No, I don't think I did.

Q. As we can see from the clinical notes--

FERNANDEZ: I'm wondering if we could pull those up, please. I think it's

tab 808. I'm wondering if we could expand the size of that, please, and could we go down to today's review and just expand that, could we - yes.

Q. What I'm showing you now is the clinical note where you've made a note that Mr Cauchi doesn't own guns. The last time he went to a range was when he was 25 years old and some other details that you can see there. That was the note you made, is that correct?
A. Yes, that's correct.

Q. In terms of him coming to see you for a medical fitness so that he could visit a gun range, did you ask him any details about why he wanted to visit a gun range?
A. I asked him why and his response was just so that he could practice target shooting.

Q. That's not referred to anywhere in your clinical notes or in any letter to any other person. Is that correct?

MATHUR: I object to that. It's factually incorrect.

SULLIVAN: ..(Not transcribable)..

FERNANDEZ: I'll withdraw that question.

Q. Did you ask him where it was that he wanted to go to, which gun club or range?
A. I can't recall whether I asked him specific details of the location but he said it was one in Brisbane.

Q. It was one in Brisbane, is that right?
A. Yeah.

Q. Could he give you any more information other than that?
A. No, he didn't give me details of the actual club or the address of the club.

Q. Did he tell you any plans about what it was that he wanted to do in terms of pistol shooting or anything like that?
A. No, just that he wanted to go to a target range and practice shooting over there.

Q. Did you ask him why he had this idea after 12 years to go to a target range to start practicing?
A. Not specifically, no, not, not in the very specific way that you have asked me that, but I did ask him why he wanted to do it and look, I can't exactly recall what it is that he said, but I think for him it was just an opportunity to socialise with people.

Q. Is that something you remember him saying an opportunity to socialise with people?
A. Not exactly in those specific words, no, but I think he just wanted to do

something in his spare time.

Q. What he wanted to do in his spare time was to go to a gun range. Is that right?
A. That, that would have been his implication, yes.

Q. Did you ask him previously when he'd been to a gun range what he'd done and for how long?
A. I did ask him and he said there was just a one occasion or something.

Q. He'd gone to a gun range once at the age of 25. Was that your understanding?
A. That was my understanding, yes.

Q. And now he wanted to join a gun range you think possibly for social reasons?
A. That, that was my inference.

Q. What he said to you was that he wanted to go to do target shooting under supervision. Is that correct?
A. Yes.

Q. He'd emphasised to you that was going to be under supervision?
A. Yes.

Q. He also said to you that it was going to be once a week or once a fortnight. Is that correct?
A. Yes.

Q. Did you get the feeling that he was trying to put your mind at ease in terms of his access to guns at a pistol range?

SULLIVAN: Your Honour, I object to - the difficulty with this is that we understand that Dr C has no recollection of the actual attendance. We've got the benefit of his notes. I'm not sure how far this can ultimately be taken.

FERNANDEZ: I press the question because we have got evidence now of additional material, additional information from this consultation which Dr C has just referred to.

HER HONOUR: Could you repeat the question?

FERNANDEZ: The question to Dr C was, did he get the impression that Mr Cauchi was, I think, was understating or was trying to reassure him as to the conditions of his pistol shooting. It was to that effect. It's not that exact question.

HER HONOUR: To give him comfort?

FERNANDEZ: Yes. Dr C.

HER HONOUR: Yes, I'll allow the other question.

FERNANDEZ: I'll try and remember that question.

Q. Did you get the impression that Mr Cauchi was giving you information to understate or to give you comfort about his access to firearms when he was speaking to you?

MATHUR: Your Honour, I maintain the objection. I did stand earlier to object and counsel assisting raised a point. We know that the eligibility certificate is limited to a very specific scenario, namely the situation as reported in Dr C's notes, namely a pistol club where shooting is under supervision. What is the relevance of impression when Dr C has specifically outlined what he was told and that is consistent with the eligibility certificate that Mr Cauchi was granted. So, there's no inconsistency between history reported and eligibility certificate which was given.

HER HONOUR: I will allow the question. He can say yes or no.

FERNANDEZ

Q. Did you get the impression that Mr Cauchi was trying to comfort you or was understating the reasons for him to go to a pistol range to shoot pistols?

MATHUR: I take the objection again. There's no understating. That's the point. Mr Cauchi's request--

FERNANDEZ: I'd ask that evidence not be stated in front of the witness.

HER HONOUR: I think the reference is to under supervision and once or twice a week.

MATHUR: But the under supervision is correct. A pistol club is not an unsupervised environment.

HER HONOUR: I'll allow the question.

FERNANDEZ: Could I just ask the question, your Honour.

HER HONOUR: Yes.

FERNANDEZ

Q. For the fourth and final time, and I'm sorry for all these interruptions.
A. That's all right.

Q. Did you get the impression that Mr Cauchi was trying to comfort you or understate his access to shooting pistols at a pistol range? Did you get that impression?

A. No, I did not get that impression.

Q. Did you ask Mr Cauchi during this consultation other than in relation to schizophrenia, did you ask him whether he'd ever been diagnosed with any other mental illnesses or conditions?
A. Yes, that would have been powerful cause for any assessment that we do.

Q. What did he tell you?
A. If it's not mentioned in the notes, then he didn't give me any information.

Q. The reference in your notes is to schizophrenia. Is that correct?
A. That's correct, yes.

Q. That's the sole reference to mental conditions that he suffered in the past, is that right?
A. Yes, yes.

Q. Did you ask him, other than the medication he'd mentioned, whether he'd been prescribed with any other medication?
A. Yes, that's a standard line of assessment. We, we always ask for any other medications that they have been on and any other comorbid with psychiatric conditions.

Q. In terms of, there's the document that you've provided that's now exhibit 5?
A. Mm-hmm.

Q. That's the consent to the sharing of information, and there's reference about Mr Cauchi referring to his mother as an emergency contact. You recall that?
A. Yes, yes.

Q. Just leaving that aside, did you specifically talk to Mr Cauchi about wanting to speak to his family to get their history or their information or insights about him?
A. No, I didn't.

Q. Did you specifically raise that with Mr Cauchi?
A. No, I did not.

Q. Why is that?
A. Because it's not something that we do as a matter of standard assessment. And a lot of the times, especially when it comes to young people, there's always a stigma around mental illness, and they don't often want many of their family members, even if they're next to kin, involved in their care that rather, you know, take more autonomy and responsibility for their own health.

Q. Was it an assumption you made that when he had this episode of schizophrenia at the age of 17, that his family would have supported him at that time?
A. Yes.

Q. There's no real stigma for him then, was there, about speaking to his family? Was that what you were thinking?
A. Yeah, I don't think there was any particular stigma when it came to his family, but he was a young man who had moved out of Toowoomba and was living independently in Brisbane now.

Q. You took what he said at face value during the course of that consultation, is that correct?
A. Yes.

Q. You later got some documents from Dr A, but you agree that speaking to family is a very important source of information about a schizophrenia patient, don't you?
A. Yes, I do.

Q. For example, Mr Cauchi told you that there was no known history of schizophrenia in his family. That's a detail that you could have specifically raised with his family members, do you agree?

MATHUR: Your Honour, I'm going to object to this further line of questioning because implicit in the questioning is that it is incumbent upon a psychiatrist to speak to family in or--

FERNANDEZ: Could this not be said in Dr C's presence? It really touches on his evidence. Could the screen be muted please, so that my friend can make her submissions?

HER HONOUR: Are we able to do that?

Q. Sorry, Dr C, it won't take long.

AUDIO VISUAL LINK DEACTIVATED

HER HONOUR: Yes, Ms Mathur.

MATHUR: The objection is that implicit in the line of questioning is that a failure to speak to family is in some way a failure on behalf of the specialist psychiatrist with respect to the assessment, or the consultation, he undertook. And in circumstances where Mr Cauchi at the time was about 36 or 37 years of age, it simply cannot be said that there is a requirement upon a psychiatrist to engage family in collateral history on every occasion unless there is something in the history that's obtained that would warrant that.

HER HONOUR: I think that Dr C is able to say that, and you're also able to ask him about that when you're examining him as well.

MATHUR: Yes, my concern is with the implication in the question, and that is that it's a requirement of the consultation--

LTS:DAT

HER HONOUR: Just one moment.

MATHUR: I note Dr C. I've made my objection. I won't--

AUDIO VISUAL LINK ACTIVATED

FERNANDEZ

Q. Dr C, you had made a note that Joel Cauchi told you that there was no known history of schizophrenia in the family, is that correct?
A. That's correct.

Q. But when you actually spoke to the family, that was something that you would be able to substantiate for yourself, is that correct?
A. If I had spoken with the family, yes, then I would have been able to find that out.

Q. You had talked about schizophrenia patients as being not entirely truthful, is that correct?

MATHUR: I don't think--

WITNESS: That's correct.

HER HONOUR

Q. Sorry, just a moment.

HER HONOUR: Do you want to--

MATHUR: It's been answered. It was somewhat of a loose question, but it's been answered.

FERNANDEZ

Q. That was something you were mindful of, the possibility that Mr Cauchi was not entirely truthful with you, is that correct?
A. It could have been a possibility, yes.

Q. You know, because you're a psychiatrist, the nature of schizophrenia is it impacts on the person's thoughts, perceptions, emotions and behaviour. That's right, isn't it?
A. Yes, it does.

Q. One characterisation of what someone might say to you in a consultation is that they're not very truthful. Do you agree that another consultation - sorry, another characterisation - is that they were trying to manipulate you. Do you agree with that?
A. I'm not sure about the use of the word "manipulation". People sometimes don't always share the truth, and yes, perhaps as you've alluded to earlier, that

there they might want to make the specialist feel a little bit more at comfort or ease.

Q. Something you also have to be mindful of is deliberate dishonesty by a patient--
A. Yes.

Q. --is that correct?
A. That's true, yes.

Q. That's why you needed to be cautious with the information that Mr Cauchi was giving you. Do you agree with that?
A. Yes, I suppose so, yes.

Q. I want to go to now the letter that you wrote of 20 January 2021. Do you recall that's the letter where you said you've had the opportunity to talk to his previous psychiatrist?
A. Yes.

Q. You described that as a semantic error, saying that you had the opportunity to speak to his previous psychiatrist. Could I just ask you this, when you wrote that letter, what did you think that someone reading your letter would understand those words to be?
A. That I had actually spoken with the person in question.

Q. Why did you not just say, "I've had access to his previous psychiatric records"?
A. As I said, that was a semantic error on my part, and I do acknowledge that I made a mistake over that.

Q. Can I just ask you that question again?
A. Sure.

Q. Why did you not just say, "I've had access to his psychiatric records"?

SULLIVAN: Your Honour, it was an error.

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

FERNANDEZ: All right, I'll move on.

Q. After you got the reports that you got from Dr A, you said that the medical information that Mr Cauchi gave you had been corroborated. Do you recall giving that evidence?
A. Yes.

Q. It's also the case though, in terms of his medical history with Clopine, that the information you got from those few reports from Dr A contradicted the information that Mr Cauchi gave you, do you agree with that?
A. Yes, just the duration of the time that he was on Clopine.

Q. But that was a substantial difference, wasn't it? Two years as opposed to 15 or 16 years?
A. That's right.

Q. Did that cause you to doubt some of the other information that Mr Cauchi had given you?
A. It would have been, but, you know, the important part of it was that he actually was on treatment and that treatment was eventually taken and ceased under medical supervision. I was more focused on that part.

Q. Is there a difference between a patient being on Clopine for two years as opposed to a patient being on Clopine for 15 to 16 years?
A. It depends on individual circumstances. I don't think we can generalise at the experience of two patients in those situations equally.

Q. For you, being asked by Mr Cauchi to give him an assessment so that he could get a - go and practice pistols, for you, was that an important difference?
A. I wouldn't say--

Q. The difference between what he gave you and what you knew as a matter of fact?
A. I wouldn't say that the duration of the treatment was as important as it was the duration of his remission.

Q. In terms of the duration of his remission, you were very much relying on the information he himself gave you, is that a correct statement?
A. No, that was the information that I was seeking from The practice as well. And the letters that I received confirmed that his medication was in fact ceased in 2019, 2020, I think. 2019.

Q. You already had a concern about why he was seeing a psychiatrist for 18 months when he didn't appear under any medication, is that correct?
A. Not concerns, but as I said earlier, it was just unusual for somebody to have monthly appointments as opposed to three monthly or six-monthly appointments. And different people have different arrangements with their treating specialists, so it's not, not my position to sort of judge them for that if they have frequent appointments. It's just sort of something that was a little bit outside usual standard practice.

Q. Being outside of the usual standard of practice, did you think to yourself, "Look, I'm going to get on the telephone to Dr A and just get some information about Mr Cauchi", was that something you thought to yourself?
A. I could have done it, yes, and I probably in hindsight should have contacted Dr A and spoken with her myself.

Q. Can you say why you didn't? Why you didn't do that?
A. I think after I received the letters there was nothing in those letters to sort of flag up any concerning signs or symptoms.

Q. After getting the letters from Dr A, did you think then, "Look, I might speak to the family now and get some more information"?
A. The letters very explicitly mentioned that Mr Cauchi's mother was present for his appointments with Dr A, and that the feedback from her was also positive.

Q. Did you--
A. So, it then - sorry.

Q. I'm sorry, I didn't mean to cut you off. Please finish.
A. No, I was just saying that at that stage I was confident that the family were in agreement with the changes that were proposed in treatment.

Q. Why was that? Because there was a note that his mother was present at a consultation?
A. Yes, yeah, at those consultations. And also gave feedback that he was actually doing better since the Clopine was stopped.

Q. Something like whether Mr Cauchi had a history of aggression or violence, that's something you could directly speak to his family about, do you agree with that?
A. Yes.

Q. You were asked questions about the limitations on you in getting all of this information in the space of a one-hour consultation. The fact of the matter is, if you had, if you wished, you could have made another time to speak to Mr Cauchi, couldn't you?
A. Absolutely, yes.

Q. And in that further consultation, you could go through these different matters that just didn't seem to match up with the history that he gave you, do you agree with that?
A. Yes, that's right.

FERNANDEZ: Those are my questions, your Honour.

HER HONOUR: Thank you. Mr Roff?

ROFF: No questions, your Honour.

FRECKELTON: No questions, thank you.

ROBB: No questions, thank you, your Honour.

WILSON: No questions.

LYNCH: Nor do I, your Honour.

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

CALLAN: No, your Honour.

CHIU: No, your Honour.

CASSELDEN: No, your Honour.

JORDAN: No questions.

HER HONOUR: Thank you. Ms Mathur.

<EXAMINATION BY MS MATHUR

Q. Can I just confirm with you, I understand your evidence was at the time of writing this certificate with respect to, back to the Queensland Police, was this your first occasion of being asked to write a certificate of this nature and receiving a letter from Queensland Police?
A. Yes, that's correct. It was my first such experience.

Q. Since this time, have you been approached again in similar terms, namely, to approve a gun licence in specific scenarios?
A. Not in specific scenarios, but it was quite coincidental that that week we actually had two referrals. Mr Cauchi's was the first one and then there was a second gentleman who was referred to the clinic for, I won't say similar circumstances, but it was again something to do with renewing his weapons licence.

Q. So, since January of 2021, is it the case that you haven't needed to revisit the legislation or the requirements with respect to a certificate of approval or eligibility?
A. No, I haven't since then.

Q. I think you've indicated you read each of the expert reports in this matter, that's correct?
A. Yes, I have, yes.

Q. It's correct, isn't it, that none of those experts make mention, do they, to the professional practice guideline that came into force in September 2023 from the Royal Australian and New Zealand College of Psychiatrists?
A. That's true, yes.

Q. Can I ask, were you sent that guideline on any College of Psychiatry portal that you access in order to bring it to your attention that it now existed?
A. Not that I can recall. Because we get a monthly newsletter from the College as well, and I don't recall seeing any item in that newsletter about these guidelines.

Q. You were asked questions in relation to the follow up and your letter which indicates that you advised Mr Cauchi to return, or to have a review in six months. In your evidence in questioning with counsel assisting, you said that you were not in a position to enforce treatment upon him. Can you tell us in

what circumstances as a specialist psychiatrist do you have powers to enforce treatment upon a patient?
A. So within the State of Queensland you have to satisfy certain criteria that - the Mental Health Act - to enforce treatment upon somebody. First of which is the presence of an active mental illness. Secondly, it has to be demonstrated that that person does not have insight into their illness. Thirdly, they lack capacity to take an informed decision about their treatment. And fourthly, there has to be a substantial risk to themselves or others as a result of the mental illness.

Q. When Mr Cauchi presented in your consulting rooms, did you form an expert opinion as a psychiatrist that he met any of those criteria?
A. No, he did not meet any of those criteria.

Q. Can I ask you, the new guideline I think you've already indicated, or sorry, the guideline of September 2023, I'd ask you firstly to assume that it is the first and only guideline in relation to firearm risk assessments which has been issued by the College of Psychiatrists. I think you've indicated in your evidence that you have had an opportunity to read that guideline, correct?
A. Yes, I have read it, correct.

Q. In that guideline, if you turn to - I don’t think you have a copy of it with you, do you?
A. I do have them.

Q. I just want to draw your attention to paragraph 5.1 and 5.2 of that guideline.
A. Yes.

Q. That's where the guideline addresses the issue of whether it should in fact be within the remit of a psychiatrist to give an opinion as to whether a person is a fit and proper person. Do you have those paragraphs there?
A. Yes, I have them in front of me.

Q. It goes on to say, doesn't it, that a psychiatrist can only conduct a risk assessment of a person at the current time in their life, their current mental state, and based upon collateral information available to them in that assessment?
A. That's right, yes, that's what the statement says.

Q. Was that your understanding - putting the guideline aside - did you operate within those, within that prism at the time when you gave a risk assessment of low with respect to Mr Cauchi?
A. I would say so, yes.

Q. Can I just lastly take you to the final page of that guideline, and it falls at paragraph 9.7?
A. Yes, I have it.

Q. Perhaps if we could bring up paragraph 9.7 on the screen. Doctor, can I ask you to read paragraph 9.7 to yourself, and when you've finished reading it,

let us know and we'll bring you back on the screen?
A. Yes, I have read it.

Q. At the time when you assessed Mr Cauchi, was it the case that you also likewise were not losing sight of your primary task, namely an assessment of the safety of the person rather than the firearm?
A. That is true. And it would have also included not just risk to himself, but risk to any other people at that point in time.

Q. And that's why you expressly state in your letter back to Queensland Police that the context of your assessment was fit and proper within a supervised environment of a pistol club. Is that correct?
A. That's correct. Yes.

MATHUR: Nothing further, thank you, your Honour.

SULLIVAN: Nothing arising, thank you, your Honour.

HER HONOUR

Q. Thank you very much, Dr C. You're excused.

NO EXAMINATION BY MS HARRIS-ROXAS, 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

AUDIO VISUAL LINK TO JAPAN CONCLUDED AT 3.16PM

SULLIVAN: Mr Murphy will take the next witness.

HER HONOUR: Thank you, Mr Murphy.

MURPHY: Your Honour, I call Dr John Pietsch. Mr Pietsch's statement is at tab 809, vol 22. And he's taking an affirmation.

LTS:DAT

<JOHN PIETSCH, AFFIRMED(3.17PM)

<EXAMINATION BY MR MURPHY

Q. Could you please state your full name?
A. Yep. John Edward Ross Pietsch.

Q. And what's your current employment?
A. So, I'm a general practitioner at Northpoint Medical Centre, as well as I'm employed as a senior medical officer as - or a GP with special interests, in a palliative care role at the Toowoomba Base Hospital.

Q. You've given a statement in this matter dated 20 June 2024?
A. Yeah, that's correct.

Q. Do you have any corrections you'd like to make to that statement?
A. No.

Q. So, you've indicated you're currently a general practitioner?
A. Yes.

Q. And you were a general practitioner at the time of your consult with Mr Cauchi on 13 November 2023, is that right?
A. Yep, correct.

Q. Your general practitioner practice is based at Northpoint Medical Centre?
A. Yes, that's correct.

Q. And that's in Toowoomba?
A. Yes.

Q. What qualifications do you have?
A. So, I've got a MBBS, which is a Bachelor of Medicine from UQ in 2008, and RCGP College Fellowship from the GP College in 2013. Subsequently, I've just received a diploma in palliative medicine over the last six months, which I had been undertaking during the time of the matter at hand.

Q. In relation to your undergraduate qualifications in 2008, and then in relation to the 2013 qualifications, was there any particular training in mental health that you undertook as part of those courses?
A. Yes. During the standard medical school training, there's always a mental health component to that. I - it may have been between eight to ten weeks throughout the course of the medical school. And during my residency years, or intern year, I at least did five weeks in a mental health term at the Southport Hospital at the Gold Coast, which went, that no longer exists. But, yeah, it's the public hospital at the Gold Coast.

Q. Did that period in which you were at that public hospital, did they have a particular focus on any types of mental health illnesses in that ward?
A. It wasn't from my memory specific, but they certainly had a range of

presentations in that ward of schizophrenic patients or bipolar would be probably the most common, and then severe depression would be the next after that, from memory.

Q. So, you've had a brief and limited period in which you had some involvement with patients suffering from schizophrenia, amongst other conditions?
A. That's correct. I mean, that's in just the specific role as a junior doctor in that time.

Q. In your role as a general practitioner, have you had any experience in dealing with patients that suffer from schizophrenia?
A. Yes, I have, over the course of the 15 years I've been working in, in that role.

Q. And have those patients been medicated for their schizophrenia?
A. The vast majority have been. I can recall maybe one patient within that 15 years' time that had a previous psychotic episode. Whether it was schizophrenia or a, a drug-induced psychosis. But, that patient is - was no longer on medication. Apart from that, most of them were, you know, chronic schizophrenics or well controlled schizoaffective or bipolar patients who might have been on these medications long-term.

Q. As a result of that experience, are you conscious or aware of the signs and symptoms associated with schizophrenia?
A. Yes. I'm aware.

Q. How do they tend to generally manifest, if you could explain that very briefly?
A. So, typically, between the umbrella groups of positive and negative symptoms, the positive symptoms are more relating to delusions of thought and hallucinations of various forms, and my understanding is the negative symptoms are more associated with withdrawal from society and lack of self-care and disorganisation generally. It's a - yeah, that's, in a nutshell.

Q. Mr Cauchi, when he attended your practice on 23 November, needed a medical assessment in order to renew his licence, is that correct?
A. Yeah, that's correct.

Q. That was because he had M category designated on his licence?
A. That's correct. So, M - in Queensland at least, the M means "medical" - well, it's a conditional licence based on a medical certificate.

Q. In effect, you need to carry a medical certificate with you when you're driving, that's the consequences of an M condition?
A. Yes, that's correct.

Q. What's the role that a general practitioner plays in relation to that M condition?
A. So, it's variable, depending on what the medical condition is. The

commonest reason we do it is generally everybody above the age of 75, it's a standard line in the sand that everybody requires a certificate once they're above that age, every year. Otherwise, it may be conditions such as diabetes or sleep apnoea are the other common ones. And epilepsy. But there's - the AustRoads Guidelines have information based on many, many medical conditions that you have to refer to if you're uncertain of what the specifications would be for each of the medical conditions.

Q. And I'll come to those guidelines shortly. Is undertaking an assessment of whether a person's fit to drive something that you do commonly in your practice as a general practitioner?
A. Yes. I did it twice yesterday morning alone. So, it's - it would be at least five or six at least per week. But, again, the majority are for over 75 year old patients.

Q. Has there been many occasions which you have done it in relation to a person suffering from a mental health condition?
A. I can't recall another instance of this. There, there is no - when a patient comes and they say they have an M class licence, there's not necessarily any, any way that the doctor, the GP, can access what the conditions were originally for in the first place. So, it could have been started 15, 20 years ago, and it's up to the patient and the doctor to figure out what the conditions were historically. So, there's not necessarily any way you can kind of know what the original conditions were specifically.

Q. So, you're reliant upon the patient disclosing information to you?
A. Yes.

Q. As well as any other collateral that you can obtain?
A. Yes, that's correct.

MURPHY: Could we bring up the document, the AustRoads document titled "Assessing Fitness to Drive", which is at vol 45, tab 1603.

Q. Is this the document that you very briefly referred to earlier?
A. Yes. It's, goes through different iterations. But yes, that's the most recent one.

Q. And you accept that it's the 2022 edition, but as at November 2023, it still remained the current edition?
A. Yeah, it's - glancing at it, it looks less familiar than the other older version that I would have looked at more often. But it - and I think there's different ways you can access it. So, yes, it's essentially the most recent one.

Q. You can take from me it is the most recent version that counsel assisting have been able to locate. Are you aware that when you're completing a medical assessment for a fitness to drive, that that must be conducted in accordance with the standards that are set out in this document?
A. Yes.

Q. Could we just briefly go to a few aspects of this document. If we could first go to page 16. And in particular, under the heading "Dealing with individuals who are not regular patients". And I'll just read some extracts of that.

> "Some drivers may seek to deceive health professionals about their medical history and health status, and may doctor shop for a desirable opinion. If a health professional has doubts about a person's reason for seeking a consultation, they should consider asking permission for the person to request their medical file from their regular health professional, conducting a more thorough examination of the person than would usually be undertaken, noting on the medical report returned to the Driver Licencing Authority the length of time the patient has been known to them, and whether the health professional had access to the full medical record/history".

Do you agree with those matters?
A. Yes, I do.

Q. And in your experience in your general practice, what particular issues do you need to be alert to when seeing a patient for the first time who's asking for a medical assessment for their licence?
A. Yeah, there's obviously a vested interest for some patients to get their licence if they've been told by another doctor - for example I've had an occasion where a - the doctor's - sorry - the patient's regular GP had taken away this patient's licence. I think he may have had early dementia or something similar. And, yeah, that's been an occasion where I've refused to complete the things, if you get a bit of a sense that something's not adding up with the patient and what they're telling you, and what your assessment is. So, it's certainly something we'd have to be wary about, if you have a new patient turning up for a licence like this.

Q. In that instance that you're talking about where the patient had been refused his licence from his consistent GP, did you obtain that information by contacting that general practitioner?
A. I can't recall that instance what happened in the end. But he - I think the patient - I may have sent a letter to the other doctor, and it - I can't recall what occurred eventually with that, the other patient. But basically, I'm illustrating that I'm aware that people can be deceptive, and you have to be mindful of that if you're having them turn up out of the blue.

Q. Is obtaining information from a previous doctor or specialist that a patient has seen, when you're seeing them for the first time, an important part of avoiding the issues that may be associated with dealing with a patient for the first time?
A. Yes. It definitely is important to get background information as much as you can. And in real time, it's difficult to get things sometimes to make an accurate assessment in that time. So, you may tell the person, "We'll just get some information first, and come back next week to do this", if it's feasible. That's not always the case.

Q. It may not be feasible because the patient might not return, or what causes it to not be feasible?
A. Yeah, they, they may not return, or, yeah. Ideally, you'd have access to all the information, but that's just not how the world works, unfortunately, in terms of having information immediately at your disposal, so it's an imperfect way that often there's a lag between requesting notes, and the notes turning up, and the quality of the notes may not be that useful, and then if the person doesn't come back again, then that's the end of it.

Q. So there may be a lag in information provided?
A. Yes. Definitely.

Q. There may be imperfect information provided?
A. Yes.

Q. And you may not have access to information at all that might be of assistance?
A. Yes.

Q. If we could just scroll to page 22 of that same document, and under the heading "What Monitoring Is Required For A Conditional Licence". I'll again just read very briefly some extracts from that. "Conditional licences should be subject to periodic review so that medical condition, disability or treatment, including the compliance with treatments, can be monitored." And then skipping to the next paragraph:

> "In the course of providing advice about a conditional licence, health professionals should advise the driver licensing authority of the period for which a conditional licence could be issued before formal review."

In your experience, how does a general practitioner, in completing an assessment, ensure that a periodic review occurs?
A. There's not really a good mechanism apart from, potentially, you could set a recall in the practice software to send a letter - an automated letter or text, perhaps, the next year, so the patient may get a reminder. Otherwise, you very much relies on the patient, themself, to do that.

Q. Could you set an expiry on the time period in which the certificate of assessment is valid?
A. Typically it's between one year and five years you split the - yeah - the - I actually don't think there's an upper limit. But one year - actually, you can do less than that. So you can have instances where you were waiting for something and you give - if you didn't extend it for a month, you couldn't get the information that you required, say like a result of a sleep apnoea test, say, you might extend it for one month until you got that information, and then they come back, and then you've got the information you need to fill out the form as appropriate.

Q. If we could then go to page 23, which is the following page. Under the

heading "7.1.1", which is down that page under the paragraph starting, "People with schizophrenia may have impairments across many domains of cognitive function", and then it lists a number of matters under there. If you just want to read them to yourself very quickly. Are they matters based on your general practice and experience dealing with patients with schizophrenia, and from reviewing these guidelines that you're familiar with when undertaking an assessment?
A. Yes.

Q. And then finally, at page 28 of that same document, the second column in the second row. That sets out the circumstances in which a person suffering from a psychiatric condition is not fit to hold an unconditional licence, and the circumstances in which a conditional licence may be considered by the driver licensing authority subject to period review. Do you see that?
A. Yes.

Q. They are all matters that you have in consideration when conducting an assessment for a person suffering from a psychiatric condition?
A. Yes.

Q. Turning to the appointment with Mr Cauchi on 13 November 2023. Had you had any prior appointment with Mr Cauchi prior to then?
A. No.

Q. And there were no subsequent appointments with Mr Cauchi?
A. No. He was going back to New South Wales the next day.

Q. Is that something that he told you during the course of his consultation?
A. I think so, yeah. There was the implication - going - he came up here to get the licence, potentially visit his parents, and then head back down to New South Wales because it was expiring the next day.

Q. Mr Cauchi completed a patient registration and information form before seeing you. Is that right?
A. Yes.

MURPHY: If we could bring that up at tab 810, vol 22 at p 5.

Q. Just going through that document. On page 6, the first table on that page, which records, "Your Health History. Do you have or have you had a history of" and it lists a number of other conditions, and then has "Other". You agree Mr Cauchi has circled "No" for the particular conditions and then has also indicated that there are no other conditions. Is that right?
A. That's correct.

Q. And then further down that page under the heading "Family History" where there's a question in relation to the family history of mental illness, Mr Cauchi has also indicated that there is no family history of mental illness. Is that right?
A. That's correct.

Q. And then on the following page, page 7, under the heading, "Is there any other information that you believe we should know that may affect or have an influence on the medical treatment advice you will be provided with", Mr Cauchi's also indicated "No". Is that right?
A. That's correct.

Q. Do you review this form prior to attending a consultation with a new patient?
A. Typically I would. I can't recall if I did in this instance, but it's - yeah - it gives general demographic information, but it's not necessarily relied upon as gospel as to what their history might be, so you always have to do a secondary assessment - initial assessment of the patient to get a history. Some people may not want to put specific details on these forms, because it's their own business, and it's for them and the doctor to talk about. So it's not uncommon for people not to put much detail on them.

Q. You understand that that's a starting point--
A. Yes.

Q. --and the rest is to be obtained during the consultation, potentially?
A. Yeah. I rely very little on that piece of paper.

Q. Do you recall approximately how long the consultation with Mr Cauchi was?
A. I think I looked at the notes the other day and it was about 16 minutes.

Q. Is that an average consultation time in your practice?
A. Standard appointments are 15 minutes. Some, you know, double appointments are 30 minutes if they're booked appropriately. But if, if things need to go longer, they need to go longer.

Q. You've indicated that Mr Cauchi suggested that he'd come up to Toowoomba in order to renew his licence and he was returning to Sydney. Did he tell you that he had done that, or how did you come to know that?
A. I think that's what he told me, from what I can recall. It may be corroborated with what I wrote in the notes. Yeah. The implication was he was returning back to Sydney, you know, very soon.

Q. They're the consult notes that you're referring to. Is that right? When you refer to "notes"?
A. Yes.

Q. They're on page 2 in tab 810. Is it your practice to prepare consult notes during a consult with a patient?
A. I typically do them immediately after the patient may have left, unless there's kind of breaks within a consult, if the patient has to go and do a urine sample, for example, you might use that time to use - to write notes, but typically it's immediately following the consultation.

Q. I'll just read out these notes:

"New patient. Needs medical for licence. Has M for medical on it. History a little hazy. After some digging found he has had significant mental health history. HPP system. Has been treated for schizophrenia on clozapine, but only as recently as 2012. Eventual transfer to Dr A since then. Has been apparently backpacking in around New South Wales/Sydney et cetera recent times. MSE today. Unusual affect. Poor eye contact. No overt bizarre behaviour otherwise. Denies being on medications any time recently. Ideally need collateral. Rang mother. Listed NOK next of kin. Confirms history of above. Had seen Dr A until two to three years ago. Had been put on M licence only when clozapine introduced due to drowsiness, and there's a question mark there. Has been weaned off antipsychotics with..(not transcribable)..but lost to follow-up over past few years. Will clarify regarding driving rules whether M licence still required."

Going through these notes just in order. You've recorded that the history is a little hazy?
A. Yep.

Q. Did Mr Cauchi disclose to you that he had a mental health history?
A. Well he asked - well he needed a medical for his licence, which was a bit unusual for a, a younger person, so if I was doing a medical for a licence I'd have to have some understanding on what the medical was - what the conditions were for in the first place. So he did seem reticent to kind of give me good detail about exactly what the history was and when it was in placed, the actual licence conditions. So then I pretty quickly resorted to other ways to try to get other information about it all.

Q. We'll come to those other ways. When you say he was "reticent to provide information", was Mr Cauchi vague, or did you consider that he was trying to conceal information from you?
A. He struck me - I said with - you can see later I said an "unusual affect", I think. By that I meant he was socially awkward and difficult to kind of converse with in a flowing kind of manner, which wouldn't be unusual for people without schizophrenia, as you can have that with severe anxiety disorders, autistic spectrum disorder, these kind of - there's a lot - a broad array of people in society who have, especially as a GP, you see a lot of different personality types and different communication styles, so - yeah - it wasn't immediately anything but saying the history was not a very flowing back and forth conversation that was easy for me.

Q. Did that raise any concerns with you?
A. It flagged that I needed to dig deeper to get more information that wasn't forthcoming.

Q. In terms of that digging deeper, you refer in the consult notes to the HPP system. Could you explain briefly what that is?
A. Yeah. So in Queensland, at least, there's the Health Practitioner Portal

which gives doctors who are able to - well who have done the appropriate paperwork and identity checks, and the such, to access the public system. For most hospitals within Queensland. I think there's a few exceptions. But it can essentially give you real time access to a lot of information from the public sector, in terms of, you know, medical history, which is very, very valuable in a real time sense.

Q. You've said that doctors will have access to that system subject to registration?
A. Yes. Correct.

Q. That system contains information about most of the public health system in Queensland?
A. There's exceptions like - I think the Mater Hospital, potentially, isn't on that system for whatever reason, but most other public hospitals are. But then not every bit of information is going to be on that system, but it's still a lot more than you would get otherwise.

Q. Does that system contain any information about private health systems?
A. Not necessarily. There's some aspects of it. Say if somebody had a scan, or blood test, that were ordered privately in a private system, you may be able to access. That's kind of through a - the My Health record. But then that's populated onto that system as well, sometimes. It doesn't always occur, though. But generally there's not any record of private, private specialists' notes or any other things from the private system. That's all very separate.

Q. Once you accessed the portal during your consultation with Mr Cauchi, what did you learn from that?
A. I learnt that he had had the history of schizophrenia being on the drug clozapine up until 2012 when he has been discharged into the private sector.

Q. As you've said, it didn't have any information about continuing treatment after 2012?
A. No, it did not.

Q. Did you ask Mr Cauchi once you had access to that information if he's treatment with clozapine continued after he's discharged from the public system?
A. Yes, and then I, yeah, I then proceeded to also ring his next of kin to collaborate the story because if he was supposed to be on a drug and he wasn't, that's immediately, well, a red flag that things would have changed quite quickly.

Q. What did Mr Cauchi say to you about his treatment with clozapine after you'd accessed the portal?
A. I mean he, he said that in collaboration with the treating psychiatrist he had been successfully weaned off the clozapine over a course of a number of years and had remained off medications successfully and functioned well enough to attend university in Brisbane in the years following being off medication.

Q. You then recalled that you conducted an MSE. Is that a mental state examination?
A. Yes, that's what it stands for.

Q. Was that before or after the call with the next of kin which is Mr Cauchi's mother to the best of your recollection?
A. It was probably, you know, in amongst the whole thing. I mean it's, yeah, it's not one thing after another necessarily, writing these notes after the fact. So, it's, yeah, it's, it was in, in around talking to him and looking at the notes and talking to the mother, and yeah, it's all a fluid thing.

Q. What was the observations that you took from the mental state examination?
A. As I stated before, he was quite reserved in nature, not necessarily in an alarming fashion and nothing, no sign of any psychotic symptoms or any, he was well kept and did give - did not give the immediate impression of someone who was mentally unwell, in a psychotic sense. I think I remember when I saw the mention of the clozapine, it seemed to not line up with what I was looking at in front of me. My understanding of clozapine was it was the last ditch effort drug. So, at the time, I think I was surprised that someone who had been on that was now successfully living a life not on that drug.

Q. When you say a last ditch effort drug, is that because you understand clozapine to be used for treatment-resistant schizophrenia?
A. Yeah, my, my memory of, and you don't, I don't, in GP, you don't often see patients on clozapine. It's, they tend to be quite unwell patients who are very much within the case management of the public psychiatric teams. The experience I'd had as a resident was the clozapine patients were quite unwell and the side effects involved are quite extreme at times. So, it's essentially, you would try to use a medication with less side effects if you can get away with it. That's the general gist is you don't resort to clozapine unless, you know, nothing else has worked. So, I guess that describes treatment resistance in a roundabout way.

Q. Given Mr Cauchi had been diagnosed with schizophrenia and then had been treated with clozapine as a treatment-resistant, or a drug used where schizophrenia is treatment-resistant, did his appearance at the consult surprise you, given the diagnosis that you'd identified in the practitioner portal?
A. Yes, it did. He, he didn't give the appearance of someone who had been unwell enough to have needed a drug of that nature. To be organised enough to get interstate, to have a medical for a licence that's due the next day, it's not something that you'd associate with someone with a psychotic illness bad enough to kind of need that kind of drug. So, there's in a, in a gut feeling way, it, it wasn't something that was immediately made sense in my head.

Q. Appreciating it's not your area of specialty?
A. No.

Q. But the fact that Mr Cauchi was suffering from schizophrenia and was

organised enough to attend your practice in advance of his licence expiring was surprising?
A. Yes, that's, yeah, yes.

Q. The notes recall that you also had a telephone call with Mr Cauchi's mother, Michele Cauchi?
A. Yes, that's correct.

Q. What was the contents of that call?
A. I think I wanted to correlate that, yes, he had been weaned off medication successfully over a period of time, and he had been in remission for a number of years since then and functioning well. I don't recall exact specifics about the conversation. But if I had been anything but reassured by the conversation, the next steps I would have taken would have been different. I, I overall remember it being a relatively reassuring conversation though, that it lined up with what the history had been given to me was.

Q. Do you recall if you asked her about whether Mr Cauchi had been exhibiting any symptoms of schizophrenia after he had come off his treatment with clozapine?
A. Yeah, I, I, I think I, I would have been asking her about, you know, whether he's been well recently at his baseline, essentially, and there was no expression at that time of any concerns.

Q. And she didn't raise any previous concerns she might have had about Mr Cauchi going off clozapine?
A. Not at that time, no.

Q. And that, we don't need to bring it up, but at 2.12 of your statement in this matter, you indicate that she informed you that he was weaned off the clozapine without any relapse. Is that right?
A. That's correct.

Q. You said that nothing that she - to the best of your recollection, what was said to you during that call didn't raise any concerns and assured you, is that right?
A. Yes.

Q. If Ms Cauchi had raised concerns with you, what might you have done differently?
A. If she had raised concerns, I would have taken that as a trigger to change the trajectory of the consult completely and look at getting emergent - well, not necessarily emergency psychiatric assessment, but be more forceful in trying to get psychiatric assessment done at that time regardless of what his stated plans might have been in terms of returning to New South Wales the next day. If I'd been given any kind of inkling of his - you know, if she'd said he's, he's unwell and he, he needs psychiatric help desperately, I would have been doing everything I could to make that happen with or without resorting to the Mental Health Act.

Q. Your notes also refer to that Mr Cauchi was lost to follow-up over the past few years?
A. Yes.

Q. Is that saying that Michele Cauchi told you during that telephone call?
A. I can't recall that specifically coming from her. I think it was just a reference to his involvement with Dr A in Toowoomba specifically and then he relocated to Brisbane. So, I didn't know the details of him seeing subsequent doctors or psychiatrists following leaving Toowoomba.

Q. Did you have any concerns upon hearing that or upon understanding that?
A. Not specifically at the time. I can't recall.

Q. Going now to the medical assessment that was undertaken and the form that was completed which is at page 8 of tab 810. Having conducted the assessment, you state in your statement in this matter that you decided to maintain the status quo in the absence of further information about why the M licence was required?
A. Yes. I think I was led to believe the reason he'd been put on it, the conditional licence, was the clozapine itself was causing drowsiness which was an issue with the driving specifically. So, I think that was where I was probably a bit confused as to the reason. If he was no longer needing medication as adjudged by the psychiatrists, then I was questioning if he's - if the only reason he was on the licence whenever that was started, if he's no longer on that medication, does he need the M licence still.

Q. Was that information given to you by Michele Cauchi during the telephone call or?
A. I think it was - that’s where that, yeah, that belief came from on my behalf.

Q. You would ask why there might be an M condition on the licence, and she'd informed you the clozapine and drowsiness?
A. Yeah, yeah.

Q. Is that right?
A. I think so, yes.

Q. The best of your recollection?
A. The best of my knowledge, yes, and recollection.

Q. Did you give any consideration to referring Mr Cauchi to a specialist psychiatrist or to a psychiatrist for any further assessment as part of this process?
A. If he hadn't been going back to New South Wales the next day, there would have been a lot more feasible options to open that avenue. I think that the time, the aspect of things in that regard may have, well I think it definitely did kind of change what may have happened otherwise. Yeah, if, if he'd stayed and engaged longer and built rapport, that definitely would have been, you know, a likely part of what would have happened down the track but--

Q. When you say if he stayed and got rapport, that is if he remained as a patient at your practice?
A. Yes, correct, or even in the State, like that's yes, if it's within the State it's one thing, into another State, that's a whole other level of difficulty to access help if you're trying to refer someone somewhere.

Q. Looking at that medical certificate that has been completed on page 8 and at the bottom of that page there's handwriting which is unfortunately side on in this document. Is that your handwriting?
A. Yes, that's my handwriting.

Q. Could you just read out what is in the text under licence condition restrictions?
A. I think previous health, sorry, mental health treatment order periodic review.

Q. And then on the following page on the right hand side under the M under other conditions and or restrictions?
A. "Periodic r/v" which means review, "previous mental health order".

Q. What did that mean from your perspective?
A. It meant from the best of my knowledge that's why he had been put on the conditional licence in the first place whenever that had been. There was no way I could know exactly when the licence started but that's what I surmised the reason was in the first place.

Q. Is the condition here that Mr Cauchi was required to attend periodic reviews going forward?
A. For the purpose of his licence, yes, he would have required medical certification periodically over time.

Q. What was that period to be?
A. It - well, in this case I made it line up with his, the actual expiry of the physical licence itself and in part that was, the timing of that's probably in relation to how reassured I'd been by the collateral I'd been given. I could have put different dates on that but being interstate as well it's - yeah, it's not necessarily - yeah, there's no exact guidance as to how many, how many months or years you're supposed to do these periodic reviews in the, in the document of AustRoads. It's, it's often left pretty broad and up to interpretation.

Q. And that expiry date is 13 November 2028?
A. Yeah, that’s correct.

Q. You indicated earlier in your evidence that the review periods could last from one year to almost unlimited?
A. I think it's basically - there's some conditions where it's a lot more specific, as in say a commercial licence for type 1 diabetes is a very specific thing saying it's within - you know, it can only be up to one year. Other conditions within the AustRoads guidelines don't have a specific review. They just say periodic review which doesn't specify a date or time, it's up to whatever you

judge it at the time.

Q. Do you agree that for a person who's suffering from a long-term mental health condition it may be preferable to have shorter review periods?
A. Yes, I'd agree with that.

Q. Could I just take you to tab 810 at page 17? This is a letter that you sent to Mr Cauchi's psychiatrist in Toowoomba, Dr A. Was this following the consultation with Mr Cauchi?
A. Yes, it would have been directly after it.

Q. In that you've asked for,

> "Seeking some clarification regarding Joel's mental health history. I met Joel for the first time today in the context of being seen as a new patient at Northpoint in order to have renewal of his driver's licence which is expiring tomorrow. Collateral from his mother. Joel wasn't frankly psychotic at this point". And then skipping ahead, "I could not find a reason why he requires an ongoing M on his licence, to be honest".

A. I think you could see the mention I made of I was under the impression that the licence was really commenced while he was on the clozapine.

Q. Yes.
A. As a result of the clozapine. So, I think that aspect of it probably misled me to some degree in this way. And it's probably essentially why - well, the tone of that letter is asking if he's not on clozapine anymore and that's fine, why does he need the M on his licence if it was only because of the clozapine? And similarly, that's probably, that would be why I wrote the five years as opposed to a shorter frame in that regard as well.

Q. You had sent this letter seeking further clarification and a response to - is it a question about why he was on a M condition licence?
A. Essentially, yes.

Q. Did you ever have any telephone calls with Dr A?
A. I don't recall of a telephone call with her, no.

Q. Is it possible that you did have a telephone call that you just don't recall?
A. It is possible, but I think my legal team's checking our phone records currently to collaborate that. But I don't recall ever talking to her.

Q. They'll be made available to this Court if they're accessed. Given the records that you have prepared in relation to this consult, is it likely that you would have included a notation about any telephone conversation with Dr A had one occurred?
A. Yes, I would have.

Q. Just to assist you, Dr A has given evidence in this matter that she did have

a phone call with you, and I'll just very briefly read that to you.

MURPHY: This is for day 13 transcript 977 to 978. Counsel assisting is questioning Dr A.

> "Q. Dr Pietsch then in November 2023 contacts the practice following his consult with Joel. At this stage it's been three years since there's been any contact between the practice and Joel. Did you make any enquiries as to how Joel was doing at that stage?
> A. He called me. It was good so I--
>
> Q. Who called you?
> Dr Pietsch. And we had a good phone conversation, and he said that the mother was there, or the mother also confirmed that he's good. So he, he mentioned in this phone call that I can't see any reason why, why he can't get a driver's licence. The M is there because of the schizophrenia, would stay, and the mother is, and he said, I can remember that the mother was there and that."

And then a further answer, "He said", in reference to yourself,

> "The first time I see this bloke and he's really good. He says he's schizophrenia and he hasn't had any problem. The mother is here and I can't see why he can't have a driver's licence and Medicare for driver's licence. And we agreed that to put the M on".

Does that prompt your recollection at all?
A. No.

Q. Does that sound like a conversation you would have had?
A. If I'd had that conversation, I would have written it in the notes.

Q. Was it common for you to speak on the telephone to psychiatrists, or to any other specialists, or would you usually do it, communicate via letter?
A. It's relatively rare to have phone conversations. Like depending on the urgency of the situation and availability of each other. You often would have to ring, leave a message and talk to them later. But in this instance, given I wrote a letter, that doesn't make sense that I would have written a letter after just talking to her.

Q. Then if we go to page 11 of page 810 - page 10, apologies - this is a letter sent from The practice and signed by Dr A dated 16 November 2023. "Dear John, thank you for your recent request for information relating to Joel who I last consulted with in April 2015". And then enclosing some letters. That covering letter doesn't refer to any telephone conversation, does it?
A. No.

Q. Then scrolling through the following pages, 11 through 14, through to 15, these are the records that you were provided with following your request?
A. That's correct.

Q. You've indicated that you subsequently reviewed those letters and determined that no further action was required in relation to Mr Cauchi, is that right?
A. It - I'm not sure when the letters came, but it would have been a number of days after the initial appointment that, when I reviewed the letters in my inbox. So it's correlated with the information I'd gotten from both the Health Practitioner Portal as well as the collateral from his mother and what the patient had said in terms of this is, you know, he's been taken off the medications and it's not all coming out of nowhere.

Q. In an ideal world would you have obtained this collateral from a former treating psychiatrist before completing the medical assessment?
A. Yes, ideally.

Q. In this instance there were time impositions that limited your ability to do so?
A. Yes, that's correct.

Q. In terms of the GP letters that were provided to you, was that information adequate for your purposes?
A. It didn't really answer the question I asked in the letter, but it did correlate with the, as I said before, it correlated with the story I'd managed to figure out. The - she may have never had anything to do with his driver's licence, so that may well preceded her involvement completely.

Q. Would you have expected to, or based on your experience and making requests of this nature, do you generally receive more or less information from specialists when requesting information?
A. More - say that again, sorry?

Q. In your experience as a general practitioner, when requesting information from specialists in relation to a patient who's consulting with you, do you tend to receive more or less information?
A. Than this instance?

Q. Than this instance?
A. I mean it's, that's a pretty broad question. And it's not often you ask, like send a letter asking a question so much as what I'd done. Most correspondence to specialists is, you know, please see this person for this reason. But, yeah, it, it didn't really answer the specific question I was asking, so in this case it didn't really change anything that I already kind of knew.

Q. Did you give any consideration to following up in order to get an answer to that question?
A. Not at that point, because it kind of lined up with the story I'd been given, and, you know, he'd apparently been well for several years at that point without medication. So who was I to judge a psychiatrist's opinion if that's what's been decided as the right thing to do.

Q. If concerns had been raised by Mr Cauchi's mother with his treating psychiatrist Dr A and the clinic of which she worked at in late 2019 and early 2020 about a possible deterioration in his mental health and the risk of relapse following the cessation of his treatment with antipsychotic medication, is that information you would have expected to be provided to you?
A. Not necessarily. I mean this was, when I saw the patient, this was four years following that. It's, yeah, it's I don't know if that information was written down anywhere. No, I don't know how to answer it, sorry.

Q. If you take from me that the information was recorded in clinical records, would you expect that to be provided to you following a request in relation to that patient?
A. I mean it would have been helpful, yes.

Q. If that information had been provided, may it have changed your assessment?
A. It's possible. The time between 2019 and 2023, that's a different, it's different somebody saying on the phone, like his mother's conversation with me, that's reassuring that she said that to me on that day. What she may have said to somebody else four years prior, I can't comment on that.

Q. One of the experts that's been retained by the Court in this matter, Professor Heffernan, in relation to the consultation with you on 13 November 2023, has stated that there was an opportunity for a more assertive recommendation about reengaging in psychiatric care in relation to your consult. With the benefit of hindsight, do you agree that this was a missed opportunity for a more assertive recommendation about reengaging in psychiatric care?
A. Yes. Again, the time factor, the interstate factor, would have coloured my way I was approaching things in the, at the time. And the reassurance I'd gotten from the next of kin also relayed my urgency in that matter. But yes, ideally, that would be, it would have been good if it was appropriate to do it at the time.

But he was not psychotic at the time, so in order to force that issue, he would either have had to have agreed to an urgent assessment, which would have been hard to justify on my behalf, given his lack of symptoms. And then if I was really going to force the issue and invoke the Mental Health Act, it would be hard to justify that, given his lack of psychotic symptoms at the time.

Q. What's available to you as a general practitioner in circumstances where a person doesn't satisfy the criteria for involuntary admission, but has symptoms that are of concern to you in order to engage that person in the mental health system?
A. Yeah, so if it's not something that's looking like an involuntary assessment order and you're sufficiently concerned, you have in a scenario like in a GP practice, you might have a patient who's exhibiting manic or depressive symptoms and they're willing to engage in acute mental health care, we are able to get them to the emergency department via generally the ambulance is how we'd transfer people.

Unless they were, they came with, if they came with a friend or family who was reliable you could, you know, let them take the patient to the emergency department where they'd be assessed by the emergency department initially and then by the acute mental health services. So that definitely can be done if it's judged to be required at the time.

Q. But in short there are no, you can't force someone to engage in treatment for their mental health unless you have the concerns--
A. No.

Q. --or meet the criteria under the Act?
A. Unless you have the concerns of acute psychotic symptoms or concerns for harm to self or others at that moment in time, which is a very fluid concept, the concept of assessing risk. That changes rapidly, so you have to do it with the best of your ability at that time. And if you're not given very strong evidence, we're unable to force things on people.

Q. You mentioned earlier in your evidence that Mr Cauchi was returning to New South Wales, or he'd indicated to you that he was returning to New South Wales. Is there anything that could have been done to link him in with New South Wales health system that you're aware of?
A. It would be quite difficult. I think his - if he has an established relationship with a treating doctor, and there was a specific referral point given to you - I have done referrals for, for example, a specific surgeon who works in Sydney this patient wants to see.

So, if you have a very, very specific target, you can do interstate referrals. That's in the private system. In the public system, which would be more in the, this case, that would be problematic. It would be possible to contact the local health service in the district that the person lives in. I think the - if you're - it would be very difficult to do, without a fixed address as well, and interstate, it would be exceedingly difficult. You could give someone a referral to that system theoretically, and then it would be up to the - so, the mental health team in New South Wales to ring the number that has been provided. But if that person doesn't pick up the phone, or they're not in the address that's given, then there's nothing else that could be done on, on the referral end of things. So, it would be very difficult to make that happen, in reality.

Q. There's no formal mechanisms or procedures in place that you're aware of?
A. Not in a - there may well be ones within the mental health system, for example, if a known case managed client is moving State, you know, you can have a, a transfer of medical, medical care from one State to another. That, but doing it in a sense as a, yeah, in a, in a, in a new referral for a problem interstate, that would be very difficult to figure out how to do to actually make it happen.

MURPHY: No further questions, your Honour.

HER HONOUR: Thank you.

Q. Doctor, there may be some other questions.

HARRIS-ROXAS: No questions from me, your Honour.

HER HONOUR: Mr Fernandez?

<EXAMINATION BY MR FERNANDEZ

Q. Doctor, my name is Lester Fernandez. I act for a person by the name of Faraz Tahir. He was the security guard who was killed on 13 April last year. I just want to briefly ask you about the evidence you gave about the difficulties in making a referral to a psychiatrist in another State or a doctor in another State.
A. Yep.

Q. Short of making a specific referral to a specific doctor or a special local health district--
A. Yep.

Q. --would there have been a benefit in speaking to Mr Cauchi just in general terms about the benefit for him of establishing a relationship with a treating doctor?
A. Yes. That would have been ideal, yes.

Q. And short of making a specific referral to a psychiatrist, noting that you had written in your notes that he'd been lost to follow up--
A. Mm-hmm.

Q. --since seeing Dr A, would there have been a benefit in talking to him about the benefits to him in having some sort of follow up with the psychiatrist?
A. Yes.

FERNANDEZ: Those are my questions.

HER HONOUR: Thank you.

ROFF: No questions, your Honour.

FRECKELTON: No questions, thank you.

ROBB: No questions, thank you, your Honour.

LYNCH: I have no questions, your Honour.

MATHUR: Likewise, your Honour. No questions.

HER HONOUR: Court 2, any questions?

CALLAN: No questions, your Honour.

CHIU: No questions.

CASSELDEN: I also have no questions.

JORDAN: We also have no questions.

HER HONOUR: Mr Wilson?

WILSON: No, your Honour.

MURPHY: Nothing arising, your Honour.

NO EXAMINATION BY MS HARRIS-ROXAS, MR ROFF, DR FRECKELTON, MR CHIU, MS CALLAN, MR JORDAN, MR CASSELDEN, MS CLARKE, MR GNECH, MS MATHUR, MR PEN, MS ROBB, MR WILSON AND MR LYNCH

<THE WITNESS WITHDREW

MURPHY: Your Honour, there's nothing further for this week. Recommence on Monday at 10am with Mr Wilson, the security expert.

HER HONOUR: Yes, thank you. I'll adjourn until Monday 10 am.

AUDIO VISUAL LINK CONCLUDED AT 4.19PM

ADJOURNED PART HEARD TO MONDAY 19 MAY 2025